COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 2227-02
Bill No.: SB 577
Subject: Health Care; Health, Public; Social Services Department
Type: Original
Date: March 6, 2007

Bill Summary: This proposal enacts the "Missouri Health Improvement Act of 2007".

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2008	FY 2009	FY 2010
General Revenue	($25,088,491 to $25,188,491)	$7,329,133 to $11,729,133	$39,188,853 to $20,988,853
Total Estimated Net Effect on General Revenue Fund	**($25,088,491 to $25,188,491)**	**$7,329,133 to $11,729,133**	**$39,188,853 to $20,988,853**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2008	FY 2009	FY 2010
Insurance Dedicated	($36,922 to $41,922)	($49,679)	($51,169)
Total Estimated Net Effect on Other State Funds	**($36,922 to $41,922)**	**($49,679)**	**($51,169)**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 21 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2008	FY 2009	FY 2010
Federal	$0	$0	$0
Total Estimated Net Effect on <u>All</u> Federal Funds	**$0**	**$0**	**$0**

* Income, Savings and Costs of approximately $40M in FY08, $62.5M to $130.2M in FY09 & $129M to $159M in FY10 would net to $0.

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2008	FY 2009	FY 2010
Insurance Dedicated	1 FTE	1 FTE	1 FTE
Total Estimated Net Effect on FTE	**1 FTE**	**1 FTE**	**1 FTE**

☒ Estimated Total Net Effect on All funds expected to exceed $100,000 savings or (cost).

☐ Estimated Net Effect on General Revenue Fund expected to exceed $100,000 (cost).

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2008	FY 2009	FY 2010
Local Government	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Office of Administration**, **Office of the State Treasurer, Missouri House of Representatives**, **Missouri Senate** and the **Office of the State Courts Administrator** each assume the proposal would have no fiscal impact on their respective agencies.

Officials from the **Office of the Attorney General (AGO)** assumes that the implementation of this proposal will create no fiscal impact for this office. However, because the AGO is responsible for defending such legislation in constitutionality claims, AGO assumes that the nature of these provisions could create a fiscal impact. As a result, AGO assumes costs are unknown, but under $100,000.

Officials from the **Department of Health and Senior Services (DHSS) - Division of Senior and Disability Services (DSDS)** assume that anyone who is currently eligible for Home and Community Based services under the Medicaid program would be eligible for those services under the MO HealthNet program.

This legislation is not expected to fiscally impact the operations of DHSS. If a fiscal impact were to result, funds to support the program would be sought through the appropriations process.

Officials from the **Office of the Secretary of State (SOS)** assume this proposal creates the MO HealthNet plan to administer Medicaid and Medicare in the state through the Department of Social Services (DSS). Also, DSS and the Department of Insurance, Financial Institutions and Professional Registration (DIFP) are to work together to provide incentives for individuals to insure for long term health care. The DSS and the DIFP are to promulgate rules to carry out these provisions. These rules would be published in both the Missouri Register and the Code of State Regulations. These rules may require as many as approximately 300 pages in the Code of State Regulations and 450 pages in the Missouri Register because cost statements, fiscal notes and the like are not repeated in Code. The estimated cost of a page in the Missouri Register is $23. The estimated cost of a page in the Code of State Regulations is $27. The estimated fiscal impact for FY '08 is $18,450 ($23 X 450 + $27 X 300). The actual fiscal impact could be greater than $18,450.

Oversight assumes the estimated fiscal impact ($18,450) is correct. If actual costs is significantly greater than the estimated cost, the SOS may request additional funding through the appropriations process.

ASSUMPTION (continued)

Officials from the **Department of Mental Health (DMH)** assumes the DMH fiscal impact for the following sections: 208.153, 208.202, 208.950.10(2), 208.950.8, 208.950.9, and 208.950.10 are included in the fiscal note response prepared by the Department of Social Services (DSS).

MO HealthNet offers individuals a choice of three plans (coordinated care, administrative service organization or point of service/disease management). It is uncertain what plan DMH clients would choose and what DMH services would be included in each of these plans. It is further uncertain if the services currently offered by DMH would be utilized in the same manner in each plan. Under this arrangement, DMH assumes these programs would be coordinated with other services and that there may be a fiscal impact.

If, however, CPRC, CSTAR, Medicaid Waiver, and TCM are operated under a point of service/disease management program, rather than under a risk based or utilization management (ASO) contract, then these services would continue to be provided in the current system through a traditional fee for service payment methodology.

The proposal is not clear as to what role and/or the extent of the role the DMH, the DMH facilities, and DMH's contract providers would play in being the health care advocate and the health care home. Depending on what the responsibilities of the health care home would be, DMH could have additional cost.

DMH assumes financial incentives related to the pay-for-performance program, costs for the enrollment broker, costs related to disease management administration, and all actuarial costs are reflected in the DSS fiscal note.

Due to the population DMH serves, additional supports and assistance may need to be offered to the DMH client for the enrollment broker, risk-assessment and health care plan development function. DMH may incur some costs associated with these functions. DMH may need to offer specific pay for performance fiscal incentives to its community based providers for its clients.

Because the specifics of the program have not been determined, DMH is uncertain as to how DMH clients will fit into options offered by MO HealthNet. DMH assumes costs would be unknown, but greater than $100,000 above and beyond the DSS calculated impact.

ASSUMPTION (continued)

Officials from the **Department of Insurance, Financial Institutions and Professional Registration (DIFP)** assume the proposed legislation will create the need for one Insurance Product Analyst II FTE. This analyst will focus on all Long Term Care (LTC) contracts in addition to those needed to be pre-certified for compliance with the Partnership Program as described in this legislation. This analyst will also track LTC rates, draft a report for the Department to present to the legislature, and coordinate with other state agencies in the Partnership Program.

Additional actuarial assistance may be needed as the evaluation and development of the program progresses.

Approximately 100 insurers may be required to submit amendments to their policies to comply with legislation. Policy amendments must be submitted to the Department for review along with a $50 filing fee. One-time additional revenues to the Insurance Dedicated Fund are estimated to be $0 - $5,000.

Oversight has, for fiscal note purposes only, changed the starting salary for the DIFP position 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 **Department of Social Services - Division of Legal Services (DLS)** assume this proposal adds facets to the Medical Assistance program. There are several places where the Administrative Hearings Unit would have the possibility of an increase in hearings. In total, DLS does not see a fiscal impact on its division.

Officials from the **Department of Social Services - Children's Division (CD)** state Section 208.151.1(26) RSMo is inserted to extend MO HealthNet coverage to children under 21 years of age and who, on the individual's 18th birthday, was in foster care under the responsibility of a State, without regard to income or assets. The CD is currently able to extend Medicaid coverage to youth age 18 to 21, but the child must still be in foster care.

The CD does not anticipate a fiscal or programmatic impact on this Division. However, this proposal would greatly benefit children released from foster care after age 18 and under the age of 21, by providing them with medical coverage that might not otherwise be available to them.

ASSUMPTION (continued)

Officials from the **Department of Social Services - Family Support Division (FSD)** assume the following:

Section 208.152.1(4) RSMo: The Deficit Reduction Act 2005 (DRA) limits the claimant's portion of equity in a home for an individual to $500,000 for those individuals applying for long term care services. FSD implemented these changes in policy in March, 2006; therefore there is no fiscal impact.

Section 208.202 RSMo: Provides for the implementation of a premium offset program by the MO HealthNet Division, and the Department of Insurance, Financial Institutions and Professional Registration (DIFP). The FSD assumes the new MO HealthNet Division will determine eligibility or contract with another entity for that service. As has been done with other entities in the past, the FSD assumes the new MO HealthNet Division, or their contractor, would have available a tool to use to determine if an applicant for the premium offset program qualifies for services offered by the FSD. If the applicant appears to meet the initial criteria for FSD services, the new MO HealthNet Division or their contractor can refer the applicant to the local FSD office.

Sections 208.631 to 208.660 RSMo: States the "Health Care for Uninsured Children" shall be null and void if there are no funds of the United States appropriated by Congress to be provided to the state. There is no impact at this time as the state of Missouri is receiving funds for this program. If funds are not appropriated by Congress to be provided to the state, the FSD would no longer offer this program.

Sections 208.690 to 208.698: There is no anticipated impact for the FSD.

Officials from the **Department of Social Services (DSS) - Information Technology Services Division (ITSD)** assume the following:

Foster Care and MO HealthNet (Section 208.151 RSMo)
ITSD assumes that no programming changes will be required to grant MO HealthNet eligibility to independent foster care adolescents without regard to income or assets. Current FACES and Children's Division legacy system can create this eligibility.

ASSUMPTION (continued)

Nursing Home Services and Home Equity Limits (Section 208.152 RSMo)
The Family Support Division (FSD) already has policy with home equity value as a factor of eligibility for some programs. Incorporating this policy into the eligibility system is expected to occur when the adult programs are rolled into FAMIS. Projecting no cost at this time as a result of this proposal.

Cost of Changing "Medicaid" to "MO HealthNet (Section 208.201 RSMo)
ITSD produces 72 different letters to client's and other external entities that refer to the Medicaid program. Assuming 8 hours of labor per letter will be required to change and compile the AFP overlays, test and implement (72 modules X 8 hours per module = 576 hours).

ITSD will be required to modify 4 AFP logos (for letterhead, etc.,) with the new MO HealthNet Division name contained in the segment. Projecting 4 hours of labor.

ITSD generates 500 or more reports and other media to DSS agencies and other entities with "Medicaid" in the titles or text. ITSD assumes that 1 report can be modified with the required changes per hour (code, test, implement). These changes fall in a lower priority category. Total labor = 500 hours.

Performance Payment Program (Section 208.153 RSMo)
ITSD assumes that the performance payment program will be administered by the MMIS (Medicaid Management Information System) fiscal agent. Assuming little or no effort on ITSD's part.

Premium Offset Program (Section 208.202 RSMo)
ITSD assumes that eligibility specialists would determine eligibility for the premium offset program. This part of the proposal is similar to HB 95 and fiscal note 0421-01. This proposal does not discuss income limits or any limitations on who may qualify other than it is for uninsured employees. FSD would need to determine that the individual is uninsured and meets citizenship requirements. FSD indicated that waivers would be required to implement this program. There would be system costs, which we assume would be for FAMIS for analysis, design, coding, and testing.

With regard to Medicaid systems, ITSD assumes that this program would be administered the same as the current HIPP (Health Insurance Premium Payment) program. The Third Party Liability unit at DMS and MMIS fiscal agent would administer the program. Little or no effort for ITSD.

ASSUMPTION (continued)

Health Care for Uninsured Children (Section 208.631 RSMo)
ITSD assumes that the existing eligibility and Medicaid system would be modified for an uninsured children program in the event the United States Congress failed to fund the current program (CHIP). Unable to estimate costs with information available. Note: That there is an unknown but very substantial cost with creating a new program for uninsured children should the current CHIP program need to be replaced.

Long-Term Care Partnership (Section 208.690 - 208.698 RSMo)
The Long-term Care Partnership Program could be implemented without eligibility system changes at this point. It would also be incorporated into FAMIS when the adult programs move to FAMIS.

Health Care Advocates: ITSD assumes that Health Care Advocates will bill for their services and a new provider type/category of service (code) would need to be added to the existing Medicaid system (claims and also Monthly Management Reporting). Depending on how they are reimbursed (with capitation or not) also may require other system changes. Estimating about 80 hours of labor to code, test and implement the new category of service.

Health Improvement Plan: ITSD assumes that individuals will be enrolled through a vehicle similar to the current managed care enrollment and administration system. Income Maintenance would require 40 hours of labor to provide data on candidates for the plan to provide to the Medicaid system and 160 hours of labor for Medicaid system changes to process and maintain enrollments.

Risk-bearing Care Coordination: ITSD again assumes that the current managed care system would be used as the bill states this is a system of health care delivery providing payment to providers on a prepaid capitated basis. Estimate is for 200 hours of labor to code, test and implement the enrollment process.

State Care Management Point of Service Program: ITSD assumes that the current managed care system or a system similar to it would be used to enroll and administer payments and services. Estimating 200 hours to code test and implement.

Total Level of Effort = 1,760 hours.

ASSUMPTION (continued)

ITSD would use a combination of existing staff and contract staff. To implement changes timely, ITSD would use contract staff for modifying external correspondence as a result of the Division and program name change (576 hours). We would also use contract staff for managed care system changes required for the Long-term Healthcare Partnership program (160 hours for each of the 3 components - Health Improvement Plan, Risk Bearing Care Coordination and State Care Management Point of Service Program). The remaining hours could be worked with existing staff.

576 hours + (3 X 160 hours) = 1,056 hours, assuming that contract staff cost is $75.00 per hour the FY '08 fiscal impact would be $79,200 (1,056 hours X $75/hour).

Oversight assumes, for fiscal note purposes only, that the current CHIP program will not need to be replaced.

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume the following:

Section 191.990 RSMo - Requires the DSS to administer the Healthcare Technology Fund. The DMS does not anticipate a fiscal impact beyond the budget request.

Section 208.001 RSMo - The medical assistance program shall be known as "MO HealthNet". No fiscal impact is expected from this change.

Section 208.151 RSMo - The projected cost for the foster care expansion is $1.4 million for FY '08 (10 months). A 4.5% trend was added for FY '09 and FY '10. Estimate is based on providing medical assistance to 970 foster care children ages 18, 19 and 20.

Section 208.152 RSMo - No fiscal impact from this change. Individuals with $500,000 equity in their home are not eligible for nursing home care. The change to this section puts into statute current Family Support Division (FSD) policy.

ASSUMPTION (continued)

Section 208.153 RSMo - Subject to appropriation, the Mo HealthNet Division shall develop a pay-for-performance program. Pay for performance programs link evidence-based performance measures to financial incentives for providers. Pay for performance will be based on documentation of adherence to evidence-based care and treatment guidelines in a patient's plan of care. Initially, pay for performance incentives will be limited in scope, focusing on health care home providers who are caring for multiple patients enrolled in the current Chronic Care Improvement Program. The FY '08 budget includes $2.9 million ($1.1 GR million) for pay-for-performance. Because the program is subject to appropriation, the fiscal impact is a range from $0 to $2.9 million for FY '08. For FY '09, the cost was increased by 4.5%. In FY '10, pay-for performance will be expanded to the general population in Mo HealthNet. Therefore, the FY '10 cost increases to $13.6 million.

Section 208.201 RSMo - No fiscal impact from changing the name from "Division of Medical Services" to "MO HealthNet Division".

Section 208.202 RSMo - The premium offset program shall be subject to appropriation and individuals eligible for the program who apply after the appropriation authority is depleted will be placed on a waiting list for that fiscal year. The FY '08 budget request includes funding totaling $26.5 million for this program. Approximately a third of the cost of the program will be from state general revenue and matching federal funds. These funds will be used to leverage the remaining 2/3 from employers and their employees. Since the premium offset program is subject to appropriation, the fiscal impact is a range from $0 to $26.5 million.

Section 208.203 RSMo - Authorizes the DSS to promulgate rules to implement the provisions of the Missouri Health Improvement Act of 2007. This section will not have a fiscal impact.

Section 208.631 RSMo - SCHIP program contingent upon federal funding. No impact from this section.

Sections 208.690, 208.692, 208.694, 208.696 and 208.698 RSMo - There will be no fiscal impact over the term of the fiscal note. The FSD does not believe than there would be any new eligibles seen in FY '08, FY '09 and FY '10. Individuals would need to plan ahead for years and purchase this over a long period of time for it to have an impact.

ASSUMPTION (continued)

Section 208.950.10.(2) RSMo - Participants can earn enhanced health improvement points. These points will provide participants the ability to use the card to pay for approved health care expenditures outside the current package of covered services. The number of individuals who will earn credits is unknown at this time. It is estimated the cost of providing the enhanced benefits for the credits earned will be in a range of $5.3 million ($2 million GR) to $53.5 million ($20.1 million GR) when everyone is enrolled in the program. There is a one year lag between the time the credits are earned and the use of the credits. Therefore, the first year of enhanced benefits will be FY 09.

Section 208.950.10.(2) RSMo - Participants whose plan or care includes therapies (physical, speech, occupational or a combination of therapies) may access these therapies if the General Assembly has passed an appropriation and the Governor has signed the appropriation for therapies. Currently children and pregnant women and blind person have access to therapies. This legislation will open therapies to adults. It is estimated the cost to provide therapies (physical, speech, occupational or a combination of therapies) is a range from $0 to $3.3 million for FY '08. A 4.5% trend was applied for FY '09 and FY '10. A range is shown since the services are subject to appropriation.

Section 208.950.10.(7) RSMo - An **unknown cost savings** is anticipated from requiring co-payments on some services that are not federally mandated and for prescription drugs. It is assumed, co-pays would not be required for services provided to children (under the age of 19), pregnant women, and blind individuals. Currently, no co-pays are required for the following optional services: hospice, DME and personal care services. A savings will result from a reduction (equal to the co-payment) in the rates for these services. The provider will be responsible for collecting the co-payments from the participants.

Section 208.950.10.(8) RSMo - No cost savings is anticipated from requiring co-insurance on emergency department visits subsequently determined to be non-emergency. Monies due from the recipient must be reduced from the provider's reimbursement as required by federal law. A hospital will not be allowed under federal law to deny an assessment in an emergency room for non-payment.

Section 208.950.8. RSMo - By July 1, 2009, all parents and children will be enrolled in managed care or a health improvement plan. Depending on the needs of the participants, current fee-for-service participants will either be enrolled in a coordinated care program, administrative service organization, or a disease management program.

ASSUMPTION (continued)

An enrollment broker will assist the participant in choosing a health care home and a health care home coordinator. Estimated enrollment broker costs are $2.8 million in FY '08. DMS assumes all fee-for-service recipients will have a health risk assessment after choosing their health care home. Current managed care participants will not need to make a change. The projected cost of the health care risk assessment is $20.6 million in FY '08.

Section 208.950.9 and .10 RSMo - The Department will begin enrolling the aged, blind and disabled populations in a health improvement plan in FY '10 with enrollment complete by July 1, 2013. Individuals will be allowed to opt-out of the program the first year but must be in a health improvement plan by July 1, 2013.

Depending on the needs of the participants, individuals will either be enrolled in a coordinated care program, administrative service organization, or a disease management program.

An enrollment broker will assist the participant in choosing a health care home and a health care home coordinator. Estimated enrollment broker costs are $0.9 million in FY '08. DMS assumes all participants will have a health risk assessment after choosing their health care home. The projected cost of the health care risk assessment is $6.5 million in FY '08.

Section 208.955 RSMo - No impact on the Division. This section establishes an oversight committee which will review reports and the operation of the program and issue their finding in a report to the General Assembly by July 1, 2013.

The transformation of Missouri Medicaid to MO HealthNet would result in some savings. The state's experience with managed care has shown that through coordinating care a savings of at least 5% can consistently be achieved. It is estimated the following savings can be achieved: $22.6M GR to $45.2M GR in FY '09 and $58.5M GR in FY '10.

DMS has ranged their fiscal impact for section 208.153, 208.202 & 208.950.10(2) on whether appropriations will be made or not. **Oversight** will assume the appropriation will be made and will show the fiscal impact cost without the $0 to range.

FISCAL IMPACT - State Government	FY 2008 (10 Mo.)	FY 2009	FY 2010
GENERAL REVENUE FUND			
Savings - Department of Social Services: Division of Medical Services			
Section 208.950.10(7)	Unknown*	Unknown	Unknown
Program Savings	$0	$22,600,000 to $45,200,000	$58,500,000
Costs - Office of the Attorney General			
Defense Costs	(Less than $100,000)	(Less than $100,000)	(Less than $100,000)
Costs - Office of the Secretary of State			
Publishing Costs	($18,450)	$0	$0
Costs - Department of Mental Health			
Program Costs	(Unknown Greater than $100,000)	(Unknown Greater than $100,000)	(Unknown Greater than $100,000)
Costs - Department of Social Services: Information Technology Services Division			
Contract Staff Costs	($79,200)	$0	$0

FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
GENERAL REVENUE FUND (continued)			
Costs - Department of Social Services:			
Division of Medical Services			
Section 208.151	($523,980)	($657,071)	($686,640)
Section 208.153	($1,100,000)	($1,143,415)	($5,094,869)
Section 208.202	($10,000,000)	($10,000,000)	($10,000,000)
Section 208.950.10(2) Earned Credits	$0	($2,000,000 to $20,100,000)	($2,000,000 to $20,100,000)
Section 208.950.10(2) Therapies	($1,253,891)	($1,310,316)	($1,369,280)
Section 208.950.8	($7,755,807)	($38,783)	($38,959)
Section 208.950.8 Broker Costs	($1,375,875)	($6,880)	($6,912)
Section 208.950.9	($2,447,163)	($12,232)	($12,304)
Section 208.950.9 Broker Costs	($434,125)	($2,170)	($2,183)
Total Costs - DOS/DMS	($24,890,841)*	($15,170,867 to $33,270,867)	($19,211,147 to $37,311,147)
ESTIMATED NET EFFECT ON GENERAL REVENUE FUND	**($25,088,491 to $25,188,491)**	**$7,329,133 to $11,729,133**	**$39,188,853 to $20,988,853**

*Oversight assumes costs will exceed savings.

FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
FEDERAL FUNDS			
Income - Department of Social Services Federal Assistance	$39,991,648	$25,052,774 to $55,116,692	$31,763,606 to $61,827,524
Savings - Department of Social Services: Division of Medical Services			
Section 208.950.10(7)	Unknown	Unknown	Unknown
Program Savings	$0	$37,500,000 to $75,100,000	$97,200,000
Total Savings - DSS	Unknown	$37,500,000 to $75,100,000	$97,200,000
Costs - Department of Social Services: Division of Medical Services			
Section 208.151	($870,326)	($1,091,389)	($1,140,501)
Section 208.153	($1,811,593)	($1,899,200)	($8,462,525)
Section 208.202	($16,470,000)	($16,470,000)	($16,470,000)
Section 208.950.10(2) Earned Credits	$0	($3,321,979) to ($33,385,897)	($3,321,979 to $33,385,897)
Section 208.950.10(2) Therapies	($2,082,699)	($2,176,421)	($2,274,360)
Section 208.950.8	($12,882,318)	($64,417)	($64,710)
Section 208.950.8 Broker Costs	($1,375,875)	($6,880)	($6,911)
Section 208.950.9	($4,064,712)	($20,318)	($20,437)
Section 208.950.9 Broker Costs	($434,125)	($2,170)	($2,183)
Reimburse Federal Funds for Savings	$0	($37,500,000 to $75,100,000)	($97,200,000)
Total Costs - DOS/DMS	($39,991,648)	($62,552,774 to $130,216,692)	($128,963,606 to $159,027,524)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**

FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
INSURANCE DEDICATED FUND			
Income - Department of Insurance, Financial Institutions & Professional Registration			
Filing Fee	$0 to $5,000	$0	$0
Costs - Department of Insurance, Financial Institutions & Professional Registration			
Personal Service	($25,657)	($31,712)	($32,664)
Fringe Benefits	($11,612)	($14,353)	($14,784)
Equipment and Expense	($4,653)	($3,614)	($3,721)
Total Costs - DIFP	($41,922)	($49,679)	($51,169)
FTE Change - DIFP	1 FTE	1 FTE	1 FTE
ESTIMATED NET EFFECT ON INSURANCE DEDICATED FUND	**($36,922 to $41,922)**	**($49,679)**	**($51,169)**
Estimated Net FTE Change for Insurance Dedicated Fund	1 FTE	1 FTE	1 FTE

FISCAL IMPACT - Local Government	FY 2008 (10 Mo.)	FY 2009	FY 2010
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

Physicians and other providers that are considered small businesses could be affected.

SEC:LR:OD (12/06)

FISCAL DESCRIPTION

This legislation establishes the Missouri Health Improvement Act of 2007, modifying various provisions relating to the state medical assistance program and changing the name of the program to MO HealthNet.

HEALTH IMPROVEMENT PLANS
This legislation provides that beginning no later than July 1, 2008, the Mo HealthNet Division, within the Department of Social Services, shall function as a third party administrator, providing by July 1, 2013, all participants of MO HealthNet a choice of three health improvement plans. The three choices for a health improvement plan include the following:

- a risk-bearing care coordination program, which consists of coordinated care with a guaranteed savings level that is actuarially sound while limiting the profit that is generated to the vendor.

-an administrative services organizations program, which consists of a system of health care delivery providing care management and health plan administration services on a non-capitated basis where the financial terms shall require that the vendor fees are reduced if savings and quality targets specified by the department are not met.

-a state care management point of service program, which consists of a system of health care delivery administered by the Department of Social Services.

The Department shall implement a risk-bearing care coordination program, an administrative services organization program, and a state care management point of service program in areas with similar demographics and populations. All models shall be evaluated annually on the basis of quality, cost, health improvement, health outcomes, social and behavioral outcomes, health status, customer satisfaction, use of evidenced-based medicine, and use of best practices. The annual evaluation by the Department shall be submitted to the "Oversight Committee on Health Improvement Plans", which is established in this legislation. The Oversight Committee shall review participant and provider satisfaction reports and other specified data to analyze and determine the health or other outcomes and financial impact from the programs. The committee shall also perform other tasks as necessary to ensure quality of care, availability, participant satisfaction and status information on the programs. By July 1, 2013, the Oversight Committee shall issue findings to the General Assembly on the success and failures of the health improvement plans and recommend whether to discontinue any of the programs.

FISCAL DESCRIPTION (continued)

The Department shall have rules outlining an exemption process for participants whose current treating physicians are not participating in either a risk-bearing care coordination or ASO network in order to prevent interruption in the continuity of medical care. However, the Department shall formulate a plan so that by July 1, 2013, all participants are enrolled in one of the health improvement programs.

By July 1, 2008, the Department shall begin enrollment of parents and children not already enrolled in Missouri Medicaid managed care in a health improvement plan, with complete enrollment by July 1, 2009. By July 1, 2009, the Department shall begin enrollment in a health improvement plan one-half of the aged, blind and disabled participants, on an opt-out basis, with complete enrollment by July 1, 2013.

This legislation specifies the elements required of all health improvement plans, including offering a health care advocate for the participant of a health improvement plan to provide comprehensive coordinated physical and behavioral health in partnership with the patient, their family, and their care givers to assure optimal consideration of medical, behavioral or psychosocial needs. The services of the health care advocate shall provide a health care home for the participant, where the primary goal is to assist patients and their support system with accessing more choices in obtaining primary care, coordinating referrals, and obtaining specialty care.

For all health improvement programs , the vendor shall issue electronic access cards bearing the vendor's logo to participants. Such cards may be used to satisfy cost-sharing at the hospital, physician's office, pharmacy, or any other health care professional and also allow participants to earn enhanced health improvement points by signing a health improvement participant agreement, participating in healthy practices, and making responsible lifestyle choices. These points will provide participants the ability to use the card to pay for approved health care expenditures. The health care advocate shall advise the participant regarding the appropriate health care expenditures for each participant consistent with the participant's plan of care. Participants engaging in a discussion with their health care advocate on the plan of care may access, under certain circumstances, physical therapy, speech therapy, or occupational therapy.

HEALTHCARE TECHNOLOGY FUND
This legislation establishes the Healthcare Technology Fund, which shall be administered by the Department of Social Services.

FISCAL DESCRIPTION (continued)

Upon appropriation, moneys in the fund shall be used to promote technological advances to improve patient care, decrease administrative burdens, and increase patient and health care provider satisfaction. Any programs or improvements on technology shall include encouragement and implementation of technologies intended to improve the safety, quality and costs of health care services in the state.

The Department shall promulgate rules setting forth the procedures and methods for implementing the provisions the section.

LONG-TERM CARE PARTNERSHIP PROGRAM
This legislation establishes the Missouri Long-Term Care Partnership Program and provides that the Department of Social Services shall, in conjunction with the Department of Insurance, Financial Institutions and Professional Registration, coordinate the program so that private insurance and MO Health Net funds shall be used to finance long-term care.

Under such a program, an individual may purchase a qualified long-term care partnership approved policy in accordance with the requirements of the Federal Deficit Reduction Act of 2005 to provide a mechanism for individuals to qualify for coverage of the cost of the individual's long-term care needs under Mo HealthNet without first being required to substantially exhaust his or her resources. Individuals seeking to qualify for MO HealthNet are permitted to retain assets equal to the dollar amount of qualified long-term care partnership insurance benefits received beyond the level of assets otherwise permitted to be retained under Mo HealthNet.

The Department of Insurance, Financial Institutions and Professional Registration may certify qualified state long-term care insurance partnership policies that meet the applicable provisions of the National Association of Insurance Commissioners (NAIC) Long-Term Care Insurance Model Act and Regulation as specified in the Federal Deficit Reduction Act of 2005. In addition, the Department shall develop requirements regarding training for those who sell qualified long-term care partnership policies.

The issuers of qualified long-term care partnership policies in this state shall provide regular reports to both the Secretary of the federal Department of Health and Human Services and to the Departments of Social Services and the Department of Insurance, Financial Institutions and Professional Registration.

FISCAL DESCRIPTION (continued)

The Departments of Social Services and the Department of Insurance, Financial Institutions and Professional Registration shall promulgate rules to implement the provisions of this legislation.

This legislation repeals sections 660.546 to 660.557, RSMo, relating to a similar long-term care partnership program but that was never approved by federal law.

PREMIUM OFFSET PROGRAM
The Department of Social Services is authorized to implement a premium offset program for making standardized private health insurance coverage available to qualified individuals. The Department shall seek to obtain federal financial participation in the program. The premium offset from the MO HealthNet Division shall only be due if the employer and employee pay their share of the required premium.

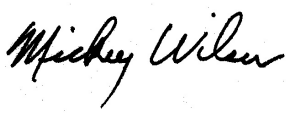
ELIGIBILITY AND SERVICES
This legislation extends MO HealthNet coverage for foster care children from the age of 18 to 21 without regard to income or assets. This legislation also provides that individuals with more than $500,000 in home equity will no longer qualify for long-term care services under MO HealthNet.

SUNSET PROVISION
This legislation repeals the provision establishing the Medicaid Reform Commission and the June 30, 2008, expiration date for the current Medicaid system. This legislation also repeals the expiration date for the Health Care for Uninsured Children program and provides that the program shall be void and of no affect if there are no funds appropriated by Congress to be provided to Missouri.

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

Office of the Attorney General
Office of Administration
Office of the State Courts Administrator
Department of Insurance, Financial Institutions and Professional Registration
Department of Mental Health
Department of Health and Senior Services
Department of Social Services
Missouri House of Representatives
Missouri Senate
Office of the Secretary of State
Office of the State Treasurer



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Director
March 6, 2007