COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 2227-06
Bill No.: Perfected SS for SCS for SB 577
Subject: Health Care; Health, Public; Health Care Professionals; Social Services Department; Medicaid
Type: Original
Date: April 5, 2007

Bill Summary: This proposal is relating to creation of the MO HealthNET program.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2008	FY 2009	FY 2010
General Revenue	(Greater than $41,838,849 to Greater than $47,810,379)	(Greater than $11,271,442 to Greater than $14,196,249)	Less than $19,841,827 to (Greater than $6,005,847)
Total Estimated Net Effect on General Revenue Fund	**(Greater than $41,838,849 to Greater than $47,810,379)**	**(Greater than $11,271,442 to Greater than $14,196,249)**	**Less than $19,841,827 to (Greater than $6,005,847)**

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 31 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 Unknown but Greater than $50,000,000 in FY08, Unknown but Greater than $131,000,000 in FY09 and Unknown but Greater than $160,000,000 in FY10 would net to $0.

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2008	FY 2009	FY 2010
General Revenue	45.5 FTE	45.5 FTE	45.5 FTE
Insurance Dedicated	1 FTE	1 FTE	1 FTE
Total Estimated Net Effect on FTE	**46.5 FTE**	**46.5 FTE**	**46.5 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 the State Treasurer, Missouri Senate, Office of Administration** and the **Office of the State Courts Administrator** each assume the proposal would have no fiscal impact on their respective agencies.

In response to a previous version of this proposal, officials from the **Missouri House of Representatives** assumed the proposal would have no fiscal impact on their agency.

Officials from the **Office of the Attorney General (AGO)** state that this proposal makes a number of changes to Medicaid provisions. AGO assumes some of these changes will create a fiscal impact.

AGO assumes that Section 208.151.4, which would preserve Medicaid lien monies upon which the State has claims, will increase recovery efforts. AGO further assumes that Section 208.151.6 will increase the numbers of case referrals, as it requires the State to be notified and made a party to third-party benefit suits in which Division of Medical Services (DMS) has an interest. Finally, AGO also assumes that Section 473.398.6, which requires personal representatives to file evidence of release from MO HealthNet, will increase the number of potential estate-recovery claims referred to this office.

AGO states that provisions in the proposal require additional, time-sensitive work, including initial pleadings, investigation and discovery, filing claims, court appearances and accountings. AGO assumes it would need 3 AAG I's to assist DMS in these recovery programs.

With respect to new Medicaid fraud provisions, AGO assumes that there will be a fiscal impact. Increasing the penalties associated with Medicaid fraud and providing mandated reports to the general assembly and governor will require additional staff. AGO assumes it would require 1/2 Assistant Attorney General II to meet the requirements of these new provisions.

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

ASSUMPTION (continued)

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.

Officials from the **Department of Mental Health (DMH)** assumes the DMH fiscal impact, including estimated costs savings, for sections 208.153, 208.202, 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 three choices for health improvement plans which includes:

- Risk bearing care coordination which guarantees a savings level that is actuarially sound while limiting profit.
- Administrative services organization which provides care management, utilization management and other services with the state retaining reimbursement.
- State care management point of service program which is a health care delivery system administered by the Division of Medical Services.

DMH can not predetermine which plan a DMH consumer may elect.

A 5% cost savings which is reflected in the DSS fiscal note may impact expenditures for Medicaid funded services within the DMH. Both the Divisions of Alcohol and Drug Abuse (DADA) and Comprehensive Psychiatric Services (CPS) are partially funded by Federal block grants. The DADA federal block grant has a maintenance of effort requirement whereby the state must demonstrate that DMH funds are available to match dollar for dollar federal funds. The CPS maintenance of effort requires that state funds be available to match dollar for dollar federal funds. Any reduction in current general revenue expenditures results in the state losing a commensurate amount of federal match. The DADA block grant is $26,000,000 and the CPS/MH block grant is $7,000,000. Potential federal block grant funding that could be lost due to the estimated 5% cost savings is approximately $3,000,000.

The DADA and CPS each participate in a federal reimbursement mechanism which generates approximately $10 million for CPS and $1.6 for DADA. Should the DMH expenditures be

ASSUMPTION (continued)

reduced to reflect the 5 % estimated savings, this would limit the federal revenue generated through this initiative. Potential funding lost due to the estimated 5% cost savings is $580,000.

Section 208.950.8 indicates that the state shall retain coverage for services provided though the rehabilitation option as outlined in Section 208.152.15. The DMH would continue to administer the Comprehensive Substance Treatment and Rehabilitation (CSTAR) services and Community Psychiatric Rehabilitation (CPR) services for clients who would choose the risk-based coordinated care option.

DMH assumes that its costs for the pay-for-performance initiative are included in the Division of Medical Services (DMS) fiscal note, subject to appropriation. This initiative provides financial incentives to providers who use evidence based practices. It is also assumed that the costs for health care credits for DMH consumers are reflected in estimated costs by DMS.

DMH assumes the expense for the electronic assess cards and readers will be paid for by the health improvement plans rather than DMH or its providers.

Section 208.950 (2) and (3) limits the Health Care Advocate to a "health care professional" which is trained and certified by the DSS. DMH assumes there could be some costs associated with the Health Care Advocate unless DSS has the discretion to certify DMH case managers who currently perform these functions.

DMH assumes that DMH is exempt from co-payments in Section 208.152.4 because of the exemption noted for services covered under Section 208.152.1(14) and (15).

DMH assumes costs would be unknown, but less than $100,000 (over and above the fiscal impact calculated by DSS) for General Revenue and Federal Funds.

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.

SEC:LR:OD (12/06)

ASSUMPTION (continued)

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 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.

Following is a short summary that addresses the amendments and other changes to the -04 version of SB 577:

Amendment #.01F - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.04S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.10S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.36S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.31S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.19S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.06S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.18S - DHSS assume the amendment would have no fiscal impact on their agency.

ASSUMPTION (continued)

Amendment #.27S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.03S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.38S - DHSS assume the amendment would not change the fiscal impact to Section 208.955 which is described below.

Amendment #.43S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.39S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.46S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.52S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.51S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.09S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.57S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.56S - DHSS assume the amendment would have no fiscal impact on their agency.

Amendment #.58S - DHSS assume the amendment would have no fiscal impact on their agency.

Subcommittee for Comprehensive Entry Point System for Long-Term Care - The 06N version of the bill added this subcommittee (Section 208.955). Amendment 38S added one more member to the subcommittee, bringing the total membership to 16. DHSS assumes we would be responsible for supporting the work of this subcommittee. Because of the reporting requirements to the Governor and General Assembly, DSDS assumes that during the first fiscal year the subcommittee would meet six times, and four times each fiscal year thereafter. At the standard cost of $160 per member per meeting, the cost for the first fiscal year would be $16,320 (17 X $160 X 6). Subsequent years are estimated at $10,880 (17 X $160 X 4). DSDS assumes any technical/clerical duties associated with the subcommittee could be absorbed.

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,

ASSUMPTION (continued)

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, were 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.

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 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.

ASSUMPTION (continued)

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.

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

ASSUMPTION (continued)

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.

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.

ASSUMPTION (continued)

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.

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 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 $1.7 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. The legislation includes an emergency clause for this section. This section shall be in full force and effect upon its passage and approval.

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 FSD policy.

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

ASSUMPTION (continued)

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 - 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.

Section 208.950.1.(2) RSMo - The DSS is required to train and certify the health care advocates for those services offered to the Medicaid population. The fiscal impact is unknown. DMS assumes no federal matching funds are available, payment would be all General Revenue funds.

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

ASSUMPTION (continued)

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) or comprehensive day rehabilitation services may access these services if the General Assembly has passed an appropriation and the Governor has signed the appropriation for therapies. Currently children and pregnant women and blind individuals have access to these services. This legislation will open therapies and comprehensive day rehabilitation services to adults. It is estimated the cost to provide therapies (physical, speech, occupational or a combination of therapies) and comprehensive day rehabilitation services is a range from $0 to $4.3 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. Currently, a $3.00 co-pay is charged to the Medicaid recipient for an outpatient service. If the visit is determined not to be an emergency, $3 is subtracted from the hospital's reimbursement when the claim is submitted for payment. 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 208.950.10.(10) RSMo - For all the plans, the vendors shall establish a 24-hour, confidential, toll-free nurse health line staffed by licensed registered nurses. The current MCO contracts and CCIP program require 24/7 toll-free nurse lines. However, many call centers triage the patients and they don't have first line access to the registered nurse (may be a LPN at the first contact). The requirement to staff the health line with licensed registered nurses will increase the cost. When ASO contracts are made, this will be a contract requirement and will increase the

ASSUMPTION (continued)

administrative costs included in the contract. The fiscal impact is expected from increased administrative costs. The cost is unknown.

Section 208.950.11. 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.

An enrollment broker will assist the participant in choosing a health care home and a health care home coordinator. Estimated enrollment broker costs are $2.7 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 208.950.12 and .13 RSMo - The Department will begin enrolling the aged, blind and disabled populations in a health improvement plan in FY '08 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.

Section 208.975 RSMo - Requires the DSS to administer the Healthcare Technology Fund. The DMS does not anticipate a fiscal impact beyond the budget request.

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.

ASSUMPTION (continued)

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** assumes the appropriation will be made and will show the fiscal impact cost.

Amendment #.01F - DOS assume the amendment would have no fiscal impact on their agency.

Amendment #.04S - DOS assume the amendment would have no fiscal impact on their agency.

Amendment #.10S - DOS assume the amendment would have no fiscal impact on their agency.

Amendment #.36S - DOS assume the amendment would have no fiscal impact on their agency

Amendment #.31S - DOS assume the amendment would have a fiscal impact of $20,000 ($10,000 GR) for FY08, FY09 and FY10).

Amendment #.19S - DOS assume the amendment would have no fiscal impact on their agency.

Amendment #.06S - DOS assume the amendment would have no fiscal impact on their agency.

Amendment #.18S - DOS assume the amendment would have no fiscal impact on their agency.

Amendment #.27S - DOS assume the amendment would have no fiscal impact on their agency.

Amendment #.03S - Officials from the **Department of Social Services - Division of Youth Services (DYS)** does not expect the division to be impacted by this proposal. Under current application practices, DYS identifies the employer of adults responsible for providing all or some of the youth beneficiary's support. Also, the DYS does not employ of the youth who may receive Medicaid benefits while in the division's care and custody.

Officials from the **Department of Social Services - Division of Budget and Finance (DBF)** assume the fiscal impact of this proposed legislation would be negligible. DBF assumed there would be very few requests for published documents given the availability of information on the DSS internet website. Those published documents that are requested would be provided through the Division of Legal Services via Sunshine requests. Requests for multiple copies would generate a fee equivalent to the costs incurred and, therefore, not generate added costs to the Division or Department.

ASSUMPTION (continued)

Officials from the **Department of Social Services - Family Support Division (FSD)** state as a routine part of the Family Support Eligibility Specialists job, they collect data regarding the employer's name and location for each Medicaid beneficiary or any adult who is responsible, according to Medicaid policy, for providing all or some of the proposed beneficiary's support. The data is collected at the time of application and updated at each subsequent reinvestigation of the household's circumstances. Currently, this process is done in both FAMIS and Legacy systems, depending on the type of assistance requested by the claimant. Medicaid applications are currently registered in the Legacy system, but this process is changing. Family Medicaid applications are in the process of being taken in the FAMIS system, with the final FSD office converting from Legacy to FAMIS in October, 2007. Adult Medicaid applications will still be processed in the Legacy System, but eventually will be processed in the FAMIS system only. Because of Executive Order 06-45, ITSD and FAMIS have made changes to the Legacy and FAMIS systems to allow the recording of employer federal ID numbers, so that the requested reports can be generated to the legislature, and be made accessible on the DSS Internet site.

Because these system changes are currently being made in FAMIS, FSD does not anticipate any cost for SFY2008 for this proposal.

Officials from the **Department of Social Services - Division of Medical Services (DMS)** state DSS shall prepare a public assistance program beneficiary employer report to be submitted annually to the Governor and the General Assembly. For an employer with at least fifty employees and twenty-five or more public assistance beneficiaries, the report shall include: the employer's name and address; the number of beneficiaries; the number of beneficiaries who are spouses/dependents of the employer's employees; the employer's health insurance benefits offered, received and level of premiums; and the state's cost for providing public assistance to the employer's employees and enrolled dependents. The report shall be issued within thirty days of the end of the calendar year but not include the names of the beneficiaries.

The information for Medicaid assistance applicants would be obtained at the time of application with the Family Support Division (FSD). The information related to those requesting uncompensated care in a hospital would have to be obtained from the individual hospitals. The FSD would develop a reporting system to obtain this information from the hospitals. Some hospitals currently capture the beneficiary's employer but not in a uniform manner from which the information could be extrapolated. The new reporting system would require standardized input for reporting purposes.

The DMS assumes that the FSD would be responsible for generating the required annual report, maintaining the Internet website, providing the requested copies, and developing a reporting

ASSUMPTION (continued)

system for the hospitals. DSS shall have the discretion to determine the appropriate cost and number of copies given.

The hospitals may require new staff to meet the reporting requirements of this proposed legislation. The additional administrative costs would be reflected on the hospital's cost report. The increase in the administrative costs would equate to an increase in the direct Medicaid payments made by the DMS to the hospitals. Therefore, the fiscal impact to the DMS would be an unknown cost of greater than $100,000.

Officials from the **Department of Social Services - Information Technology Services Division (ITSD)** assume the division would have to build a secure internet application and database that would allow hospitals to enter employer information for patients requesting services but have no health insurance and will not provide payment. The internet page must also contain fields to capture employer information for employed adults that are responsible for the patient's support in those instances where the patient is not employed.

Build a Web Page for Hospitals to Report on Patients Requesting Services That Have No Insurance:

1. The web page will contain fields to collect the name and SSN of the beneficiary, the name of their employer, the name, SSN and relationship of the person responsible for the beneficiary's support if the beneficiary is not employed and the name of their employer and the vendor number for the hospital. Programming will attempt to find a dcn from the SSN. CICS/Web Aware or active server page -- number of hours = 80.

2. Secure hospital web interface with RACF security. Each hospital provides a pre-ASAP form to a DMS or FSD security officer. The security officer will complete ASAP (Automated Security Access Processing) forms on behalf of hospital staff needing access. ITSD security team will process the access requests and maintain the necessary security groups. Assuming 3,000 users at hospitals state-wide, time to process initial requests will be about 500 hours (3,000 X 10 min per request).

3. Create a DB2 database to capture and store information captured on the web page described in item #1. DBA hours = 40.

4. ITSD is assuming that the contractor hired by DMS to provide list of employers with information on whether they offer insurance to employees and the cost of the insurance will provide that information for this bill. Zero hours.

ASSUMPTION (continued)

5. Write program(s) and job(s) to validate employer information collected by hospitals. Since hospitals probably will not have employer id numbers, we will attempt to match on name and produce error report(s) for FSD policy staff. Estimated # of hours for design, code and test = 80.

Generate Annual Report to be Submitted to Governor and General Assembly:

1. Write program to combine data from hospitals, Income Maintenance Proof file and FAMIS Medicaid. Drop duplicates and produce single, integrated file to match against employer and insurance info file provided by DMS contractor. Estimated # of hours to develop = 80 for design, code and test.

2. Write program to match file produced in item #1 against Medical Claims files provided by DMS Medicaid claims vendor (IFOX) to obtain those employers that have more than 50 employees and more than 25 public assistance beneficiaries. Match on SSN when a DCN cannot be found. The report will include the name and address of the employer, the number of public assistance beneficiaries, the number of public assistance beneficiaries who are spouses or dependents of employees of the employer, whether the employer offers health insurance to employees and their dependents, whether the employee receives health insurance benefits through the company, the amount of the insurance premiums if they do receive health insurance benefits and the cost to the State of Missouri of providing public assistance benefits for the employer's employee's and enrolled dependents. Estimated # of hours to develop (design, code, test) = 160.

3. Publish the report through the DSS department internet site. Includes page giving descriptive information on the report and the report itself in a pdf format. Web Resources hours = 40.

4. Assumes information captured via IMU5 and stored on IM databases, proof and extract files for exec order 06-45 will be adequate for requirements of this bill. Estimated number of hours = 0.

Total Hours:

Applications Development and Programming:	400 hours
Cyber-security Services:	500 hours
DBA Services:	40 hours
Internet Publishing Services:	40 hours

SEC:LR:OD (12/06)

ASSUMPTION (continued)

Total Level of Effort = 980 hours

Database work (40 hours), Security Access Grants (500 hours) and Publishing the Report on the Internet (40 hours) would be done in-house by ITSD staff.

Due to existing demands on ITSD's applications development teams, ITSD would request one to two contractors for the web application and batch programming.

400 hours X $75.00 per hour = $30,000.

Programming will already be implemented to meet the remaining requirements of the bill that refer to public assistance applicants. Programming was started in early December 2006 to meet the requirements outlined in Executive Order of the Governor 06-45 signed on November 27, 2006. Programming will be implemented in the first calendar quarter of 2007.

Amendment #.38S - DOS assume the amendment would have no fiscal impact on their agency.

Amendment #.43S - DOS assume the amendment would have no fiscal impact on their agency.

Amendment #.39S - DOS assume the amendment would have no fiscal impact on their agency.

Amendment #.46S - DOS assume the amendment would have no fiscal impact on their agency.

Amendment #.52S - DOS-DMS assumes the amendment would have a fiscal impact of $4.3M ($429,920 GR) in FY08, $5.4M ($539,119 GR) in FY09 and $5.6M ($563,380 GR) in FY10.

DOS-FSD assumes the amendment would have a fiscal impact of $837,079 GR in FY08, $886,931 GR in FY09 and $913,539 GR in FY10.

Amendment #.51S - DOS assume the amendment would have no fiscal impact on their agency.

Amendment #.09S - DOS assume the amendment would have a fiscal impact of $665,247 ($250,000 GR) in FY08, FY09 and FY10.

Amendment #.57S - DOS assume the amendment would have no fiscal impact on their agency.

Amendment #.56S - DOS assume the amendment would have no fiscal impact on their agency.

ASSUMPTION (continued)

Amendment #.58S - DOS assume the amendment would have no fiscal impact on their agency.

Following is a DOS summary of changes that fiscally impact their agency between the -04 and -06 version of SB 577:

Section 208.152.1(19)-DME - DOS assume the section would have a fiscal impact of $19.7M ($7.4M GR) in FY08, $20.6M ($7.7M GR) in FY09 and $21.5M ($8.1M GR) in FY10.

Section 208.152.1(19)-Electronic PA system - DOS assume the section would have a fiscal impact of $2M ($1M GR) to $2.5M ($1.25M GR) for FY08, FY09 and FY10.

Section 208.152.4 - DOS assume the section would have a fiscal impact of $5.7M to $11.4M in FY08, $7.2M to $14.3M in FY09 and $7.5M to $15M in FY10.

Section 208.215.1 - DOS assume the section would have a fiscal impact of Greater than $312,500 ($117,437 GR) in FY08 and Greater than $375,000 ($140,925 GR) in FY09 and FY10.

Section 208.215.7 - DOS assume the section would have a fiscal impact of Greater than $208,330 ($78,290 GR) in FY08 and Greater than $250,000 ($93,950 GR) in FY09 and FY10.

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			
Personal Services	($99,781)	($123,330)	($127,030)
Fringe Benefits	($45,161)	($55,819)	($57,494)
Equipment and Expense	($62,213)	($42,180)	($43,444)
Total Costs - AGO	($207,155)	($221,329)	($227,968)
FTE Change - AGO	3.5 FTE	3.5 FTE	3.5 FTE

FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
GENERAL REVENUE FUND (continued)			
Costs - Office of the Secretary of State			
Publishing Costs	($18,450)	$0	$0
Costs - Department of Mental Health			
Program Costs	(Unknown Less than $100,000)	(Unknown Less than $100,000)	(Unknown Less than $100,000)
Costs - Department of Health and Senior Services			
Program Costs	($16,320)	($10,880)	($10,880)
Costs - Department of Social Services: Information Technology Services Division			
Contract Staff Costs	($79,200)	$0	$0
Amendment #.03S Costs	($30,000)	$0	$0
Amendment #.52S Costs	($25,500)	$0	$0
Total Costs - DOS:ITSD	($134,700)	$0	$0
Costs - Department of Social Services: Division of Legal Services			
Amendment #.52S Costs	(Less than $100,000)	(Less than $100,000)	(Less than $100,000)
Costs - Department of Social Services: Family Support Division			
Amendment #.52S Costs			
Personal Services	($474,712)	($586,979)	($604,588)
Fringe Benefits	($214,855)	($265,667)	($273,637)
Equipment and Expense	($147,512)	($34,285)	($35,314)
Total Costs - DOS:FSD	($837,079)	($886,931)	($913,539)
FTE Change - DOS	42 FTE	42 FTE	42 FTE

Costs - Department of Social Services:			
Division of Medical Services			
Section 208.151	($628,776)	($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 208.950.1(2)	(Unknown)	(Unknown)	(Unknown)
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	($1,629,691)	($1,703,027)	($1,779,663)
Section 208.950.10(10)	(Unknown)	(Unknown)	(Unknown)
Section 208.950.11	($7,755,807)	($38,783)	($38,959)
Section 208.950.11 Broker Costs	($1,375,875)	($6,880)	($6,912)
Section 208.950.12	($2,447,163)	($12,232)	($12,304)
Section 208.950.12 Broker Costs	($434,125)	($2,170)	($2,183)
Amendment #.03S	(Greater than $37,580)	(Greater than $37,580)	(Greater than $37,580)
Amendment #.09S	($250,000)	($250,000)	($250,000)
Amendment #.31S	($10,000)	($10,000)	($10,000)
Amendment #.52S	($429,920)	($539,119)	($563,380)
Section 208.152.1(9) DME	($7,408,941)	$7,742,343	($8,090,748)
Section 208.152.1(9) PA System	($1,000,000 to $1,250,000)	($1,000,000 to $1,250,000)	($1,000,000 to $1,250,000)
Section 208.152.4	($5,721,540 to $11,443,070)	($7,174,807 to $14,349,614)	($7,497,673 to $14,995,347)
Section 208.215.1	(Greater than $117,437)	(Greater than $140,925)	(Greater than $140,925)
Section 208.215.7	(Greater than $78,290)	(Greater than $93,950)	(Greater than $93,950)
Total Costs - DOS/DMS	(Greater than $40,425,145 to Greater than $46,396,675)*	(Greater than $32,552,302 to Greater than $58,077,109)*	(Greater than $37,305,786 to Greater than $63,153,460)
ESTIMATED NET EFFECT ON GENERAL REVENUE FUND	**(Greater than $41,838,849 to Greater than $41,838,849)**	**(Greater than $11,271,442 to Greater than $14,196,249)**	**Less than $19,841,827 to (Greater than $6,005,847)**
*Oversight assumes cost will exceed savings.			
Estimated Net FTE Change for General Revenue Fund	45.5 FTE	45.5 FTE	45.5 FTE

SEC:LR:OD (12/06)

FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
FEDERAL FUNDS			
Income - Federal Assistance	Unknown but Greater than $50,000 000	Unknown but Greater than $131,000 000	Unknown but Greater than $160,000 000
Costs - Program Costs	(Unknown but Greater than $50,000 000)	(Unknown but Greater than $131,000 000)	(Unknown but Greater than $160,000 000)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**
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.

FISCAL DESCRIPTION

This proposal 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 proposal 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: (1) A risk-bearing care coordination plan, which consists of coordinated care with a guaranteed savings level that is actuarially sound; (2) An administrative services organizations plan, 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; and (3) a state care management point of service plan, 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 plan, an administrative services organization plan, and a state care management point of service plan. The Office of Administration shall commission an independent evaluation and comparison 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 proposal. 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

FISCAL DESCRIPTION (continued)

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. The oversight committee shall also create a subcommittee to develop a Comprehensive System Point of Entry for long-term care.

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 proposal 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. The health care advocate shall be a licensed health care professional trained and certified by the department of social services to provide the services outlined in the proposal.

For all health improvement plans, the vendor shall issue electronic access cards 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 consistent with the participant's plan of care and unique health care needs and goals. 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

FISCAL DESCRIPTION (continued)

health care advocate on the plan of care may access, under certain circumstances, physical therapy, speech therapy, occupational therapy or comprehensive day services. The MO HealthNet Division shall promulgate a list of expenditures, including but not limited to: Medicaid eligible services, co-pays, spenddown, over-the-counter drugs, and vitamins.

All plans shall also establish a twenty-four hour, confidential, toll-free nurse health line to be staffed by licensed registered nurses. Participants shall be encouraged to call when symptomatic, before making appointments or visiting an urgent care room. The nurse shall assess symptoms and provide care recommendation to seek services at the appropriate time and level of intervention. The nurses shall not diagnose nor provide treatment.

All plans shall partner with FQHCs, Rural Health Clinics, Community Mental Health Centers, local public health agencies, or a program designated by the department of mental health within a 60 mile radius to ensure availability of care, as well as with telehealth providers. (Sections 208.950 and 208.955)

HEALTH CARE TECHNOLOGY FUND

This proposal establishes the Healthcare Technology Fund, which shall be administered by the Department of Social Services.

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 of the section and establish criteria for the disbursement of funds to include preference for not-for-profit health care entities where the majority of the patients and clients served are either MO HealthNet participants or are from the medically underserved population. (Section 208.975)

LONG-TERM CARE PARTNERSHIP PROGRAM

This proposal 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

FISCAL DESCRIPTION (continued)

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 Insurance, Financial and Professional Regulation.

The Departments of Social Services and Insurance, Financial and Professional Regulation shall promulgate rules to implement the provisions of this proposal.

This proposal 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. (Sections 208.690 to 208.698)

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, or both, pay their share of the required premium. The qualified uninsured individual shall not be entitled to Mo HealthNet wraparound services. (Section 208.202)

FISCAL DESCRIPTION (continued)

ELIGIBILITY AND SERVICES

This proposal extends MO HealthNet coverage for foster care children from the age of 18 to 21 without regard to income or assets. This proposal also provides that individuals with more than $500,000 in home equity will no longer qualify for long-term care services under MO HealthNet. This proposal also allows for durable medical equipment if medically necessary. (Sections 208.151 and 208.152)

There is an emergency clause for the provisions relating to foster care eligibility.

SUNSET PROVISION

This proposal repeals the provision establishing the Medicaid Reform Commission and the June 30, 2008, expiration date for the current Medicaid system. This proposal 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. The proposal also extends the sunset date for the consumer-directed personal care assistance services program for non-Medicaid eligible clients from June 30,2008 to June 30, 2009. (Sections 208.014, 208.631, and 208.930)

MO HEALTHNET DIVISION

This proposal modifies provisions relating to the MO HealthNet Division's authority to collect from third party payers and the provisions relating to annuities and estate recovery. (Sections 208.212 to 208.217 and 473.398)

PRIMO PROGRAM

Adds psychiatrists and psychologists to the list of providers eligible for assistance through the Primary Care Resource Initiative for Missouri (PRIMO) program. (SECTION 191.411)

Senate Amendment #1 - Provides that the departments shall govern, rather than permit the practice of telehealth, in the MO HealthNet program rather than in the "State of Missouri."

Senate Amendment #1 to Senate Substitute Amendment #1 for Senate Amendment #2 - Modifies the make-up of the Professional Services Payment Committee from 15 members to 18 members, geographically balanced. The members shall also include the Attorney General and two patient advocates.

SEC:LR:OD (12/06)

FISCAL DESCRIPTION (continued)

Senate Amendment #3 - Includes other mental health providers licensed under Chapter 337, RSMo, in the PRIMO program.

Senate Amendment #4 - Adds language specifying that the Department of Social Services shall provide payment to the Recorder of Deeds the fees set for similar filings in connection with the filing of a lien and any other necessary documents.

Senate Amendment # 5 - Provides that the Oversight Committee on Health Improvement Plans shall have 14 members instead of 13, to include the Attorney General.

Senate Amendment #6 - Provides that the Department of Social Services shall engage in a public process for the design, development, and implementation of the health improvement plans, health advocates, and health improvement points and other provisions of the MO HealthNet and include consumers, health advocates, disability advocates, and other key stakeholder parties.

Senate Amendment #7 - Specifies that participants of MO HealthNet shall have a choice of which health improvement plan to enroll in. The state is to provide information on all three plans and the participant shall choose between available vendors in the plans. No provision shall be construed to require the ADD population to enroll in a risk-bearing care coordination plan unless there is no other plan available in the area.

Senate Substitute Amendment for Senate Amendment #8 - Specifies that nothing in the proposal shall be construed to deny a currently eligible service if such participant fails or is unable to follow their health improvement participation agreement.

Senate Amendment #11 - Enacts provisions of the Public Assistance Beneficiary Employer Disclosure Act.

Senate Substitute Amendment #1 for Senate Amendment #12, as amended - Adds members to the subcommittee on the central entry point system.

Senate Amendment #13 - Amends provisions regarding third party payers and MO HealthNet subrogation claims.

Senate Amendment #15 - Adds provisions regarding the request for proposal process for health improvement plans.

FISCAL DESCRIPTION (continued)

Senate Substitute Amendment for Senate Amendment #16 - Adds provisions regarding women's health care.

Senate Amendment #17 - Adds provisions regarding Medicaid Fraud

Senate Amendment #18 - Adds provisions regarding participating in drug court.

Senate Amendment #19 - Adds provisions regarding hospice.

Senate Amendment #20 - Adds provisions regarding promulgated rules.

Senate Amendment #20 - Adds provisions regarding independent living.

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

Mickey Wilson

Mickey Wilson, CPA

SEC:LR:OD (12/06)

Director
April 5, 2007