COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 2227-07
Bill No.: HCS for SS for SCS for SB 577
Subject: Health Care; Health, Public; Health Care Professionals; Social Services Department; Medicaid
Type: Original
Date: May 10, 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	(Unknown Greater than $61,346,642 to Unknown Greater than $62,596,642)	(Unknown Greater than $40,997,327 to Unknown Greater than $22,995,474)	(Unknown Greater than $10,671,151 to Unknown Greater than $15,738,776)
Total Estimated Net Effect on General Revenue Fund	**(Unknown Greater than $61,346,642 to Unknown Greater than $62,596,642)**	**(Unknown Greater than $40,997,327 to Unknown Greater than $22,995,474)**	**(Unknown Greater than $10,671,151 to Unknown Greater than $15,738,776)**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 49 pages.

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)
State Legal Expense*	$0	$0	$0
Missouri Healthcare Access Fund**	$0	$0	$0
State School Money Fund***	$0	$0	$0
Total Estimated Net Effect on Other State Funds	**($36,922 to $41,922)**	**($49,679)**	**($51,169)**

*Oversight assumes unknown transfers in and unknown costs would net to $0.
**Oversight assumes potential transfers in-gifts, grants, or donations of $10,000,000 and appropriations of $5,000,000 would equal to the disbursements of $15,000,000 and net to $0.
***Oversight assumes unknown savings and costs in FY09 and FY10 would net to $0.

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

* Income, Savings and Costs of approximately Unknown but Greater than $132,000,000 in FY08, Unknown but Greater than $211,000,000 in FY09 and Unknown but Greater than $289,000,000 in FY10 would net to $0.

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2008	FY 2009	FY 2010
General Revenue	65.27 FTE	65.27 FTE	65.27 FTE
Federal	61.23 FTE	61.23 FTE	61.23 FTE
Insurance Dedicated	1 FTE	1 FTE	1 FTE
Total Estimated Net Effect on FTE	**127.5 FTE**	**127.5 FTE**	**127.5 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

SECTIONS 105.711 - 620.510, 1 & 2 & 3 (MO HealthNet Program):

Officials from the **Office of the State Treasurer, 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** and the **Missouri Senate** each assumed the proposal would have no fiscal impact on their respective agencies.

ASSUMPTION (continued)

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 states this proposal expands the scope and manner of Legal Expense Fund (LEF) coverage (Section 105.711). AGO assumes that there will be some additional costs associated with defending the LEF because this proposal expands both the types of health care providers that are eligible for coverage and also expands the acts they are covered to "services" rather than simply "treatment."

In addition, AGO assumes additional costs from language granting health care providers the right to consent in settling a pending claim. AGO assumes that this new language may create impediments to LEF settlements, when providers do not want to settle. AGO assumes that some cases may be forced to trial, which will create additional costs.

While AGO cannot predict the impact of this expansion of coverage under the LEF, AGO assumes that the impact to the AGO will be under $100,000 and that the impact on the LEF is unknown.

With respect to new Medicaid fraud provisions (Sections 191.900 to 191.914), 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 ½ Assistant Attorney General II to meet the requirements of these new provisions.

This proposal also makes changes to Medicaid lien and estate recovery provisions. AGO assumes that Section 208.151.4, which would preserve Medicaid lien monies upon which the State has claims, will increase AGO recovery efforts. AGO assumes that because of changes to Section 208.151.13(2), which requires MO HealthNet to provide payment of filing fees for TEFRA liens, the number of referrals for TEFRA lien recovery cases will increase significantly. 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 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.

ASSUMPTION (continued)

AGO states that these provisions in this 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 the Division of Medical Services in these recovery programs.

Oversight assumes the AGO could absorb any additional costs due to the expansion of the scope and manner of the State Legal Expense Fund coverage.

Officials from the **Office of the Secretary of State (SOS)** assume the DSS and the DIFP are to promulgate rules to carry out this proposal. 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.

Officials from the **Department of Mental Health (DMH)** assumes that total costs related to this proposal are unknown, but greater than $100,000.

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 (DSS) - Information Technology Services Division (ITSD)** state the cost of Changing "Medicaid" to "MO HealthNet": Total hours for this component = 1080. Estimating that half of this labor would be completed by temporary contract staff (540 hours) with the remainder being completed by existing staff.

Cost of Ticket to Work Provisions: Total Hours for MAWD Component = 560. In view of current staffing levels on the Medicaid and Income Maintenance teams, all of the effort for

ASSUMPTION (continued)

Medicaid would be completed by contract staff and 320 hours for IM would be completed by contract staff (440 contract staff hours and 120 ITSD staff hours).

Foster Care and MO HealthNet: Total hours for this component = 80. All of the work would be completed by contract staff as the system is currently under development with temporary contract staff.

Missouri Healthcare Responsibility Act: Total Hours = 160 with existing staff as project is under development with existing staff.

Uninsured Women's Health Program: Total hours = 360. Would use contract staff due to competing demands for Income Maintenance and Medicaid teams.

Implementation of the Administrative Services Organization (ASO) Model: Total hours = 80 using existing staff.

Implementation of the Managed Care Model: Total hours = 200. Income Maintenance work would be done with existing staff. Medicaid work would require temporary contract staff.

Total Estimate-

Existing Staff: 860 hours
Contract Staff: 1580 hours at a cost of $75.00 per hour = $118,500.00

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** states 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: $0 in FY08, $22.6M GR to $45.2M GR in FY '09 and $58.5M GR in FY '10.

Officials from the **Department of Elementary and Secondary Education (DESE)** state there is no state cost to the foundation formula associated with this proposal. Should the new crimes and amendments to current law result in additional fines or penalties, DESE cannot know how much additional money might be collected by local governments or the DOR to distribute to schools. To the extent fine revenues exceed 2004-2005 collections, any increase in this money distributed to schools increases the deduction in the foundation formula the following year. Therefore the affected districts will see an equal decrease in the amount of funding received through the formula the following year; unless the affected districts are hold-harmless, in which case the districts will not see a decrease in the amount of funding received through the formula (any

ASSUMPTION (continued)

increase in fine money distributed to the hold-harmless districts will simply be additional money). An increase in the deduction (all other factors remaining constant) reduces the cost to the state of funding the formula.

Oversight notes that local school districts would see an increase in fine revenue as a result of this proposal. As stated by DESE, this fine revenue would be a deduction the next year for some of the school districts. Oversight assumes an unknown amount of revenue would be realized each year by school districts and a corresponding decrease in school funding from the state the following year. Oversight assumes the fine revenue will fluctuate from year to year, therefore, the net fiscal impact to local school districts from FY 2009 on could be Unknown to (Unknown).

Officials from the **Department of Corrections (DOC)** have not responded to Oversight's request for fiscal information.

SECTION 105.711 (State Legal Expense Fund):

Officials from the **Office of Administration – General Services Division (COA)** assume offering legal expense fund protection to specialty care providers without restriction on the type of services covered could increase the exposure to the legal expense fund significantly. The legislation also adds any social welfare board created under section 205.770, RSMO, and any medical care providers who are referred to provide specialty care without compensation. In this section no limits have been established, thus leaving the legal expense fund exposed to unlimited risk of loss.

COA states the State self-assumes its own liability protection under the state legal expense fund, Section 105.711, RSMo. It is a self-funding mechanism whereby funds are made available for the payment of any claim or judgment rendered against the State in regard to the waivers of sovereign immunity or against employees and specified individuals. Investigation, defense, negotiation or settlement of such claims is provided by the Office of the Attorney General. Payment is made by the Commissioner of Administration with the approval of the Attorney General.

COA assumes the proposal has the potential for significant costs to the state legal expense fund that cannot be determined at this time. COA assumes these costs could exceed $100,000 per year. COA has reflected the costs affecting the state legal expense fund.

ASSUMPTION (continued)

SECTION 135.096 (Long-Term Care Insurance Premiums):

Officials from the **Office of Administration, Division of Budget and Planning** (BAP) assumed the proposal would have no fiscal impact to their organization. Further, BAP stated that the proposal would double the deduction for long-term care insurance premiums from 50% to 100% of premium amounts. BAP estimates this proposal will reduce general and total state revenues by $2.7 million.

Officials from the **Department of Revenue** assumed a previous version of this proposal would have no fiscal impact on their organization.

According to the Department of Revenue's Tax Credit Analysis for the Long Term Care Tax Credit (Deduction), $64 million in deductions were claimed in Fiscal Year 2006. Couple this with a 4.5% marginal tax rate, and General Revenue was reduced by $2,880,000 from the 50% deduction.

Oversight assumes that General Revenue Fund tax revenues would be reduced an additional $2,880,000 if the deduction was increased from 50% to 100%. Since the new deduction rate would be effective for tax years beginning on or after January 1, 2007, Oversight assumes a full year's worth of deductions would apply in FY 2008.

Oversight is not able to estimate the potential for revenue reductions as a result of additional taxpayers filing returns who would not have filed a tax return under existing conditions, and Oversight is not able to determine the potential for revenue reductions due to the impact of this proposal on the existing Circuit Breaker and Homestead Exemption provisions.

SECTION 167.182 (Cervical Cancer Prevention):

Officials from the **Department of Mental Health (DMH)** assume DMH would be required to incur the cost for the vaccination for DMH clients. DMH assumes the number of DMH female adolescents is not significant, so the cost would be under $100,000.

Officials from the **Department of Health and Senior Services (DHSS) - Division of Community and Public Health (DCPH)** assume a variety of campaigns are needed to reach parents, women and health care providers.

ASSUMPTION (continued)

A Health Program Representative III is necessary to take on the additional responsibilities. A position at this level is needed to serve as the point person for the various educational campaigns, to collaborate with medical organizations and provide professional education, to directly contact health care professionals, and to work with other appropriate organizations to reach the target audiences.

Education Costs:
A public education campaign focusing on radio and TV has been shown to be an effective way of reaching and educating the target population. An investment of $500,000 will generate a minimum of $2,000,000 in actual radio and TV air time, using the current state contract with the Missouri Broadcasters Association.

A focus on professional education is needed to reach health care professionals and to complement the public education campaign. To estimate these costs, data from similar DHSS efforts have been used. This covers bringing in experts to professional meetings and conferences, developing materials to complement the educational campaigns, and one-on-one visits with health care professionals/groups who may not be available in other forums.

The costs of printing and/or purchase of educational materials are based on data from similar DHSS efforts. These will be needed to complement the public education campaign.

Funding to support the department's Tel-Link efforts is requested, as this campaign will increase the burden on this statewide health information line. Costs were determined based on costs of the current Tel-Link contract.

Vaccine Costs:
Staffing costs are calculated based on combined FTE of a senior epidemiology specialist, a public consultant health nurse and health program representative. Expected efforts are to:

- develop the plan to prescribe to schools for gathering names and addresses of all parents and guardians of entering 6th grade female students;
- set up a data receiving mechanism to enter data received from each school district whenever a student in this population is enrolled;
- determine analysis needs; and
- perform statistical analysis.

ASSUMPTION (continued)

Section 167.182.6. of this bill specifically requires that "…Funds for the administration of this section and for the purchase of vaccines for children of families unable to afford them shall be appropriated to DHSS from general revenue or from federal funds if available. There are no federal funds currently available for this vaccine; therefore the state would be financially obligated to appropriate funding.

Population estimates were determined by using Census data that shows that there are approximately 79,000 children in the 11-year age cohort (the age of most children when they enter 6th grade). Assuming that approximately one-half are females, the number is reduced to 39,600. Of those 39,600, approximately (18,374) 46.4% are served through the Vaccines for Children program.

It is assumed that approximately (15,270) 38.6% may have private insurance that covers the vaccine cost. The remaining 15% (5,940) are not identified in either group above; therefore, cost of vaccine is calculated as follows, based on current CDC vaccine pricing list:

$ 120.50	per dose
X 3	dose series
$ 361.50	per series
5,940	potential recipients
$2,147,310	
+ $3,300	estimated shipping cost
$2,150,610	total cost for vaccine*

*Current funds have been made available through the Missouri Foundation for Health, but it is unclear at this time whether the funds will last beyond the current year and whether the funds will be administered consistently to this age group.

Oversight assumes based on a DHSS response to a similar proposal (HB 802) that the campaign program does not need radio and tv advertisement and can consist of education materials only. Therefore, for fiscal note purposes only, oversight will show a fiscal impact of $8,333 for FY08 and $10,000 for FY09 and FY10 for educational materials. Oversight assumes DHSS can absorb any staffing needs.

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have a fiscal impact to GR of $56,370 in FY08, $67,644 in FY09 and $67,644 in FY10.

ASSUMPTION (continued)

SECTIONS 135.575 & 191.1050 - 191.1056 (Missouri Healthcare Access Fund):

Officials from the **Department of Administration - Budget and Planning** assume the proposal creates a tax credit for individual taxpayers for qualifying donations made to the new fund. The proposal limits the amount of tax credits issued in any single fiscal year to $5M. Therefore, general and total state revenues may be reduced by this amount annually beginning in FY08.

Officials from the **Department of Elementary and Secondary Education** state this proposal establishes a tax credit, the cumulative amount of which shall not exceed $1 million per year. DOR will likely experience an administrative burden. No impact to DESE. Tax credits will reduce income tax receipts flowing to the General Revenue fund. More tax credits mean less General Revenue available statewide for state use including education and funding the foundation formula.

Officials from the **Department of Health and Senior Services (DHSS)** states this proposal establishes the Missouri Healthcare Access Fund and specifies the state of Missouri shall provide matching moneys from the general revenue fund equaling one-half of the amount deposited into the fund, limited to five million dollars annually. The Department has no way of determining how much money will be deposited into the Missouri Healthcare Access Fund through gifts, donations, and other devises. Therefore, the cost to General Revenue will range from $0 to $5,000,000 annually.

This proposal authorizes DHSS to designate eligible facilities in an area of defined need and approve disbursements from the fund to any eligible facility to attract and recruit health care professionals and other necessary personnel, to purchase or rent facilities, to pay for facility expansion or renovation, to purchase office and medical equipment, to pay personnel salaries, or to pay any other costs associated with providing primary healthcare services to the population in the facility's area of defined need. The DHSS's PRIMO program already performs similar work and therefore, the Department believes existing staff can absorb the additional workload. Since the amount of revenue deposited into the fund remains unknown, DHSS has no way to determine how much funding will be disbursed to healthcare areas of defined need. If this legislation results in a significant amount of new workload that the Department determines cannot be absorbed by existing staff, funds to support the program would be sought through the appropriations process.

Officials from the **Department of Revenue (DOR)** assume this legislation establishes a new tax credit with carry-forward provisions. Personal Tax would require 1 Tax Processing Technician I for every 4,000 credits claimed.

ASSUMPTION (continued)

Office of Administration Information Technology (ITSD DOR) estimates the IT portion of this request can be accomplished within existing resources, however; if priorities shift, additional FTE/overtime would be needed to implement. Office of Administration Information Technology (ITSD DOR) estimates that this legislation could be implemented utilizing 4 existing CIT III for 2 months at a rate of $33,488.

Oversight assumes there will be less than 4,000 individuals that will apply for the tax credit. Therefore, DOR will not require an additional FTE as a result of this proposal.

Oversight assumes there would be some positive economic benefit to the state as a result of the changes in this proposal, however, Oversight considers these benefits to be indirect and therefore, have not reflected them in the fiscal note.

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have an unknown fiscal impact to their agency.

Oversight assumes the tax credits will be $0 to $500,000 in FY08, $0 to $1,500,000 in FY09 and $1,000,000 in FY10 based on this legislation and have adjusted the DOR and DOH cost accordingly.

SECTION 192.632 (Chronic Kidney Disease Task Force):

Officials from the **Department of Health and Senior Services (DHSS)** assume the task force will be in existence for only one year, since the proposal requires the task force to prepare its final recommendations in the form of a report to the General Assembly within 365 days of its first meeting. Although the proposal does not specify how often the task force is to meet, it is assumed that the task force will meet up to six times annually. The DHSS assume the task force will be appointed in September, start meeting in October and meet every other month through August.

The proposal lists 17 required members and allows for other members. As several required members are specialty physicians, it is assumed that most members will come from the Kansas City and St. Louis areas. It is also assumed that a member of the Missouri Organ Donor Program will serve on the task force. Since other members may also be chosen to serve on the task force, costs are calculated for a total of 25 task force members. DHSS assumes a standard cost of $160 per member per meeting for lodging, meals, and mileage for a total cost of $24,000 ($160 X 25 members X 6 meetings).

ASSUMPTION (continued)

Oversight assumes the minimum members required (17) would make up the Task Force for a total cost of $16,320 ($160 X 17 members X 6 meetings), with 5 meetings being held in FY08 and one being held in FY09.

SECTION 198.069 (Review Physician Orders):

Officials from the **Department of Health and Senior Services - Division of Senior and Disability Services (DSDS)** assume review of the discharge plans for individuals returning to an assisted living facility from a skilled nursing facility or hospital would be considered a normal function of care plan review. Any adjustments in care plans that result in an increase (or decrease) in the number of Home and Community Based (HCB) services necessary for an individual to remain in the assisted living facility rather than a nursing facility would be reviewed and authorized by DSDS Home and Community Services (HCS) staff as necessary.

DSDS assumes there would be no fiscal impact as a result of implementation of this proposal. However, if, at a later time, the division determines there would be fiscal impact related to this bill, funding would be sought through the appropriations process.

SECTION 208.146 (Medical Assistance for the Working Disabled):

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

This bill would restore a portion of persons who qualified for the Medical Assistance-Workers with Disabilities (MA-WD) Program, with specific criteria pertaining to disabled person's earned income. To qualify for the new program, persons receiving SSDI would have to earn at least twice what their spenddown would be for the regular Medicaid program for persons with disabilities. Persons earning over 100% FPL will be required to pay a premium.

ELIGIBLES: Essentially, there are three (3) different sub-populations impacted by the proposed legislation:

Old MA-WD only;
Spenddown Met;
Spenddown Not Met;

ASSUMPTION (continued)

If this bill is passed, FSD estimates the following would occur:

664 persons-Old MA-WD only*
594 persons--Spenddown Met
542 persons--Spenddown Not Met

1,800-Total eligibles

*This is the old population that was eligible for MA-WD and above the Substantial Gain Allowance (SGA).

Existing FSD staff will absorb this new population of eligibles.

Officials from the **Department of Health and Senior Services - Division of Senior and Disability Services (DSDS)** assume costs related to this section will mirror those found in HB 39: Total Costs: 3.00 FTE: FY2008--$178,236; FY2009--$194,512; FY2010--$200,348

*Note: The Family Support Division (FSD) has not recalculated the number of eligibles under the change from $5,000 to $2,500 in Medical Savings Accounts and Independent Living Savings Accounts as used to determine and individuals' assets. If the Family Support Division were to change the number of projected eligibles for this program, DSDS would make adjustments in our cost accordingly.

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

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have a fiscal impact to GR of $6,492,435 in FY08, $6,784,595 in FY09 and $7,089,900 in FY10.

SECTION 208.151 (Eligibility):

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

ASSUMPTION (continued)

age and who, on the individual's 18th birthday, were in foster care under the responsibility of the 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 (DSS) - Division of Medical Services (DMS)** assume the foster care expansion language in this proposal would have a fiscal impact to GR of $628,776 in FY08, $657,071 in FY09 and $686,640 in FY10.

DMS assumes the drug court language in this proposal would have a fiscal impact to GR of $250,000 in FY08, $250,000 in FY09 and $250,000 in FY10.

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

208.151.1 (2): The FSD anticipates 86 participants would be eligible for the extended eligibility period for persons participating in a drug court. No new staff would be needed.

208.151.1 (22): Existing FSD staff will be able to prepare the reports required by this section. There is no fiscal impact.

Officials from the **Department of Health and Senior Services - Division of Senior and Disability Services (DSDS)** assume DSDS will contract for staff to do the projects related to the populations that DSDS serves. Current FTE are unable to provide for this project, as DSDS is currently operating with a FTE deficit. This is a one-time cost. Total Costs: FY2008-$150,000; FY2009-$0; FY2010-$0

SECTION 208.152 (Services):

Officials from the **Department of Social Services - Family Support Division (FSD)** state section 208.152.10 **NOTE: These are the costs for this section of the legislation if it were addressed according to the Technical Memo. However, where this section is placed in the legislation as it is currently written there is no fiscal impact.** Based on available information, it is FSD's contention that if income for individuals eligible for employment at a sheltered

ASSUMPTION (continued)

workshop were to be disregarded from consideration as income for purposes of eligibility for Medicaid that approximately 1,604 Missourians could be potentially eligible. These eligibles comprised of three (3) sub-groups of the Medicaid population: 1) Individuals moving from spenddown to nonspenddown; 2) Individuals who are nonspenddown and earn less than $65; and, 3) Individuals who have a reduced spenddown.

1) Individuals moving from spenddown to nonspenddown: Of this population, approximately 464 are expected to move from spenddown to nonspenddown.

2) NonSpenddown and remain nonspenddown due to earnings less than $65: This population contains 178 individuals. These are current eligibles that will remain eligible. There is no impact for this sub-group.

3) Spenddown individuals who have a reduced spenddown: It is estimated that 962 individuals will have a reduction in spenddown. Of the 962 individuals impacted, 722 were already meeting spenddown. Of the 240 individuals remaining, 41 will meet a reduced spenddown and the other 199 did not previously meet spenddown and are not projected to meet spenddown with this change.

Any additional staffing need will be absorbed by FSD.

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume section 208.152.2 would have a savings of $527,623 in FY08, $1,102,732 in FY09 and $1,152,355 in FY10.

DMS assume the section 208.152.1(19)-DME 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.

DMS assume the section 208.152.1(19)-Therapies and Comp Rehab would have a fiscal impact to GR of $1.6M in FY08, $1.7M in FY09 and $1.8M in FY10.

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

DMS assume the sections 208.152.1(21)(22)(23)(24) would have a fiscal impact to GR of $13.2M in FY08, $27.6M in FY09 and $28.8M in FY10.

ASSUMPTION (continued)

DMS assume the section 208.152.1(27) would have a fiscal impact to GR of $0 in FY08, Greater than $41.6M in FY09 and Greater than $83.3M in FY10.

DMS assume the section 208.152.2 would have a fiscal impact to GR of $2.2M to $4.3M in FY08, $2.7M to $5.43M in FY09 and $2.8M to $5.6M in FY10.

Oversight assumes since 208.152.2 does not go into effect until January 1, 2009 that there would be none of the cost for FY08 that the DMS stated and ½ the cost in FY09 that the DMS stated.

DMS assume the section 208.152.10 would have a fiscal impact to GR of $1.2M in FY08, $1.3M in FY09 and $1.3M in FY10.

Officials from the **Department of Elementary and Secondary Education** state section 208.152.1(25) indicates that current Medicaid reimbursements would be subject to appropriations and may be subject to pre-certification. These additional requirements could place in jeopardy the current system by which local school districts access Medicaid reimbursements. Local school districts reported Medicaid receipts totaling $30.5 million during FY 06.

Oversight assumes the appropriation will be made and will not show the $30.5 million fiscal impact.

Officials from the **Department of Mental Health (DMH)** assume persons served by DMH and who are employees of sheltered workshops will benefit from the exclusion of their workshop earnings from Medicaid eligibility determinations. The client working at a sheltered workshop would have increased personal benefits. The actual number of sheltered workshop clients is unknown. DMH is unable to validate the number of clients working in sheltered workshops with DESE Vocational Rehabilitation records due to confidentiality issues. Any increase in personal benefits for DMH clients employed by the sheltered workshops would be applied toward the cost of their care and services.

Officials from the **Department of Health and Senior Services - Division of Senior and Disability Services (DSDS)** assume DSDS cannot estimate costs related to this subdivision (14), as it will affect reimbursement rates for all Medicaid reimbursed residents of residential care or assisted living facilities. Current Personal Care and Adults with Disabilities Home and Community-Based waiver services could not be paid on a tiered basis because of specific

reporting requirements dictated by CMS. Any new waivers including a tiered payment system would require approval by CMS before implementation. SB 616 (2006) requires that the

ASSUMPTION (continued)

Departments of Social Services and DHSS create a new waiver to cover these residents, to be submitted to the Centers for Medicare and Medicaid by July 1, 2007. This waiver may include a tiered system for payment, but may also include some other form of payment. DSDS would defer to the Department of Social Services for costs related to this Medicaid program, but would classify this as an unknown GR cost. Total Costs: FY2008-Unknown; FY2009-Unknown; FY2010--Unknown

Section 208.152.1(27) - DSDS will defer cost increases due to increasing reimbursement rates for providers to Medicare levels, a percentage of average provider charges, or the average cost borne by providers. However, if these rate increases are put into effect, DSDS will need to reimburse providers of non-Medicaid services at the same rate. DSDS estimates that the GR cost for this increase is unknown, less than $2,000,000. Total Costs: FY2008-Unknown < $2M; FY2009-Unknown < $2M; FY2010-Unknown < $2M

SECTION 208.153 (Pay-for-Performance):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume the COLA language in this proposal would have a fiscal impact to GR of $473,508 in FY08, FY09 and FY10.

DMS assume the out-of-pocket language in this proposal would have an unknown fiscal impact to their agency.

Officials from the **Department of Social Services (DSS) - Family Support Division (FSD)** assume due to the timing of the COLA adjustment for SSA and the adjustment to the FPL, some Medicaid participants are moved from non-spenddown to spenddown and all spenddown participants see an increase in spenddown amount. FSD estimates this affects 24,651 Medicaid participants.

FSD arrived at this number in this manner: For those participants that currently meet their spenddown or pay-in to meet their spenddown obligation (21,494). Their spenddown amount is affected for two months (21,494 x 2 = 42,988). When the cost-of-living-adjustment is completed, FSD saw an increase in spenddown cases of 3,157. These cases would be affected by the change in their spenddown for three months (3,157 x 3 = 9,471).

42,988 + 9,471 = 52,459 months

ASSUMPTION (continued)

Officials from the **Department of Mental Health (DMH)** state since many of DMH services do not have a corresponding Medicare rate, DMH assumes allowances will be made for DMH services.

SECTION 208.197 (Professional Services Payment Committee):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have an unknown fiscal impact to their agency.

SECTION 208.213 (Personal Care Contract):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have an unknown savings to their agency.

SECTION 208.215 (Pay Claims, Third Party Payors & Recorder of Deeds):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume section 208.215.1 would have a fiscal savings of Greater than $117,437 in FY08, Greater than $140,925 in FY09 and FY10.

DMS assume section 208.215.7 would have a fiscal savings of Greater than $78,290 in FY08, Greater than $93,950 in FY09 and FY10.

DMS assume section 208.215.13 would have a fiscal impact to GR of $10,000 in FY08, FY09 and FY10.

SECTION 208.225 (Nursing Home Reimbursement Rates):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have a fiscal impact to GR of $865,296 in FY08, $614,159 in FY09 and $641,796 in FY10.

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume the Retro Adjustment language in this proposal would have a fiscal impact to GR of $2M in FY08, $1.1M in FY09 and $1.2M in FY10.

ASSUMPTION (continued)

SECTION 208.230 (Public Assistance Beneficiary Employer Act):

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.

SECTIONS 208.631 - 208.640 (SCHIP Eligibility):

Officials from the **Department of Social Services - Family Support Division (FSD)** state 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.

This section also requires Mo HealthNet to follow all Title XIX requirements for SCHIP children up to 150% FPL. This will add 3,450* children to the program, and add prior quarter coverage services for 8,208** children currently being approved for SCHIP each year.

*FSD arrived at this number in this manner: 3,252 children were closed because of dropped insurance or they had other insurance. 66% (2146) were below 150% FPL (3252 x 66%). 75% of those would drop the insurance to become eligible, or 1,610 (2146 x 75% = 1,610). 3,504 children were rejected because of dropped insurance or they had other insurance. 50% (1,752)

were below 150% FPL (3,504 x 50%). 75% of those would drop insurance to become eligible, or 1,314 (1,752 x 75% = 1,314). FSD anticipates 30% of those rejected below 150% FPL may apply and be found eligible (1,752 x 30% = 526).

Total new children: 1,610 + 1,314 + 526 = 3,450

ASSUMPTION (continued)

**FSD currently approves 8,208 children under the MC+ SCHIP program who do not receive prior quarter coverage services. These children would be eligible for three months of prior quarter TXIX services. There would not be new children added to the program.

Any additional staffing would be absorbed by FSD.

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

208.640.1: This legislation changes the definition of "affordable employer-sponsored health care insurance or other affordable health care coverage". For those parents and guardians required to pay a premium with a gross income above 150% to 185% FPL the affordability standard is 3% of 150% FPL ($64.00). $2147 x 3% = $64.41, rounded to $64.00. 7629 children in this income group were no longer eligible for this program due to changes implemented with SB 539 (2005). Approximately 3,967 children were returned to the SCHIP program with changes implemented to the affordability standard in the summer of 2006. The FSD estimates 3,662 children would be found eligible for this program with this legislation.

For those parents and guardians required to pay a premium with a gross income above 185% to 225% FPL, the affordability standard is 4% of 185% FPL ($106.00). $2648 x 4% = $105.92, rounded to $106.00. 2,031 children in this income group were no longer eligible for this program due to changes implemented with SB 539 (2005). Approximately 1,451 children were returned to the SCHIP program with changes implemented to the affordability standard in the summer of 2006. The FSD estimates 580 children would be found eligible for this program with this legislation.

For those parents and guardians required to pay a premium with a gross income above 225% and below 300% FPL, the affordability standard is 5% of 225% FPL ($161.00). $3220 x 5% = $161.00. 2,107 children in this income group were no longer eligible for this program due to changes implemented with SB 539 (2005). There were no children returned to the SCHIP program in this income group when changes were implemented to the affordability standard in

the summer of 2006. The FSD estimates 2,107 children would be found eligible in this income group for this program with this legislation.

This section also states that health insurance plans that do not cover pre-existing conditions for an eligible child is not considered affordable employer-sponsored health care insurance or other affordable health care coverage. FSD estimates this would add 2,353 children. FSD arrived at this number in this manner: 11,765 cases that were originally affected by the change in

ASSUMPTION (continued)

affordability from SB 539 (2005), x 2 kids per case = 23,530. According to US Census and Kaiser Foundation, 10% of children take medication on a regular basis, so FSD assumes these children would have a pre-existing condition that may be affected by this definition of affordable health insurance. 23,530 x 10% = 2,353 new eligibles. Total New Eligible Children: 3,662 + 580 + 2,107 + 2,353 = 8,702

Existing staff of the Family Support Division (FSD) would absorb the increase in applications and caseload size.

208.640.2: This section expands the organizations that are considered to be qualified entities for determining presumptive eligibility for children receiving medical assistance benefits. The FSD anticipates an increase in the number of children approved as presumptive eligibility, and a subsequent increase in the number of children approved for SCHIP. FSD anticipates 3,629 new children to be approved for SCHIP. FSD arrived at this number in this manner: According to the US Census 2005, there are 54,000 uninsured children under 150% FPL. 20% of number would receive services from a qualified entity (10,800). 42% of those receiving services from a qualified entity would be found eligible for SCHIP (10,800 x 42% = 4,536). 20% of these children would become eligible earlier than a normal SCHIP case (4,536 x 20% = 907). The remaining 3,629 (4536 - 907 = 3,629) would apply and be found eligible for SCHIP.

FSD anticipates 6,264 children that received SCHIP as presumptive eligibles to be rejected for SCHIP. 6,264 children/2 children per application = 3,132/12 months = 261 new applications per month.

3,629 children/2 children per case = 1,814.50, rounded up to 1,815 new cases.

New FTE: 1,815/243 caseload standard = 7; 261 new applications/243 = 1. 8 new Eligibility Specialists.

New Eligibility Supervisor: 10-1 ratio: 8/10 = .8, rounded up to 1 new Eligibility Supervisor

8 + 1 = 9/6 professional support staff: 1.50, rounded up to 2 OSA.

Total new FTE: 8 + 1 + 2 = 11

Section 208.640 will provide medical assistance benefits to those children who have exceeded the annual coverage limits for any needed health care service within their provided insurance, thus the child is not considered insured and does not have access to affordable health insurance.

ASSUMPTION (continued)

The FSD anticipates an increase in the number of children eligible. FSD anticipates 9,200 new children to be eligible for medical assistance benefits. FSD arrived at this number in this manner:

Number of cases that were rejected in one month because of

Insurance	114
Affordable Insurance	155
Dropped Insurance	4
Total	273 x 12 months = 3276 cases

Number of cases that were closed in one month because of

Insurance	136
Affordable Insurance	287
Dropped Insurance	1
Total	424 x 12 months = 5088 cases

Number of children in cases that were rejected or closed in one year = (3276+5088) x 2 children per case = 16,728.

FSD anticipates that those children who were rejected or closed due to insurance availability have annual limited service clauses within the current policy. FSD anticipates that 50% of these children will exceed some form of limited service and become eligible for medical assistance benefits. 16,728 x 50% = 8,364 new children to be eligible for medical assistance benefits. FSD anticipates and additional 10% of this population to represented by general public that may not have requested assistance before. 8364 x 10% = 836 + 8,364 = 9,200 new children to be eligible for medical assistance benefits.

9,200 children/2 children per case = 4,600 new cases.

New FTE: 4,600/243 caseload standard = 18.93; 19 new Eligibility Specialists.

New Eligibility Supervisor: 10-1 ratio: 19/10 = 1.9, rounded up to 2 new Eligibility Supervisors.

19 + 2 = 21/6 professional support staff: 3.5; 1 SOSA and 2 OSA.

ASSUMPTION (continued)

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have varied fiscal impact to their agency. See breakdown on page 33.

SECTION 208.659 (Uninsured Women's Health Program):

Officials from the **Department of Social Services - Family Support Division (FSD)** assumes DHSS will change the definition of screening for BCCCP to include screenings by any Medicaid provider. This will allow 783 women to move from the EWHS program to the BCCT program. FSD arrived at this number in this manner: 82,571 women would be eligible for EWHS. Currently, 0.188% of the female population have been diagnosed with breast cancer (82,571 x 0.188% = 155). Currently, .01% of the female population have been diagnosed with cervical cancer (82,571 x 0.01% = 8). 155x5 years of treatment = 775 females receiving breast cancer treatment.

Total moving from EWHS to BCCT: 775 + 8 = 783

The FSD anticipates 81,788 new eligible women to participate in this program. 80% of this population would be known to the FSD as a parent/guardian of a child receiving benefits through the MC+ Medicaid program. (81,788 X 80%= 65,430) This makes total new cases of 16,358.

New FTE: 16,358/243 caseload standard: 67.32 rounded down to 67 new Eligibility Specialists.

New Eligibility Supervisor: 10-1 ratio: 67/10 = 6.7 rounded down to 6 Eligibility Supervisors.

67 + 6 = 73/6 Professional support staff: 12, with 9 OSA and 3 SOSA.

Total new FTE: 67 + 6 + 12 = 85

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume the proposal would have a fiscal impact to GR of $996,832 in FY08, $1.3M in FY09 and $1.3M in FY10.

DMS assume the cancer language in this proposal would have a fiscal impact of $872,816 in FY08, $2,125,088 in FY09 and $3,287,337 in FY10.

ASSUMPTION (continued)

SECTION 208.670 (Telehealth Services):

Officials from the **Department of Mental Health (DMH)** assumes some of DMH's providers have the capacity to participate in telehealth. DMH assumes there would be an unknown cost related to equipment and training for this program.

SECTIONS 208.690 - 208.698 (Long-Term Care Partnership Program):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume there will be no fiscal impact over the term of the fiscal note. The FSD does not believe that 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.

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.

ASSUMPTION (continued)

SECTION 208.950 (Health Improvement Plans):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have an unknown fiscal impact to their agency.

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have a fiscal saving to GR of $13.6M in FY08, FY09 and FY10.

SECTION 208.952 (Plan Study):

Officials from the **Department of Mental Health (DMH)** assume Section 208.952.2 states each provider of services listed in Section 208.152 shall be entitled to receive sufficient reimbursement from the state to ensure that each recipient, subject to best practices, receives in a timely fashion the medically necessary and needed health care services listed in Section 208.152. DMH assumes that "sufficient reimbursement" for many services, is likely to mean reimbursement at a level greater than the current level. DMH could incur an additional unknown cost if rates are increased for DMH providers.

Section 208.952.6 requires the maximization of technology to increase efficiency and reduce paperwork. While this section requires the cost of purchasing any electronic medical record software to not be born by providers, DMH assumes there could be an unknown administrative cost.

DMH assumes there would be some costs related to the independent study as provided in Section 208.952.11. DMH assumes costs would be unknown but greater than $100,000.

Section 208.952.19 requires DOS, in conjunction with DOH and DMH, shall implement and link all systems necessary to develop databases, patient and provider profiles, ad hoc reports,

pharmacy services, mental health services, etc for MO HealthNet participants. It states DOS shall choose a contractor or contractors to assist in implementation of such systems and that such systems shall be linked and operated by the division and shall be made available to all providers caring for participants. DMH assumes that implementing this section would have a cost that is unknown, but greater than $100,000. Cost would be dependent upon how much the contractor or contractors assist in implementation of such systems and how much of the work falls to DMH.

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have an unknown fiscal impact to their agency.

ASSUMPTION (continued)

SECTION 208.954 (Pre-authorization):

Officials from the **Department of Mental Health (DMH)** assumes if all services of DMH clients would need pre-authorization, there would be a significant administrative cost to the DMH at both state-operated facilities as well as DMH providers. In addition, pre-authorization and continued authorization would present a huge obstacle for DMH clients with chronic conditions.

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have an unknown fiscal impact to their agency.

SECTION 208.956 (MO HealthNet Oversight Committee):

Officials from the **Department of Health and Senior Services (DHSS)** assume the Department would be responsible for supporting the work of this subcommittee. There are 22 members of the 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 $21,120 (22 X $160 X 6). Subsequent years are estimated at $14,080 (22 X $160 X 4). DSDS assumes any technical/clerical duties associated with the subcommittee could be absorbed; however, if we determine that a support person is needed for this subcommittee, DSDS will pursue that support staff through the appropriations process. Total Costs: FY 2008-$21,120; FY 2009-$14,080; FY 2010-$14,080

Officials from the **Department of Mental Health (DMH)** assumes there would be costs associated with implementing the recommendations which would be unknown, greater than $100,000.

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have an unknown fiscal impact to their agency.

SECTION 208.958 (Advisory Working Group):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have an unknown fiscal impact to their agency.

ASSUMPTION (continued)

SECTION 208.960 (Joint Committee on Mo HealthNet):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have an unknown fiscal impact to their agency.

SECTION 208.962 (Enroll in Plans):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have a varied fiscal impact to their agency. See breakdown on page 34.

SECTION 208.964 (Aged, Blind and Disabled):

Officials from the **Department of Mental Health (DMH)** assume that the Aged, Blind and Disabled (ABD) population is excluded from any health improvement plan using a managed care model. In addition, services provided through DMH to eligible ABD participants shall be provided through the basic state plan and not included though an Administrative Services Organization (ASO) plan, Managed Care Plan (MCP), or a component state plan for those individuals. Eligible children or parents participating through an ASO or PCP plan may receive mental health services through the basic state plan or a component state plan authorized by the DMH. Finally, children in foster care may receive mental health services provided through the basic state plan and not included as part of an ASO or MCP for those individuals.

Officials from the **Department of Health and Senior Services (DHSS)** state this proposal requires completion of a health risk assessment, risk prediction, independence screening, and a preadmission screening and resident review if needed. If the independent screening indicates eligibility for long term care services, the participants shall be referred to DHSS or a natural point of entry for eligibility determination and services. DSDS cannot determine the number of

individuals who will be referred to our agency versus a natural point of entry for eligibility determination. If the individuals are referred to DHSS, DSDS assumes new FTE and associated expense & equipment would be required to process these referrals. Total Costs: FY2008-Unknown; FY2009-Unknown; FY2010-Unknown

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have a varied fiscal impact to their agency. See breakdown on page 34.

ASSUMPTION (continued)

SECTION 208.968 (Universal Information System):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have an unknown fiscal impact to their agency.

SECTION 208.975 (Healthcare Technology Fund):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** states the proposal requires the DSS to administer the Healthcare Technology Fund. The DMS does not anticipate a fiscal impact beyond the budget request.

SECTION 473.398 (Probate Estate Recovery):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume the proposal would have a fiscal savings to GR of $172,173 in FY08, $206,690 in FY09 and $206,690 in FY10.

SECTION 620.510 (Missouri Health Profession Shortage Planning Commission):

Officials from the **Department of Economic Development (DED)** assume DED would be required to provide support for the Missouri Health Profession Shortage Planning Commission organizing meetings, providing supplies, space, and assisting with drafting of an annual report. It is uncertain how large the commission is because of the unknown number of legislative committee members. It appears commission membership could be as high as 30. DED would need one person to coordinate activities the first year to get a report prepared between August

28, 2007 and January 1, 2008. Cost would depend on how many meetings were held. DED anticipates the number of meetings would drop to around 4 the second year.

DED assumes the need for one full time person the first year and .5 FTE thereafter for staff support plus, staff travel/other expenses, and related administrative costs. There would be additional printing costs for reports. DED anticipates $400 per meeting for general expenses plus per person cost of $80 for hotel, $99.60 for mileage based on .415 per mile and 240 mile round trip average, plus $50 per day for meals or $6,140 per meeting with a minimum of 25 board members. Six meetings the first year would cost $36,840 and four meetings per year thereafter would cost would be $24,560. DED cost projections are based on these assumptions. However, all amounts could increase if the number of meetings increased or the length of meetings increased past one day. Staff costs could increase if the commission made more requests for

ASSUMPTION (continued)

support. Costs could also increase or decrease depending on the actual number of members on the commission. DED may need to request additional funding depending on all factors noted.

Oversight assumes DED will incur the meeting expense, but if additional duties result from the new commission, DED can request the funding through the appropriations process. Oversight assumes there will be 21 members for a fiscal impact of $31,330 in FY08 and $20,886 for FY09 and FY10. Oversight assumes the DED could absorb 1.5 FTE.

SECTION 3 (Pharmacy Rebates):

Officials from the **Department of Mental Health (DMH)** state because DMH is not receiving any rebates from manufacturers under the new pharmacy program DMH is implementing there will be no fiscal impact resulting from this section.

SECTION 4 (HPV Vaccine):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have an unknown fiscal impact to their agency.

FISCAL IMPACT - State Government	FY 2008 (10 Mo.)	FY 2009	FY 2010
GENERAL REVENUE FUND			
Savings - DSS: DMS			
Sections 105.711 - 620.510, 1, 2, 3 & 4	$0	$22,600,000 to $45,200,000	$58,500,000
Section 208.152.2	$527,623	$1,102,732	$1,152,355
Section 208.213	Unknown	Unknown	Unknown
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
Section 208.950.1(25)	$13,627,415	$13,627,415	$13,627,415
Section 473.398	$172,173	$206,690	$206,690
Total Savings - DSS	Unknown Greater than $14,522,938	Unknown Greater than $37,771,712 to Unknown but Greater than $60,371,712	Unknown Greater than $73,721,335
Savings - Reduced appropriations to State School Moneys Fund (from deduction of fine revenue from previous year)	$0	Unknown	Unknown

Costs - AGO:			
Sections 105.711 - 620.510, 1, 2, 3 & 4			
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
Costs - SOS:			
Sections 105.711 - 620.510, 1, 2, 3 & 4 Publishing Costs	($18,450)	$0	$0
FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
Costs - DMH			
Sections 105.711 - 620.510, 1, 2, 3 & 4	(Unknown Greater than $100,000)	(Unknown Greater than $100,000)	(Unknown Greater than $100,000)
Costs - DHSS			
Section 167.182 Education Materials	($8,333)	($10,000)	($10,000)
Section 167.182 Vaccine & Shipping	($1,792,175)	($2,215,128)	($2,281,582)
Section 192.632	($13,600)	($2,720)	$0
Section 208.146 Personal Services	($54,496)	($56,131)	($57,815)
Section 208.146 Fringe Benefits	($24,665)	($25,405)	($26,167)
Section 208.146 Equipment & Expense	($20,927)	($10,336)	($10,645)
Section 208.151.1(22)	($150,000)	$0	$0
Section 208.152.1(14)	(Unknown)	(Unknown)	(Unknown)
Section 208.152.1(27)	(Less than $2,000,000)	(Less than $2,000,000)	(Less than $2,000,000)
Section 208.956	($21,120)	($14,080)	($14,080)
Section 208.964	(Unknown)	(Unknown)	(Unknown)
Total Costs - DHSS	($4,085,316)	($4,333,800)	($4,400,289)
FTE Change - DHSS	1.77 FTE	1.77 FTE	1.77 FTE

Costs - DED			
Section 620.510	($31,330)	($20,886)	($20,886)
Costs - DSS: ITSD			
Sections 105.711 - 620.510, 1, 2, 3 & 4	($118,500)	$0	$0
Costs - DSS: DLS			
Section 208.659	(Less than $100,000)	(Less than $100,000)	(Less than $100,000)
FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
Costs - DSS: FSD			
Sections 105.711 - 620.510, 1, 2, 3 & 4			
Personal Services	($1,342,686)	($1,660,224)	($1,710,030)
Fringe Benefits	($613,070)	($758,058)	($780,800)
Equipment and Expense	($297,702)	($64,829)	($66,774)
Total Costs - DOS:FSD	($2,253,458)	($2,483,111)	($2,557,604)
FTE Change - DOS	60 FTE	60 FTE	60 FTE
Costs - DSS: DMS			
Section 167.182	($56,370)	($67,644)	($67,644)
Section 191.1056	Unknown	Unknown	Unknown
Section 208.146	($6,492,435)	($6,784,595)	($7,089,900)
Section 208.151	($628,776)	($657,071)	($686,640)
Section 208.151	($250,000)	($250,000)	($250,000)
Section 208.152.1(19) DME	($7,408,941)	$7,742,343	($8,090,748)
Section 208.152.1(19) Therapies/Comp Rehab	($1,629,691)	($1,703,027)	($1,779,663)
Section 208.152.1(19) PA System	($1,000,000 to $1,250,000)	($1,000,000 to $1,250,000)	($1,000,000 to $1,250,000)
Section 208.152.1(21)(22)(23)(24)	($13,190,580)	($27,568,312)	($28,808,886)
Section 208.152.1(27)	$0	(Greater than $41,626,239)	(Greater than $83,252,289)

Section 208.152.2	$0	($2,696,292 to $5,392,585)	($2,817,626 to $5,635,251)
Section 208.152.10	($1,226,198)	($1,281,378)	($1,339,041)
Section 208.153 Cola	($473,508)	($473,508)	($473,508)
Section 208.153 Out-of-Pocket	(Unknown)	(Unknown)	(Unknown)
Section 208.197	(Unknown)	(Unknown)	(Unknown)
Section 208.215.13	($10,000)	($10,000)	($10,000)
Section 208.225	($865,296)	($614,159)	($641,796)
Section 208.225 Retro Adjustment	($1,989,317)	($1,149,393)	($1,201,115)
Section 208.631.1	($4,676,227)	($4,860,788)	($5,079,524)
Section 208.640.1	($2,056,744)	($2,149,298)	($2,246,016)
Section 208.640.1 Pre-existing cond.	($762,210)	($796,510)	($832,353)
Section 208.640 Kids	($2,980,309)	($3,114,423)	($3,254,573)
Section 208.640.2	($3,236,308)	($3,381,941)	($3,534,129)
Section 208.640.2(2)	(Unknown)	(Unknown)	(Unknown)
FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
Costs - DSS: DMS (continued)			
Section 208.659	($996,832)	($1,250,027)	($1,306,279)
Section 208.659 Cancer	($872,816)	($2,125,088)	($3,287,337)
Section 208.950	(Unknown)	(Unknown)	(Unknown)
Section 208.952.11	(Unknown)	(Unknown)	(Unknown)
Section 208.952.13	(Unknown)	(Unknown)	(Unknown)
Section 208.952.19	(Unknown)	(Unknown)	(Unknown)
Section 208.954.3	(Unknown)	(Unknown)	(Unknown)
Section 208.954.6	(Unknown)	(Unknown)	(Unknown)
Section 208.956	(Unknown)	(Unknown)	(Unknown)
Section 208.958	(Unknown)	(Unknown)	(Unknown)
Section 208.960	(Unknown)	(Unknown)	(Unknown)
Section 208.962	($7,755,807)	($38,783)	($38,959)
Section 208.962 Expansion Groups	($2,587,806)	($116,460)	($121,703)
Section 208.962 Broker	($1,375,875)	($6,880)	($6,912)
Section 208.962 Broker Expan Group	($459,075)	($20,660)	($21,590)
Section 208.964	($2,447,163)	($12,232)	($12,304)
Section 208.964 Expansion Group	($95,942)	($4,312)	($4,510)
Section 208.964 Broker	($434,125)	($2,170)	($2,183)
Section 208.964 Broker Expan Group	($17,020)	($765)	($800)
Section 208.968	(Unknown)	(Unknown)	(Unknown)

Section 4 Total Costs - DOS/DMS	(Unknown) (Unknown Greater than $65,975,371 to Unknown Greater than $66,225,371)	(Unknown) (Unknown Greater than $68,529,913 to Unknown Greater than $70,128,060)	(Unknown) (Unknown Greater than $74,005,739 to Unknown Greater than $77,073,364)
Loss - Decreased Income Tax Receipts from increasing the long-term care insurance premium deduction from 50% to 100% (Section 135.096)	(Approximately $2,880,000)	(Approximately $2,880,000)	(Approximately $2,880,000)
FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
Loss - DOR Sections 191.1050-191.1056			
Tax Credits	$0 to ($500,000)	$0 to ($1,500,000)	$0 to ($1,000,000)
Transfer out - DHSS Sections 191.1050-191.1056			
Transfer to the Missouri Healthcare Access Fund	$0 to ($500,000)	$0 to ($1,500,000)	$0 to ($1,000,000)
Transfers out - to State Legal Expense Fund (Section 105.711)	(Greater than $100,000)	(Greater than $100,000)	(Greater than $100,000)
ESTIMATED NET EFFECT ON GENERAL REVENUE FUND	**(Unknown Greater than $61,346,642 to Unknown Greater than $62,596,642)**	**(Unknown Greater than $40,997,327 to Unknown Greater than $22,995,474)**	**(Unknown Greater than $10,671,151 to Unknown Greater than $15,738,776)**
Estimated Net FTE Change for General Revenue Fund	65.27 FTE	65.27 FTE	65.72 FTE

FEDERAL FUNDS

Income - Federal Assistance	Unknown but Greater than $132,000,000	Unknown but Greater than $211,000,000	Unknown but Greater than $289,000,000
Costs - Program Costs	(Unknown but Greater than $132,000,000)	(Unknown but Greater than $211,000,000)	(Unknown but Greater than $289,000,000)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**
Estimated Net FTE Change for Federal Fund	61.23 FTE	61.23 FTE	61.23 FTE
FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
INSURANCE DEDICATED FUND			
Income - DIFP Sections 208.690-208.698			
Filing Fee	$0 to $5,000	$0	$0
Costs - DIFP Sections 208.690-208.698			
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

STATE LEGAL EXPENSE FUND

Transfers in - from General Revenue Fund (Section 105.711)	Greater than $100,000	Greater than $100,000	Greater than $100,000
Costs - Office of Administration			
Section 105.711 Increased Liability	(Greater than $100,000)	(Greater than $100,000)	(Greater than $100,000)
ESTIMATED NET EFFECT ON STATE LEGAL EXPENSE FUND	**$0**	**$0**	**$0**

FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
MISSOURI HEALTHCARE ACCESS FUND			
Transfer in - Appropriations, gifts, grants, or donations (Section191.1050-191.1056)*	$0 to $15,000,000	$0 to $15,000,000	$0 to $15,000,000
Costs - Department of Health and Senior Services			
Disbursements (Section 191.1050-191.1056)*	$0 to ($15,000,000)	$0 to ($15,000,000)	$0 to ($15,000,000)
ESTIMATED NET EFFECT ON MISSOURI HEALTHCARE ACCESS FUND	**$0**	**$0**	**$0**

*Oversight assumes potential transfers in-gifts, grants, or donations of $10,000,000 and appropriations of $5,000,000 would equal disbursements of $15,000,000 and net to $0.

STATE SCHOOL MONEY FUND

Savings - Reduced distribution to schools	$0	Unknown	Unknown
Losses - Reduced appropriations from the General Revenue Fund	$0	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON STATE SCHOOL MONEY FUND	**$0**	**$0**	**$0**

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 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.

Section 105.711 (State Legal Expense Fund): This bill allows physicians and dentists who provide specialty care without compensation and who were referred by his or her city or county health department, city health department operating under a city charter, combined city-county health department, a nonprofit community health center, or any social welfare board established under Section 205.770, RSMo, to be included in the list for whom the State Legal Expense Fund is available. The fund is not available to a physician who performs an abortion procedure.

Any claim or judgment arising from these provisions is limited to a maximum of $1 million based upon the same act or acts in a single cause of action and $1 million for any one claimant. Liability or malpractice insurance will not be considered available to pay any portion of the judgment when the fund is liable.

Section 135.096 (Long-Term Care Insurance Premiums): The proposal would allow Missouri residents to deduct from their taxable income 100% of all non-reimbursed amounts paid for long-term care insurance premiums.

Section 167.182 (Cervical Cancer Prevention): The proposal required an education campaign and vaccines to be given.

Section 191.411 (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 191.900 - 191.907 (Medicaid Fraud): A person commits a "knowing" violation of sections prohibiting Medicaid fraud if he or she has actual knowledge of the information, acts in deliberate ignorance of the truth or falsity of the information, or acts in reckless disregard of the truth or falsity of the information, but provides that the use of the terms "knowing" or "knowingly" shall be construed to include the term "intentionally." This legislation also expands

FISCAL DESCRIPTION (continued)

the definition of "health care provider" to include any employee, representative, or subcontractor of the state.

Current law provides that any person committing such a violation shall be guilty of a Class D felony upon a first conviction, and shall be guilty of a Class C felony upon subsequent convictions; this legislation provides that such person shall be guilty of a Class C felony upon a first conviction, and shall be guilty of a Class B felony upon subsequent convictions. Also, any person who has been convicted of such violations shall be referred to the federal Office of Inspector General.

Any person who is the original source of the information used by the Attorney General to bring a Medicaid fraud action shall receive 10 percent of any recovery by the Attorney General unless he or she participated in the fraud or abuse.

The legislation also contains "whistle-blower" protections, providing that a person who is discharged, demoted, suspended, threatened, harassed, or in any way discriminated against in terms of employment due to a lawful act taken by the person in furtherance of an action for Medicaid fraud shall be entitled to reinstatement with the same seniority status, not less than two times the amount of back pay, interest on the back pay. However, such protections shall not apply if the court finds that the employee brought a frivolous or clearly vexatious claim, planned,

initiated, or participated in the conduct upon which the action is brought, or is convicted of criminal conduct arising from Medicaid fraud violations.

The Attorney General's office and the Department of Social Services shall make a detailed report to the General Assembly and the Governor regarding implementation and administration of the provisions of this act, as provided therein. Additionally, a financial audit of the medicaid fraud unit within the Attorney General's office and of the program integrity unit of the Department of Social Services shall be annually conducted by the State Auditor, to quantitatively determine the amount of money invested in such units and the amount of money actually recovered by them.

All Medicaid health care providers shall maintain adequate records regarding services provided, claims submitted, and payments requested, and shall maintain such records for at least five years after the date payment was received or for at least five years after the date on which the claim was submitted, if payment was not received. No person shall conceal or destroy such records before five years time, or he or she shall be guilty of a Class A misdemeanor.

Any person who intentionally files a false report or claim alleging a Medicaid fraud violation is guilty of a Class A misdemeanor and guilty of a Class D felony for any subsequent violations. In

FISCAL DESCRIPTION (continued)

addition, it shall be a class D felony for any person to receive any compensation in exchange for knowingly failing to report any Medicaid fraud violations.

An advisory working group is created to study and determine whether an Office of Inspector General shall be established. Such office would be responsible for oversight, auditing, investigation, and performance review to provide increased accountability, integrity, and oversight of state medical assistance programs. The commission will consist of ten members, five from the House and five from the Senate. Additionally, the directors of the Departments of Social Services, Health and Senior Services, and Mental Health shall serve as ex-officio members of the advisory working group.

This legislation also allows for the deposit of moneys recovered in a Medicaid fraud action to be used to increase Medicaid provider reimbursement until amount equals the average Medicare provider reimbursement for comparable services. Such funds shall be deposited for this purpose so long as there are any funds remaining after the appropriation of funds to the Attorney General for cost of investigation and prosecution and which have been appropriated to the Department of Social Services for administering the state medical assistance program.

Sections 135.575 & 191.1050 - 191.1056 (Missouri Healthcare Access Fund): This legislation creates the Missouri Healthcare Access Fund to be used to expand healthcare services in state and federally designated areas with healthcare shortages. The Department of Health and Senior Services has the authority to designate eligible facilities in an area of defined need and is required to re-evaluate eligible facilities every six years. Beginning January 1, 2007, individuals making a donation in excess of $100 to the fund will be eligible for a tax credit.

The provisions of the bill will expire six years from the effective date.

Section 192.632 (Chronic Kidney Disease Task Force):

This legislation creates the "Chronic Kidney Disease Task Force." The list of 17 members are specified in the legislation. The duties of the task force include developing a plan to educate the public and health care professionals about the advantages and methods of early screening, diagnosis, and treatment of chronic kidney disease. Also, the task force shall submit a report of its findings and recommendations to the General Assembly within a year of its first meeting.

FISCAL DESCRIPTION (continued)

Section 198.069 (Review Physician Orders):

This legislation requires assisted living facilities to review any physician orders for residents who return to the facility after a hospital or skilled nursing facility stay.

Sections 208.014, 208.631 & 208.930 (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. 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.

Section 208.146 (Medical Assistance for the Working Disabled): This legislation requires the Department of Social Services to determine the eligibility of an employed disabled person requesting medical assistance whose family gross income is less than 250% of the federal poverty level. The legislation:

(1) Requires that an individual meet the definition of a disabled person under the Federal Supplemental Security Income Program or of an employed individual with a medically improved disability under the Federal Ticket to Work and Work Incentives Improvement Act of 1999;

(2) Requires an individual who has a net income that does not exceed the limit for permanent and totally disabled individuals to receive non-spenddown Missouri Medicaid benefits;

(3) Requires any participant whose gross income exceeds 100% of the federal poverty level to pay a premium for participation in this program;

(4) Requires an individual to participate in an employer-sponsored health insurance plan if the department determines that it is more cost effective;

(5) Exempts any income earned through certified extended employment at a sheltered workshop for the purposes of determining eligibility; and

(6) Exempts deposits of up to $5,000 per year into a medical savings and/or an independent living account from the asset limits for eligibility. The provisions of this proposal will expire three years from the effective date. The legislation contains an emergency clause.

FISCAL DESCRIPTION (continued)

Sections 208.151 (Eligibility): Under this legislation, individuals who receive medical assistance due to the receipt of aid to families with dependent children, shall continue to be eligible for such assistance for sixty days despite having a child or children removed from their custody, if such person is a participant in a drug court program.

Section 208.152 (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. This legislation also allows for durable medical equipment if medically necessary as well as hospice care.

Section 208.153 (Pay-for-Performance): The Mo HealthNet Division shall develop a pay-for-performance program.

Section 208.197 (Professional Services Payment Committee): The proposal establishes the Professional Services Payment Committee.

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

Section 208.215 (Pay Claims, Third Party Payors & Recorder of Deeds): This legislation requires health benefit plans to pay claims for three years. This legislation requires HIPAA rules to apply to third-party payors and requires payment to recorders of deeds.

Section 208.225 (Nursing Home Reimbursement Rates): The proposal regards nursing home reimbursement rates and a retroactive adjustment.

Section 208.230 (Public Assistance Beneficiary Employer Act): An applicant for benefits under the state Medicaid system, or any person requesting uncompensated care in a hospital, shall identify his or her employer. The Department of Social Services shall to submit to the General Assembly an annual report, starting in calendar year 2008, identifying all such identified employers who employ 25 or more public assistance program beneficiaries. There shall also be public access to the report through the Department's Internet website.

Sections 208.631 - 208.640 (SCHIP Eligibility): 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. This legislation changes eligibility for SCHIP.

FISCAL DESCRIPTION (continued)

Section 208.659 (Uninsured Women's Health Program): This legislation requires revision of eligibility requirements for the uninsured women's health program to include women who are at least 18 years old and with a net family income of at or below 185 percent of the federal poverty level. Such women shall not have assets in excess of 250,000 dollars, nor shall they have access to employer-sponsored health insurance. There is an emergency clause for the provisions relating to foster care eligibility.

Section 208.670 (Telehealth Services): The proposal is in regards to telehealth services.
Sections 208.690 - 208.698 (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 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 legislation.

FISCAL DESCRIPTION (continued)

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.

Sections 208.950 (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 plan, which consists of coordinated care with a guaranteed savings level that is actuarially sound.

- 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.

- 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 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. 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

FISCAL DESCRIPTION (continued)

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. No provision in the legislation shall be construed to require the aged, blind, or disabled population to enroll in a risk-bearing care coordination plan unless there is no other plan available in the area.

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. 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 legislation.

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. A participant shall not be denied currently eligible services if such participant fails or is unable to follow their health improvement participation agreement. Participants engaging in a discussion with their 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.

FISCAL DESCRIPTION (continued)

All plans shall also establish a twenty-four, 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.

Section 208.952 (Plan Study): This proposal is in regards to a plan study.

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Section 208.954 (Pre-authorization: This proposal is in regards to pre-authorizations.

Section 208.956 (MO HealthNet Oversight Committee): This legislation establishes the MO HealthNet Oversight Committee.

Section 208.958 (Advisory Working Group): This proposal is in regards to an advisory working group.

Section 208.960 (Joint Committee on Mo HealthNet): This proposal establishes the Joint Committee on Mo HealthNet.

Section 208.962 (Enroll in Plans): This proposal is in regards to enrolling in plans.

Section 208.964 (Aged, Blind and Disabled): This proposal is in regards to ABD.

Section 208.968 (Universal Information System): This proposal establishes a Universal Information System.

Section 208.975 (Health Care Technology Fund): This legislation 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.

FISCAL DESCRIPTION (continued)

The Department shall promulgate rules setting forth the procedures and methods for implementing the provisions 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 473.398 (Probate Estate Recovery): This proposal is in regards to probate estate recovery.

Section 620.510 (Missouri Health Profession Shortage Planning Commission):

This legislation establishes the Missouri Health Profession Shortage Planning Commission within the Department of Economic Development. Members appointed to the commission are to be recognized as experts in the field of health, finance, economics, or health facility management and must be appointed within 30 days of the effective date of the legislation. Non-legislative members will serve a three-year term, while legislative members will serve the duration of their current legislative term.

The commission's duties include monitoring data and trends in the health profession workforce, making recommendations on the economic cluster for health care professions, identifying recruitment and retention strategies for higher education health care programs, promoting diversity, making recommendations on financial and other assistance to students enrolled in health care programs, and identifying recruitment and retention strategies for health care employers.

The commission will annually submit a report on its findings and recommendations to the appropriate standing committees of the House of Representatives and Senate.

Section 3 (Pharmacy Rebates): This proposal is in regards to pharmacy rebates.

Section 4 (HPV Vaccine): This proposal is in regards to HPV Vaccine.

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 - Budget and Planning
Office of Administration
Office of the State Courts Administrator
Department of Economic Development
Department of Elementary and Secondary Education
Department of Insurance, Financial Institutions and Professional Registration
Department of Mental Health
Department of Health and Senior Services

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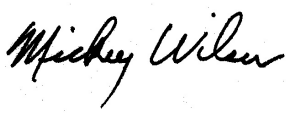
Department of Revenue
Department of Social Services
Missouri House of Representatives
Missouri Senate
Office of the Secretary of State
Office of the State Treasurer

Not Responding: Department of Corrections



Mickey Wilson, CPA
Director
May 10, 2007

SEC:LR:OD (12/06)