COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 2227-16
Bill No.: Truly Agreed To and Finally Passed CCS for HCS for SS for SCS for SB 577
Subject: Health Care; Health, Public; Health Care Professionals; Social Services Department; Medicaid
Type: Original
Date: June 4, 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 $108,509,047 to Unknown Greater than $109,759,047)	(Unknown Greater than $110,607,055 to Unknown Greater than $93,953,348)	(Unknown Greater than $115,790,803 to Unknown Greater than $120,858,428)
Total Estimated Net Effect on General Revenue Fund	**(Unknown Greater than $108,509,047 to Unknown Greater than $109,759,047)**	**(Unknown Greater than $110,607,055 to Unknown Greater than $93,953,348)**	**(Unknown Greater than $115,790,803 to Unknown Greater than $120,858,428)**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 42 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 and appropriations would equal the disbursements and net to $0.
***Oversight assumes unknown savings and costs beginning 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 $180,000,000 in FY08, Unknown but Greater than $231,000,000 in FY09 and Unknown but Greater than $301,000,000 in FY10 would net to $0.

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2008	FY 2009	FY 2010
General Revenue	49.68 FTE	49.68 FTE	49.68 FTE
Federal	44.82 FTE	44.82 FTE	44.82 FTE
Insurance Dedicated	1 FTE	1 FTE	1 FTE
Total Estimated Net Effect on FTE	**95.5 FTE**	**95.5 FTE**	**95.5 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 - 473.398, 1 & 2 & 3 (MO HealthNet Program):

Officials from the **Office of the State Treasurer, Office of Administration - Division of Accounting**, **Missouri Senate**, **Missouri House of Representatives** and the **Office of the State Courts Administrator** each assume 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 the 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)** assume any costs for other eligibility changes noted in Sections 208.146, 208.151, 208.152, 208.631, and 208.640 will be reflected in the fiscal impact prepared by the DSS. DMH assumes that DSS will calculate the fiscal impact in total, as well as that related to DMH funding MO HealthNet services specifically.

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)** assume this proposal would have a fiscal impact. Contract Staff: 1,820 hours at a cost of $75.00 per hour = $136,500.

ASSUMPTION (continued)

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 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 (OA)** 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.

ASSUMPTION (continued)

OA states this proposal removes "community" from 105.711 (2) (3) f , expanding the referrals from "nonprofit health centers". The definition of "nonprofit health center" is unknown. A non-profit health center could include most hospitals in the state, rural health clinics and perhaps your local YMCA. The removal of "community" may significantly expand the state legal expense fund coverage with increased potential costs that cannot be determined at this time.

OA 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.

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

SECTION 135.096 (Long-Term Care Insurance Premiums):

Officials from the **Office of Administration, Division of Budget and Planning** (BAP) assume 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.

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ASSUMPTION (continued)

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.

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

Officials from the **Office 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)** state these sections create the Missouri Healthcare Access Fund to be used to expand healthcare services in state and federally designated areas with healthcare shortages. DHSS is authorized to designate eligible facilities in an area of defined need to be eligible for disbursements from the fund. In addition to gifts, grants, and other sources of revenue deposited in the fund as approved by the oversight committee, the state shall provide matching moneys from the General Revenue fund equaling one-half of the amount deposited into the fund, up to $500,000 in FY 2008, $1,500,000 in FY 2009, and $1,000,000 annually thereafter. Since the amount of revenue deposited into the fund remains unknown, the amount of GR required is also unknown. DHSS assumes a range from $0 to the cap noted for each year.

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.

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

ASSUMPTION (continued)

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.

SECTIONS 191.900 - 191.914 (Audit Requirements):

Officials from the **Office of the State Auditor (SAO)** state this proposal contains two audit requirements. SAO states an annual financial audit of the Medicaid fraud unit within the Attorney General's Office is required. This audit requirement is primarily a cost/benefit analysis of the unit. SAO estimates that this audit will require 1 FTE at the Staff Auditor III level. SAO states an annual financial audit of the program integrity unit of the Medicaid program within the Department of Social Services is required. This audit requirement is primarily a cost/benefit analysis of this unit. SAO estimates that this audit will require 1 FTE at the Staff Auditor III level.

Oversight assumes the SAO can carry out the requirements of this proposal with 1 FTE.

SECTION 192.632 (Chronic Kidney Disease Task Force):

Officials from the **Department of Health and Senior Services (DHSS)** state this bill 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 additional members can be appointed to the task force, costs are calculated for a total of 25 task force members.

ASSUMPTION (continued)

The bill does not specify how often the task force is to meet, but does require it to prepare its final recommendations in the form of a report to the general assembly within 365 days of its first meeting. With that time frame, it is assumed that the task force will meet six times annually. The provisions expire August 28, 2008 so no expenses will be needed beyond that point.

The Bureau of Cancer and Chronic Disease Control will utilize existing staff to provide support for the task force, however additional expense and equipment will be needed to support the task force. The task force will be in existence for only one year, since the bill 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. The task force will be appointed by September, start meeting in October and meet every other month through August, assuming they will meet 5 times in FY 2008 and 1 time in FY 2009. At the standard cost of $160 per member per meeting, the total cost would be $24,000 (25 X $160 X 6).

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 (MAWD) Program, with specific criteria pertaining to

ASSUMPTION (continued)

disabled person's earned income and the purchase of dental and optical insurance. To qualify for the new program, persons receiving SSDI would have to earn at least twice what their spenddown, minus $50, would be for the regular Medicaid program for persons with disabilities.

ELIGIBLES: Essentially, there are four (4) different sub-populations impacted by the proposed legislation:

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

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

664 persons-Old MA-WD only*
1,310 persons--Spenddown Met
1,135 persons--Spenddown Not Met
131 New Eligibles**

3,240-Total eligibles

*This is the old population that was eligible for MA-WD and above the Substantial Gain Allowance (SGA).
**Due to the increase of disregarding 250% to 300% of the disabled workers earned income. This is based on MO Census information from 2005. The total population of people earning 250% to 300% of the FPL divided by the total population of people from 0% to 300% of the FPL. This % (16%) was used to project 131 new eligibles from the old MA-WD participants (664) with earnings over the SGA, plus people currently receiving Medicaid earning over the 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 the Department of Social Services will calculate the fiscal impact associated with determining eligibility under the new requirements, the cost of services for the new group of eligible recipients, and the cost of any administrative hearings regarding denial of eligibility.

ASSUMPTION (continued)

Information provided by the Department of Social Services, Family Support Division indicates the legislation would result in an estimated 3,240 MAWD (Medical Assistance for the Working Disabled) eligibles for purposes of determining eligibility for Medicaid (public assistance): 664 Old MAWD clients + 1,310 who met spenddown + 1,135 who didn't meet spenddown + 131 new eligibles due to disregard of 250-300% of disabled workers income.

Of these eligibles, 1,310 are currently receiving Medicaid through spend-down and thus would already be included in the 3,240 clients. Therefore, the number of additional eligibles is estimated to be 1,930 (3,240-1,310).

In FY05 the Division of Senior and Disability Services served 1,071 MAWD clients in its in-home services program and 719 MAWD clients in its consumer directed services program (transferred under Executive Order from the Department of Elementary and Secondary Education, Division of Vocational Rehabilitation to the Department of Health and Senior Services, Division of Senior and Disability Services) for a total of 1,790 clients out of the total 16,962 total MAWD population (number of eligibles when the program was discontinued in FY 06 as reported by the Family Support Division) giving the division a participation rate of 10.6% of all MAWD clients that are served by the division and who need either in-home services or consumer directed services.

Applying the Division's participation rate of 10.6% to the 1,310 additional eligibles will result in 205 additional Medicaid recipients that will access home care or consumer directed care (1,930 X 10.6%). The DHSS will need to provide case management for new clients participating in the in-home services or consumer directed services program. Note: the DSS will include costs for services for the new eligibles including the cost of in-home services or consumer directed services.

As of June 30, 2006, caseloads for DSDS Social Services Workers average approximately 174 per FTE ((46,428 In-Home + 8,805 Consumer Directed)/318.04). Pursuant to 660.021 RSMo, the Caseload Standards Advisory Committee recommended that caseloads should be no more than a recommended 80 per worker. The division would request additional staff in an effort to reduce average caseloads to at least 100 per Social Service worker.

Keeping with the previous request to reduce caseloads to 100 per worker, the division will require 2.00 Social Service Worker positions to case manage the new MAWD eligibles and the new Medicaid eligibles as a result of exempting sheltered workshop income.

ASSUMPTION (continued)

Social Service Worker duties include the responsibility for the investigation of hotlines, eligibility determination and authorization of state-funded in-home services; care plan management, and provide oversight and accountability for the performance of the Social Service Workers including case review, evaluation, and guidance. Total Costs: FY2008 - $129,247; FY2009 - $118,801; FY2010 - $122,365.

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 $11,001,595 in FY08, $11,496,666 in FY09 and $12,014,016 in FY10.

Officials from the **Department of Mental Health (DMH)** state Section 208.146.6 states if an employer-sponsored health insurance plan is more cost effective, the person shall participate in the employer-sponsored plan. DMH assumes there could be an unknown cost if employer-sponsored plans do not cover CPRC or CSTAR services. DMH assumes it would still provide these services for DMH clients.

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 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.

ASSUMPTION (continued)

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.

SECTION 208.152 (Services):

Officials from the **Department of Social Services - Family Support Division (FSD)** assume based on available information, it is FSD's contention that if income for individuals eligible for employment at a sheltered 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.

ASSUMPTION (continued)

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume section 208.152 would have a savings of $1,041,718 in FY08, $1,088,595 in FY09 and $1,137,582 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 $7.5M in FY08, $7.7M in FY09 and $8.1M 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) would have a fiscal impact to GR of $26M in FY08, $27.2M in FY09 and $28.4M in FY10.

DMS assume the section 208.152.1(23) would have a fiscal impact to GR of Greater than $25.2M in FY08, Greater than $58.5M in FY09 and Greater than $91.7M in FY10.

DMS assume the section 208.152.4 would have a fiscal impact to GR of $0 in FY08, $2.7M to $5.4M in FY09 and $2.8M to $5.6M in FY10.

DMS assume the section 208.152.111 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

ASSUMPTION (continued)

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 the language in this subsection can be divided into two parts - the language currently in state statute, and those changes that affect residents of residential care or assisted living facilities. The new language presumes that a tiered based system will be created. SB 616 (2006) requires that the Departments of Social Services and DHSS create a new waiver to reimburse facilities for care of these residents, to be submitted to the Centers for Medicare and Medicaid (CMS) by July 1, 2007. This new waiver may include tiered rates, but is not required to include such a reimbursement system, and is still subject to CMS approval. As written, the language notes that payment will be subject to appropriations. In this version, physicians will authorize for up to one hour of services, and only for those clients who meet level of care requirements. The department notes that this is the current practice of the state, and thus any fiscal impact related to this bill would be sought through the appropriations process, as indicated in the fiscal note for SB 616. (Note: there may be some increased costs related to restrictions on unit reductions. DSDS feels that these costs will be minimal.) Further, language in section 10.690 of HB 10 (2007) makes significant changes to the authorization process for personal care services, including services for residents in facilities. As personal care is an entitlement service for this population, DSDS will seek additional funding as needed through the appropriations process. Finally, the provisions of this section require CMS approval before enacting. If CMS fails to approve the waivers and/or state plan amendments related to this section, the provisions are null and void. If this occurs, there will be no fiscal impact to the department. DSDS currently assumes no fiscal impact, however, if at a later time DSDS determines there would be a fiscal impact related to this bill, funding would be sought through the appropriations process.

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.

ASSUMPTION (continued)

DMS assume the section 208.153.2 would have a cost of $1,100,000 in FY08, $1,143,415 in FY09 and $5,094,869 in 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

Officials from the **Department of Mental Health (DMH)** assume there will be an unknown increase in expenses related to tracking portions of payments due to multiple providers, such as state employees billing Medicaid and receiving payment. The state would need to develop a mechanism to pay state employees for this pay-for-performance program. It is unclear whether some DMH programs would be included under pay-for-performance since most of the services are provided by clinicians other than physicians. DMH assumes if these programs are included, there would be an unknown programmatic cost. In addition, DMH assumes there would be an unknown administrative cost.

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 208.202 (Premium Offset Program):

Officials from the **Department of Social Services (DSS) - Division of Medical Services (DMS)** assume this proposal would have a fiscal impact to GR of $5,000,000 in FY08, FY09, FY10.

SEC:LR:OD (12/06)

ASSUMPTION (continued)

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 208.215.7 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 208.230 (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 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.

ASSUMPTION (continued)

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

**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.

Section 208.640.1 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.

ASSUMPTION (continued)

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 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.

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.

The FSD anticipates an increase in the number of children eligible. FSD anticipates 1,367 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
Number of cases that were closed in one month because of	
Insurance	136
Affordable Insurance	287
Dropped Insurance	1

ASSUMPTION (continued)

Number of children in cases rejected or closed due to affordable insurance in one year: 10,608 (155 + 287 = 442 X 2 kids X 12).

Number of children in cases that were rejected or closed in one year due to insurance or dropped insurance = 6,120 (114 + 136 + 4 + 1 = 255 X 2 X 12).

FSD anticipates that 10% of the children rejected or closed due to affordable insurance will exceed the annual service limit and become eligible for medical assistance benefits. 10,608 x 10% = 1,061 new children to be eligible for medical assistance benefits.

FSD anticipates 5% of the children rejected of closed due to insurance or dropped insurance will exceed the annual service limit and become eligible for medical assistance benefits. 6,120 x 5% = 306.

Total new kids added: 1,061 + 306 = 1,367/2 kids per case: 684 cases

New FTE: 684/243 caseload standard = 2.82; 3 new Eligibility Specialists.

New Eligibility Supervisor: 10-1 ratio: 3/10 = .30, rounded down to 0 new Eligibility Supervisors.

3 + 0 = 3/6 professional support staff: 1; 1 OSA.

Total new FTE: 3 + 1 = 4
Oversight assumes the FSD could absorb 1 Office Support Assistant. **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 varied fiscal impact to their agency. See breakdown on page 28.

ASSUMPTION (continued)

SECTION 208.659 (Uninsured Women's Health Program):

Officials from the **Department of Social Services - Family Support Division (FSD)** assume 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 $883,224 in FY08, $2,150,425 in FY09 and $3,326,532 in FY10.

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.

ASSUMPTION (continued)

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.

SECTION 208.930 (Non-Medicaid Eligible Program):

Officials from the **Department of Health and Senior Services** state the sunset is extended from June 30, 2008, to June 30, 2019. DSDS assumes the program will continue as it is presently operated. There are 119 slots in the Non-Medicaid Eligible program. The average approved care plan for each of the 119 consumers in FY 2006 was $17,393. The program currently has 85 slots in use by consumers. At the average cost of $17,393 per consumer, an estimated $1,478,405 will be expended for FY 2007. However, because up to 119 consumers may utilize this program (if

ASSUMPTION (continued)

they meet specific criteria), up to $2,069,764 could be expended. The current appropriation is $2,277,300, which includes 10% for possible increases in care plan cost. Since the sunset is extended for eleven years, cost savings would not be realized until FY 2019.

SECTION 208.950 (Health Improvement Plans):

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 28 and 29.

Officials from the **Department of Mental Health (DMH)** assume this would increase the cost to DMH depending on the credentials necessary of the individual overseeing the health improvement plan.

SECTION 208.952 (Plan Study):

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 208.955 (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

This section establishes a comprehensive entry point system subcommittee to make recommendations for the implementation of entry point system. Since it is unknown what recommendations the subcommittee will have at this time, ITSD assumes no fiscal impact. However, depending upon what is recommended by the subcommittee, it should be noted that a new comprehensive entry point system would likely have a significant cost to ITSD.

ASSUMPTION (continued)

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 Mental Health (DMH)** assume some of the funds would be expended for DMH administrative activities.

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 2 (Prescription Drugs):

Officials from the **Department of Mental Health (DMH)** assume that there would be a yearly cost due to inflation of these psychotropic drugs. DMH would need the same inflationary increases for medication that DSS receives. In addition, if a significant number of people end up in a managed care plan where access is not protected, this could create extra cost for DMH to provide the drugs to these people. DMH assumes cost would be greater than $100,000.

FISCAL IMPACT - State Government	FY 2008 (10 Mo.)	FY 2009	FY 2010
GENERAL REVENUE FUND			
Savings - DSS: DMS			
Sections 105.711 - 473.398, 1, 2 & 3	$0	$22,600,000 to $45,200,000	$58,500,000
Section 208.152.1	$1,041,718	$1,088,595	$1,137,582
Section 208.213	Unknown	Unknown	Unknown
Section 208.215.7	Greater than $78,290	Greater than $93,950	Greater than $93,950
Section 473.398	$172,173	$206,690	$206,690
Total Savings - DSS	Unknown Greater than $1,292,181	Unknown Greater than $23,989,235 to Unknown but Greater than $46,589,235	Unknown Greater than $59,938,222
Savings - Reduced appropriations to State School Moneys Fund (from deduction of fine revenue from previous year)	$0	Unknown	Unknown
Costs - AGO:			
Sections 105.711 - 473.398, 1, 2 & 3			
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 - 473.398, 1, 2 & 3 Publishing Costs	($18,450)	$0	$0

FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
Costs - Office of the State Auditor			
Personal Services	($32,188)	($39,784)	($40,977)
Fringe Benefits	($14,568)	($18,006)	($18,546)
Equipment and Expense	($5,954)	($309)	($318)
Total Costs - SAO	($52,710)	($58,099)	($59,841)
FTE Change - SAO	1 FTE	1 FTE	1 FTE
Costs - DMH			
Sections 105.711 - 473.398, 1, 2 & 3	(Unknown Greater than $100,000)	(Unknown Greater than $100,000)	(Unknown Greater than $100,000)
Costs - DHSS			
Section 192.632	($13,600)	($2,720)	$0
Section 208.146 Personal Services	($36,331)	($37,421)	($38,543)
Section 208.146 Fringe Benefits	($16,443)	($16,937)	($17,445)
Section 208.146 E&E	($13,951)	($6,890)	($7,097)
Section 208.955	($21,120)	($14,080)	($14,080)
Total Costs - DHSS	($101,445)	($78,048)	($77,165)
FTE Change - DHSS	1.18 FTE	1.18 FTE	1.18 FTE
Costs - DED			
Section 620.510	($31,330)	($20,886)	($20,886)
Costs - DSS: ITSD			
Sections 105.711 - 473.398, 1, 2 & 3	($136,500)	$0	$0
Costs - DSS: FSD			
Sections 208.640 & 208.659			
Personal Services	($984,775)	($1,217,669)	($1,254,199)
Fringe Benefits	($449,648)	($555,988)	($572,667)
Equipment and Expense	($304,624)	($66,335)	($68,325)
Total Costs - DOS:FSD	($1,739,047)	($1,839,992)	($1,895,191)
FTE Change - DOS	44 FTE	44 FTE	44 FTE

FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
Costs - DSS: DMS			
Section 191.1056	(Unknown)	(Unknown)	(Unknown)
Section 208.146	($11,001,595)	($11,496,666)	($12,014,016)
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) 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)	($26,042,940)	($27,214,872)	($28,439,542)
Section 208.152.1(23)	(Greater than $25,249,752)	(Greater than $58,458,071)	(Greater than $91,666,390)
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 208.153.2 P-4-P	($1,100,000)	($1,143,415)	($5,094,869)
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 208.202	($5,000,000)	($5,000,000)	($5,000,000)
Section 208.215.13	($10,000)	($10,000)	($10,000)
Section 208.631.1	($4,676,227)	($4,860,788)	($5,079,524)
Section 208.631.1 Affordability	($2,056,744)	($2,149,298)	($2,246,016)
Section 208.640.1 Pre-existing cond.	($762,210)	($796,510)	($832,353)
Section 208.640.1 Coverage Limit	($442,731)	($462,654)	($483,474)
Section 208.659	($996,832)	($1,250,027)	($1,306,279)
Section 208.659 Cancer	($883,224)	($2,150,425)	($3,326,532)
Section 208.950	($7,755,807)	($38,783)	($38,959)
Section 208.950 Expansion Groups	($2,587,806)	($116,460)	($121,703)
Section 208.950 Broker	($1,375,875)	($6,880)	($6,912)
Section 208.950 Broker Expan Group	($459,075)	($20,660)	($21,590)
Section 208.950 ABD	($2,447,163)	($12,232)	($12,304)
Section 208.950 ABD Expan Group	($140,192)	($6,313)	($6,595)
Section 208.950 ABD Broker	($434,125)	($2,170)	($2,183)

FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
Costs - DSS: DMS (continued)			
Section 208.950 ABD Broker Group	($24,870)	($1,120)	($1,170)
Section 208.952	(Unknown)	(Unknown)	(Unknown)
Section 208.955	(Unknown)	(Unknown)	(Unknown)
Total Costs - DOS/DMS	(Greater than $104,434,591 to Greater than $104,684,591)	(Greater than $129,297,936 to Greater than $132,244,229)	(Greater than $170,367,974 to Greater than $173,435,599)
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)
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 $108,509,047 to Unknown Greater than $109,759,047)**	**(Unknown Greater than $110,607,055 to Unknown Greater than $93,953,348)**	**(Unknown Greater than $115,790,803 to Unknown Greater than $120,858,428)**
Estimated Net FTE Change for General Revenue Fund	49.68 FTE	49.68 FTE	49.68 FTE

FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
FEDERAL FUNDS			
Income - Federal Assistance	Unknown but Greater than $180,000,000	Unknown but Greater than $231,000,000	Unknown but Greater than $301,000,000
Costs - Program Costs	(Unknown but Greater than $180,000,000)	(Unknown but Greater than $231,000,000)	(Unknown but Greater than $301,000,000)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**
Estimated Net FTE Change for Federal Fund	44.82 FTE	44.82 FTE	44.82 FTE
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

FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
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**
MISSOURI HEALTHCARE ACCESS FUND			
Transfer in - Appropriations, gifts, grants, or donations (Section191.1050-191.1056)*	$0 to $1,000,000	$0 to $3,000,000	$0 to $2,000,000
Costs - Department of Health and Senior Services Disbursements (Section 191.1050-191.1056)*	$0 to ($1,000,000)	$0 to ($3,000,000)	$0 to ($2,000,000)
ESTIMATED NET EFFECT ON MISSOURI HEALTHCARE ACCESS FUND	**$0**	**$0**	**$0**

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

FISCAL IMPACT - State Government (continued)	FY 2008 (10 Mo.)	FY 2009	FY 2010
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 legislation 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.

FISCAL DESCRIPTION (continued)

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 legislation would allow Missouri residents to deduct from their taxable income 100% of all non-reimbursed amounts paid for long-term care insurance premiums.

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 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

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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 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.

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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.

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 208.631 & 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;

FISCAL DESCRIPTION (continued)

(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.

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 legislation 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.

FISCAL DESCRIPTION (continued)

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 208.230 (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.

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): This legislation 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.

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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.

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 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

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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.

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 legislation is in regards to a plan study.

Section 208.955 (MO HealthNet Oversight Committee): This legislation establishes the MO HealthNet Oversight Committee.

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.

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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.

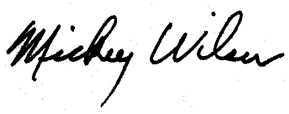
Section 2 (Prescription Drugs): This legislation specifies that the fee for service policies that prescribe psychotropic medications will not include any new limits to the initial access requirements.

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 – General Services Division
Office of Administration - Division of Accounting
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
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



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