COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 5271-04
Bill No.: SCS for SB 1283
Subject: Health Care; Health, Public; Health Department; Boards, Commissions, Committees, Councils; Insurance-Medical; Insurance Department
Type: Original
Date: April 14, 2008

Bill Summary: This legislation creates the Missouri Health Transformation Act.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2009	FY 2010	FY 2011
General Revenue	(Unknown but Greater than $57,833,353)	(Unknown but Greater than $60,429,770)	(Unknown but Greater than $61,465,711)
Total Estimated Net Effect on General Revenue Fund	**(Unknown but Greater than $57,833,353)**	**(Unknown but Greater than $60,429,770)**	**(Unknown but Greater than $61,465,711)**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 42 pages.

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2009	FY 2010	FY 2011
Tobacco Use Prevention, Cessation and Enforcement Trust Fund*	$0	$0	$0
MO Healthfinder Fund**	$0	$0	$0
Health Transformation Fund***	$0	$0	$0
Missouri Free Clinics Fund****	$0	$0	$0
Federal Reimbursement Allowance Fund	(Unknown but Greater than $31,249,639)	(Unknown but Greater than $85,878,594)	(Unknown but Greater than $114,985,582)
Total Estimated Net Effect on Other State Funds	**(Unknown but Greater than $31,249,639)**	**(Unknown but Greater than $85,878,594)**	**(Unknown but Greater than $114,985,582)**

*Income and costs of approximately $13 million would net to $0.
**Income and costs of approximately Unknown but Greater than $14,000,000 would net to $0.
***Income and costs of Unknown would net to $0.
****Income and costs of $500,000 in FY09 would net to $0.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2009	FY 2010	FY 2011
Federal	(Unknown)	(Unknown)	(Unknown)
Total Estimated Net Effect on All Federal Funds	**(Unknown)**	**(Unknown)**	**(Unknown)**

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2009	FY 2010	FY 2011
General Revenue	18.78 FTE	18.78 FTE	30.78 FTE
Tobacco Use Prevention, Cessation and Enforcement	2 FTE	2 FTE	2 FTE
MO Healthfinder	68 FTE	68 FTE	68 FTE
Missouri Free Clinics	1 FTE	1 FTE	1 FTE
Federal	1.22 FTE	1.22 FTE	1.22 FTE
Total Estimated Net Effect on FTE	**91 FTE**	**91 FTE**	**103 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 2009	FY 2010	FY 2011
Local Government	**$10,500,000**	**$10,500,000**	**$10,500,000**

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Department of Public Safety**, **Missouri Senate**, **Missouri Governor's Office**, **Budget and Planning Division**, **Department of Economic Development**, **Department of Higher Education**, **Office of Administration**, **Legislative Research - Oversight Division**, **Department of Labor and Industrial Relations**, **Department of Natural Resources**, **Office of the Lieutenant Governor**, **Missouri House of Representatives** and the **Department of Agriculture** each assume the proposal would have no fiscal impact on their respective agencies.

Officials from the **Office of the Attorney General** assume any potential costs arising from this proposal can be absorbed with existing resources.

Officials from the **Department of Mental Health** assumes the Division of ADA will continue to receive tobacco funds. However, if the Division of ADA tobacco funds are a part of the first $5M used toward the "Tobacco Use Prevention and Cessation Trust Fund" then the cost would have an unknown impact upon the Substance Abuse Prevention and Treatment programs. Failure to fund these programs will also jeopardize the Division's federal Block Grant funding because of reduced maintenance of effort.

Provisions contained in this bill will create additional work for the Department in preparing reports (shifting demographics study). These costs cannot be quantified.

On the other hand, some provisions contained in this bill can be expected to create a savings for the Department. It is assumed that the DMH currently serve individuals who do not have health insurance and who would be eligible for services under the provisions of 208.133 - 208.1345 (Insure Missouri) above. That coverage could create a savings for the Department. It is not known how many individuals would be affected or what services they might receive through the Insure Missouri program therefore the projected savings are unknown.

Overall, the fiscal impact is unknown.

Officials from the **Department of Corrections (DOC)** assumes the proposal appears to have no fiscal impact for the DOC, however it is unknown what rules and regulations may be promulgated by the created cabinet. It is assumed that if tracking of employee issues or some similar function would be implemented by the cabinet, that OA Personnel would address any resulting fiscal impact on behalf of the agencies.

ASSUMPTION (continued)

Officials from the **Department of Highways and Transportation (DHT)** assume the vast majority of the provisions in this bill will not have an impact upon DHT, Missouri State Highway Patrol (MSHP) or on the DHT/MSHP medical plan. The only provision that could have any fiscal impact on the Plan is section 191.1321. This section requires health care providers, health care facilities and health insurers to provide certain information to the Department of Health and Senior Services so that the Department has the necessary data to carry out its duties. The parameters of the data requests will be developed by DHSS through administrative rules, so it is not yet clear exactly what sort of information health insurers, including the MoDOT/MSHP medical plan, would be required to provide. However, the statute states that such information may include (but is not limited to) claims, premium, administration and financial information.

Whether or not this provision would have a fiscal impact upon the Plan would depend up the type of information requested and whether or not reports providing such information are already prepared. The Plan may be responsible for costs to vendors to prepare reports outside the parameters of their contracts.

Oversight assumes the DHT could absorb the cost of section 191.1321 related to this proposal. Oversight assumes any significant increase in the workload of the DHT would be reflected in future budget request.

Officials from the **Department of Elementary and Secondary Education (DESE)** state the following:

Section 26.853:
This section will result in insignificant travel expenses.

Section 191.1300:
Depending upon the requirements enacted by the Department of Health and Senior Services, local and state agencies could incur significant costs to collect, store, share, or transmit health-related data or to make that data compatible with the Department's requirements.

Oversight assumes the DESE could absorb the additional caseload that may result from Section 191.1300 within existing resources. Oversight assumes any significant increase in the workload of the DESE would be reflected in the future budget request.

ASSUMPTION (continued)

Officials from the **Department of Revenue** states the following:

Customer Assistance would require - One Tax Collection Technician I for every 15,000 calls a year on the income tax phone line. One Tax Collection Technician I for every 24,000 calls a year to the delinquency phone line and four Tax Processing Technician I for every additional 4,800 contacts in the field offices (Taxation anticipates most customers will contact the Department via phone, therefore, the Department will only request 1 Full Time Employee for each of the larger field offices including Kansas City, St. Louis, and Springfield)

Office of Administration Information Technology (ITSD/DOR) estimates that this legislation could be implemented utilizing 1 existing CIT III for 2 months for modifications to MINITS and 3 existing CIT III for 1 month for modifications to the corporate systems. The estimated cost is $20,930. ITSD/DOR estimates the information technology portion of this request can be accomplished within existing resources. However; if priorities shift, additional FTE/overtime would be needed to implement.

Personal Tax would require -

Section 143.116
- 2 Temporary Tax Employees for key entry
- 1 Tax Processing Technician I for every additional 19,000 returns to be verified
- 1 Tax Processing Technician I for every additional 2,400 pieces of correspondence generated

Officials from the **Missouri Consolidated Health Care Plan (MCHCP)** states that currently MCHCP covers the following preventative services at 100%: Annual Physical Exam/Wellness Exam, Immunizations, Mammograms, Outpatient Diagnostic Lab and X-Rays, Pap Smears, Prostate Cancer Screenings, Colorectal Screenings, Colonoscopy and Sigmoidoscopy Screenings, and Well Child Care.

The U.S. Preventive Services Task Force (USPSTF) has graded a listing of preventive services with an "A" (strongly recommended) or a "B" (recommended) grade. These "A" and "B" graded services could be regularly charged for counseling but some of the services also include tests and/or procedures which will add cost. Total cost at this point in unknown, but could easily be in excess of $100,000.

ASSUMPTION (continued)

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

Section 8.365:
Requires the Office of Administration, in consultation with the DHSS to submit a report to the Governor and General Assembly by December 31, 2008 detailing the opportunities for the state to implement a minimum health promotion standard for construction or substantial renovation of a state building. The Department assumes that current staff will absorb this responsibility.

Section 26.853:
Creates the Missouri Health Cabinet to ensure that the public policy of this state relating to health is developed to promote interdepartmental collaboration and program implementation in order that services designed for health are planned, managed, and delivered in a holistic and integrated manner to improve the health of Missourians. One of the duties of the cabinet is to create a health impact statement for evaluating proposed legislation, requested appropriations, and programs. It is not stated in the legislation that the Department would be required to assist the cabinet in creating the health impact statement for each proposed legislation, but if this would be required, additional staff would be needed in the department's Governmental Policy and Review Unit and the Budget Services and Analysis Unit to meet this demand.

Section 26.859:
Eliminates the State Boards of Health and Senior Services and replaces them with the "Health Policy Council". DHSS assumes no fiscal impact for this section.

Section 26.900:
Creates a workgroup made up of representatives from leadership staff of all state departments to review each Department's major policies, programs, etc. in light of increasingly older and more diverse populations; and develop a policy brief by September 1, 2009 (updated annually) that highlights critical functions and issues affected by shifting demographics that should be addressed in the next ten years

The Department assumes that both the Division of Regulation and Licensure (DRL) and the Division of Senior and Disability Services (DSDS) would play a significant role in complying with this section. The amount of staff time required is unknown at this time. DSDS would require a consultant to complete the review and policy brief. This consultant services would be contract via a request for proposal and assumes a cost of greater than $100,000 annually, funded from General Revenue. DRL estimates that the amount of staff time required is unknown but is assumed it could be accomplished with existing staff.

ASSUMPTION (continued)

Section 191.845:
Creates the "Health Transformation Fund" to be administered by the Department of Health and Senior Services. Monies in the fund shall be used to establish pilot projects in the greater St. Charles and southeast boot heel areas of the state. These pilot projects should include the involvement of the local community health coalition and will establish new approaches to expand coverage for the uninsured population in the participating communities and to create healthier populations through a single comprehensive health care plan that is focused on both of the participating areas. The Department is responsible for promulgating rules setting forth the procedures and methods for implementing the pilot project and establishing criteria for the disbursement of funds. The proposal should include a plan that is established at the community level; will improve population health, create a culture of health, and develop a model for providing one hundred percent health services coverage; and provides for the submission of a feasibility study by August 2009 which identifies the infrastructure and resources needed for the implementation of the pilot projects and that analyzes the feasibility of extending the pilot projects or expanding the project state-wide.

The Division of Community and Public Health, Office of Primary Care and Rural Health estimates the need for three additional Health Program Rep IIIs (HPR III) to carry out the provisions of this section. Two of the HPR IIIs will be responsible for managing contracts relating to the Health Transformation Fund; managing the pilot projects in the St. Charles area and the Southeast boot heel area; and interacting with community health coalitions in providing knowledge of population health status and the overall goals of public health. One HPR III will be responsible for researching data and key determinants needed to develop and implement a feasibility study that analyzes the infrastructure and resources needed for expanding the pilot projects. Standard expense and equipment costs are included for these positions.

The Health Transformation Fund shall consist of gifts, donations, transfers, and moneys appropriated by the General Assembly, and bequests to the fund. DHSS assumes an unknown amount of revenue will be deposited into the fund to implement the pilot projects. With the uncertainty of the revenue generated by the fund, DHSS assumes the additional staff and operating costs to administer the program will paid from General Revenue, and the funding deposited into the fund will be used as program funding to implement the pilot projects in the targeted areas.

Section 191.1025:
Requires the Department of Health and Senior Services to develop the Missouri Healthy Workplace Recognition Program for the purposes of granting official state recognition to employers with more than fifty employees for excellence in promoting health, wellness, and

ASSUMPTION (continued)

prevention. This activity is already underway in the form of a workgroup within the Missouri Council of Activity and Nutrition (MoCAN). Should the MoCAN group cease this activity, a DHSS internal committee could handle the duties. While there may be on-going costs for incidentals such as plaques and postage, there should not be any significant fiscal impact.

Section 191.1271:
Requires the DHSS to promulgate quality control rules and regulations to be used in removing and improving the services of telehealth practitioners. The Department assumes that the Division of Regulation and Licensure (DRL) we would have a significant role in these activities. There is no way to determine how many telehealth practitioners there would be if the legislation were to pass. Therefore, DRL is unable to estimate how many additional staff would be needed in order to comply with telehealth requirements, however it is assumed it would result in costs greater than $100,000.

Sections 191.1300 - 191.1324 (Division of Community and Public Health):
Require collection of unprecedented levels and types of data, far beyond that statutorily authorized for the DHSS, and across other state agencies. The requirements for analysis and reporting are similarly unprecedented, including creation of a website called Missourihealthfinder.

Based on the Department's experience, there is currently no other agency or entity that acts as a central repository for any kind of sensitive cost, charge or utilization of healthcare data. In the past, data on outpatient procedure charges were collected by the Bureau of Health Informatics through surveying of the hospitals, however due to the cost to collect this information, the project was terminated with the last available data from 2003. In the past, the Missouri Center for Health Statistics surveyed a wide variety of health professionals (doctors, dentists, dental hygienists, nurses, optometrists, etc.) to obtain demographics and availability information by region. These surveys were also terminated due to high cost of the project. Nursing home and residential care facilities also were surveyed at one time, however this also is no longer being done due to the cost and loss of funding.

Physicians, pharmacies and other health professionals tend to have little or no in-house experience with data collection, electronic file creation and data reporting. As a consequence, DHSS staff would need to spend a considerable amount of time with each facility and profession, assisting their staff members with understanding both the technical aspects as well as the substantive content of the required data reporting. DHSS staff will need to go through several iterations of edit checks and error corrections of the data. These data management activities frequently involve extensive follow-up communications, data re-submissions and

ASSUMPTION (continued)

re-editing/correcting of data. In Missouri, there are roughly 1,200 nursing homes, 130 acute care hospitals, 90 ambulatory surgical centers, 2,900 dentists, 2,100 dental hygienists, 62,000 nurses, 22,000 LPNs, and over 12,000 physicians. Additionally, the bill mentions federal, state and local agencies, of which there are potentially a very large number, depending on how they are defined. With this large number of professionals and agencies targeted by the legislation, a large number of staff to provide these services will be required.

It is anticipated that the availability of these data would dramatically increase the number of data requests the Department would need to respond to, as well as the complexity of the requests. Additional staff and resources will be required to respond to the requests, and address the handling of data request fees. None of the additional data collection activities can be absorbed into the current hospital/ASC reporting system, since the latter operates without the use of state funding.

It is likely that attempts to collect cost and charge data from health professionals and agencies will be met with resistance due to the cost and time to provide this information. The legislation states, "This section does not confer on the department the power to demand or require that a health care provider or professional furnish information, records of interviews, written reports, statements, notes, memoranda, or data other than as expressly required by law." It is likely reporting requirements will have to be added in statute and regulations making provisions of these data reporting requirements mandatory in order to receive sufficient information to make the website useful to the consumers and other entities reviewing the data.

The bill requires DHSS to develop cost, charge, and utilization measures. These measures must be appropriately risk-adjusted and made available using an interactive query system, on the DHSS website. Selection of these measures is to be based upon input from the Health Policy Council and other knowledgeable professionals. The financial data provided on the website must be accompanied by information that will assist the site visitors in using the site and making informed decisions. This will also require developing extensive documentation on risk-adjustment measures, comparison methods, and the assumptions and methods used in collecting and displaying the wide variety of data this bill mandates.

The lack of a central repository for these data in other agencies means that developing an annual online survey would likely be the best way to obtain standardized financial data from the professions and health agencies. The proposed Center would require the development of online surveys for each profession and agency of interest, to attempt to collect standardized, detailed, and representative data from such a wide variety of health entities.

ASSUMPTION (continued)

In addition this bill calls for the following types of data to be collected and analyzed: health care cost and finances, life expectancy, environmental health hazards, pharmaceuticals, quality of care measures, health care utilization, health plan measures, health knowledge and practices, maternal and infant health indicators, family formation growth and dissolution. The Department is also required to develop and implement a strategy for the adoption and use of electronic health records, including the development of an electronic health information network for the sharing of electronic health records among health care facilities, health care providers, and health insurers. Also the Department has been given the responsibility to initiate, oversee, manage, and evaluate the integration of health care data from each state agency that collects, stores, and reports on health care issues and make that data available to any health care practitioner through a state health information network.

DHSS will require for Center Administration/ Health Policy Support, 1 Research Mgr. Band III FTE, 1 Center Director FTE, 1 Research Mgr. Band II FTE, 3 Planner III FTE's, 1 Research Analyst IV FTE, 1 Health Program Rep I FTE, 2 AOSA FTE and 1 SOSA FTE to meet the requirements of this proposal.

The unit will have overall administrative and operational responsibility for the Center, including coordination with other agencies, development and management of the memoranda of agreements with other state departments and data sources, grants/contracts review and management, rule development/modifications, standards for publication and data release, development of long range plans for data collection and reporting, and the five mandated annual reports.

DHSS will require for Health Care Costs/Financing/Economics 1 Manager, Economic Analysis FTE, 1 Accounting Analyst III FTE, 1 Research Analyst IV FTE, 1 Research Analyst IV - Demographer FTE, 1 Planner IV - Healthcare Policy Specialist FTE, 3 Research Analyst III FTE and 1 AOSA FTE to meet the requirements of this proposal.

This unit will oversee the collection and analysis of healthcare cost and financial data from facilities and health professionals. They will be responsible for the special research projects related to trends in healthcare prices and costs, the impact of illness and disability on the state economy, the impact of uncompensated charity care on healthcare facilities and providers, the implication of increasing hospital cost by providing non-urgent care in emergency departments and the state's role in assisting to fund indigent care. In addition, this unit must specify a uniform system of financial reporting for each type of facility based on a uniform chart of accounts developed by the national association for such facilities and generally accepted accounting principles.

ASSUMPTION (continued)

DHSS will require for Quality of Care 1 Res. Mgr. Band II FTE, 3 Research Analyst IV FTE, 3 Research Analyst III FTE and 1 AOSA FTE to meet the requirements of this proposal.

This unit will collect and analyze the quality of care data from facilities and providers. Additionally they will determine which conditions, procedures, health care quality measures, and patient charge data to disclose based upon input from the Health Policy Council, as well as from those national entities that establish standards to measure the performance of health care providers. They also will determine the method and format for public disclosure of the quality of care data; the data shall be made available on the department's Missourihealthfinder Internet website in a manner that allows consumers to conduct an interactive search that allows them to view and compare the information for specific providers. These data will be risk adjusted according to nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality.

DHSS will require for Health Insurance Plans 1 Insurance Financial Analyst Specialist FTE, 2 Research Analyst IV FTE's and 3 Research Analyst III FTE's to meet the requirements of this proposal.

This unit will collect and analyze data from health insurers including, but not limited to claims, premiums, plan membership satisfaction, enrollment, provider networks, plan administration and financial information. In conjunction with the Department of Insurance, Financial Institutions and Professional Registration, this unit will also study the availability and affordability of health insurance.

DHSS will require for Missourihealthfinder/Public Information 1 Research Analyst IV FTE, 1 Librarian II FTE and 1AOSA FTE to meet the requirements of this proposal.

This unit will manage detailed information on data maintained by other local, state, federal, and private agencies in order to advise those who use the center of potential sources of data which are requested but which are not available from the center. They will monitor innovations in health information technology, informatics, and the exchange of health information and maintain a repository of technical resources to support the development of a health information network. Also, the unit will be responsible for indexing, abstracting, translation, publication and other services leading to a more effective and timely dissemination of health care statistics. The unit will coordinate the presentation format and navigation of the website to ensure that the website enhances informed decision-making among consumers and health care purchasers, and will include guidance on how to use the data and an explanation of why the data may vary from provider to provider.

ASSUMPTION (continued)

DHSS will require for Data Collection/Management/Analysis/Special Studies 1 Research Mgr. Band II FTE, 1 PH Epidemiologist FTE, 1 Research Analyst IV - Survey/Sampling Design FTE, 1 Research Analyst IV - Biostatistician FTE, 1 Research Analyst IV - Database Management FTE, 15 Research Analyst III FTE's, 1 SOSA FTE and 1 AOSA FTE to meet the requirements of this proposal.

This unit will collect and analyze data on:

- the extent and nature of illness and disability of the state population, including life expectancy, the incidence of various acute and chronic illnesses, and morbidity and mortality indicators;
- environmental, social, and other health hazards;
- health knowledge and practices of the people in this state and determinants of health and nutritional practices and status;
- health resources, including physicians, dentists, nurses, and other health professionals, by specialty and type of practice and acute, long-term care and other institutional care facility supplies and specific services provided by hospitals, nursing homes, home health agencies, and other health care facilities;
- utilization of health care by type of provider;
- family formation, growth, and dissolution.

Responsibilities will also include performing special studies relating to these data, as well as responding to data requests and providing technical assistance to persons and other organizations engaged in health planning on effective use of statistics.

DHSS will require for Pharmacy 1 Research Analyst IV FTE, 2 Research Analyst III FTE's and 1 AOSA FTE to meet the requirements of this proposal.

This unit will collect a statistically valid sample of data on the retail prices charged by pharmacies for the one hundred most frequently prescribed medicines from any pharmacy licensed by this state. The unit will make these data available on the Missourihealthfinder Internet website for each pharmacy along with the drug prices for a 30-day supply at a standard dose. The data collected will be reported for each drug by pharmacy and by metropolitan statistical area or region and updated quarterly.

DHSS will require for EHR Facilitation 1 Planner III FTE and 5 Health Program Rep III FTE's to meet the requirements of this proposal.

ASSUMPTION (continued)

This unit will develop and implement a five-region outreach strategy for the adoption and use of electronic health records, including the development of an electronic health information network for the sharing of electronic health records among health care facilities, health care providers, and health insurers. The unit will assist with developing the rules, and any related legislative recommendations, to facilitate the functionality and protect the confidentiality of electronic health records.

Division of Regulation and Licensure:
Sections 191.1300 through 191.1324.4. involves the collection, analysis, reporting, etc. of large amounts of data (both health related and financial) from health care providers and insurers. The Department believes that the Division of Regulation and Licensure (DRL) will be involved in determining what is to be collected, how it is analyzed, etc. An unknown number of health-related professional staff will be needed in order to accomplish this.

Section 191.1324.5. requires the Department to develop and implement a strategy for the adoption and use of electronic health records and the development of an electronic health information network for the sharing of electronic records among health care facilities, health care providers, and health insurers. The DRL assumes the Division would be the coordinator of any electronic health record development due to our oversight of hospitals, long-term care facilities and other health care facilities that maintain health records. Development of coordination between facilities and sharing of information will be costly and very time-consuming. The Department currently has no expertise in electronic health records and would need to recruit staff with the appropriate healthcare and technology background to accomplish this task. The number of staff needed is unknown.

Office of Administration, Information Technology Services Division:
Support from ITSD will be needed to develop a minimum of seven separate or integrated data systems that will become a comprehensive health information system to provide for the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of both purposefully collected and extant health-related data and statistics. The systems will collect data on health care quality, charges, utilization, practices, resources, insurance coverage, and source of payment from health professionals (physicians, dentists, nurses and others), health agencies (hospitals, ambulatory surgery centers, nursing homes, and home health agencies), and managed care entities and health plans. Data systems will also need to be created to collect health care cost data from federal, state and local agencies. The information will be displayed for consumers and others on an interactive website that will allow a comparison of information for specific providers. ITSD would create a website called Missourihealthfinder to report consumer-useful comparative health care information.

ASSUMPTION (continued)

In addition to creation of the data collection systems and the Missourihealthfinder website, ITSD staff will be used to provide technical assistance to the persons, organizations or data sources providing and receiving information from DHSS.

Due to the unprecedented levels and types of data required to be collected, an exact cost and number of staff from ITSD is unknown, but estimated to cost more than $9,000,000.

Program Funding:
Section 191.1315 establishes the Missourihealthfinder Fund, which shall consist of gifts, donations, transfers, and moneys appropriated by the general assembly, and bequests to the fund. The fund shall be used to administer the responsibilities of the Center for Health Information Management and Evaluation outlined in sections 191.1300 to 191.1324. Section 191.1315, subsection 2 authorizes the center to charge reasonable fees for services as the Department prescribes by rule. At this time, it is unknown how much if any fees would be charged and deposited into this fund. Since the Missourihealthfinder Fund is established to provide administrative costs to administer this program, DHSS assumes all staff and other operating costs will be paid from this fund. However, DHSS also assumes the revenue into the fund will need to be transferred from General Revenue since there is no other guaranteed revenue sources into the fund, therefore operating costs of this program are assumed to be a cost to the General Revenue Fund.

Section 192.083:
Requires the Office of Minority Health (OMH) to solicit proposals from community programs and organizations representing minorities to develop culturally appropriate solutions and services relating to health and wellness. It also requires OMH to solicit proposals from faith-based organizations on initiatives to educate citizens on the value of personal responsibility and wellness. Within the current budget, the office is able to approve approximately 25 community proposals each year. Assuming the office will increase their community and faith-based proposal by 25 new proposals through solicitation, additional funds will be needed. Currently the Office of Minority Health has three Health Program Representative III that work within the community and receive proposal requests for funding of activities and events. One additional Health Program Representative III would be needed to take on the additional duties to solicit for more community proposals, participate at various events, provide outreach and education within the communities on minority health issues to reduce health disparities, provide technical assistance and advice to faith-based and community organizations, and provide presentations in the community on various minority health issues. Each year we are able to approve approximately 25 community contracts. If the office adds 25 more community contracts at the estimated amount of $3,000, additional funds in the amount of $75,000 will be needed.

ASSUMPTION (continued)

Section 192.990:
Creates the "Missouri Free Clinics Fund" which is to be administered by the Department of Health and Senior Services for use by clinics in the Missouri free clinics association. Subject to appropriation, one-time funding of $500,000 shall be disbursed via contracts in accordance with applicable guidelines, policies, and requirements established by the Department. Grant support will be limited to capacity building projects for existing clinics. Capacity building projects means "activities that improve an organization's ability to achieve its mission by providing existing clinics an opportunity to increase their infrastructure and bolster their sustainability in order to serve a greater number of people in a more effective manner." One Health Program Rep III will be required to manage contracts relating to funding Missouri Free Clinics and capacity building projects. DHSS assumes the $500,000 will be transferred from General Revenue into the Missouri Free Clinics Fund on a one-time basis. The funding will be used to support administration and program costs of the program.

Section 196.1200:
Establishes the Tobacco Use Prevention and Cessation Trust Fund, which shall be funded by the first five million dollars received from the strategic contribution payments received under the Master Settlement Agreement. Moneys in the fund shall be used for a comprehensive tobacco control program including but not limited to prevention and cessation of tobacco control programs.

DHSS estimates that two additional FTE will be required for the implementation of this program one Program Coordinator responsible for the implementation and oversight of the program, including: contract monitoring, supervision of the HPR III, providing technical assistance to schools and counties, coordinating publicity for the new programs, and evaluation effectiveness and one Health Program Representative III responsible for providing technical assistance, training and other resources to local organizations working to reduce tobacco use, and other duties as directed by the coordinator. Standard expenses and equipment, fringes, and indirect costs would also be needed for the two staff.

The remaining funds would be used as follows: $2.5 million will provide grants to community-based groups and $1.361 million will provide grants to school districts. These programs are to provide individual and group cessation and/or prevention counseling for youth.

It is assumed the increased revenue in the Tobacco Use Prevention and Cessation Trust Fund will be offset by a reduction in revenue to the General Revenue Fund. Based on the estimates provided by the Attorney General's Office, the lost revenue to the General Revenue fund will be approximately $5 million.

ASSUMPTION (continued)

Section 194.554.3:
Requires hospitals to report any serious reportable event in healthcare to the patient or the patient's legally authorized representative. The Division of Regulation and Licensure assumes that this could result in a higher number of complaints, therefore requiring additional inspections. The number of additional inspections is unknown at this time and therefore the Department assumes an unknown number of additional FTE.

Sections 208.1306.1-3
Define the services covered by the "Insure Missouri" program. The program will cover specified medically necessary services in the manner and extent determined by the MO HealthNet Division.

Section 208.1306.2 (17) specifies that one of the services covered will be personal care. The DHSS assumes the Department of Social Services will calculate the fiscal impact associated with determining eligibility under the "Insure Missouri" program, the cost of services for the eligible recipients, and the cost of any administrative hearings regarding denial of eligibility.

DSDS assumes the "Insure Missouri" program administration will be similar to that of the MO HealthNet program. Based on this assumption, DSDS has determined that it would be the agency designated to assess and authorize requests for personal care services under the new program. Services would be provided for individuals with incomes up to 225% of Federal Poverty Level (FPL).

Estimates provided by the Department of Social Services (DSS) on March 14, 2008, indicate the "Insure Missouri" program will cover approximately 213,692 individuals after the complete phase-in. Based on utilization of MO HealthNet for eligibility categories which exclude the disabled and those over age 65, DSDS assumes that approximately .17% of the eligible individuals would utilize personal care services equaling 363 individuals (213,692 X .0017 = 363.28). DSDS assumes these individuals will be added in phases.

As of June 30, 2007, caseloads for the Division's Social Service Workers averaged approximately 156 per FTE ((41,504 In-Home + 10,068 Consumer-Directed)/329.60). Pursuant to Section 660.021, RSMo, the Caseload Standards Advisory Committee recommended that caseloads should be no more than 80 per worker. The division would request additional staff in an effort to reduce average caseloads to at least 100 per Social Service Worker. These standards are the basis for FTE estimates.

ASSUMPTION (continued)

Phase I - Upon implementation on July 1, 2008, DSS estimates 42,222 individuals would become eligible. Applying the .17% rate for personal care, DSDS estimates 72 individuals would begin accessing these services (42,222 X .0017 = 71.77). Keeping with the previous request to reduce caseloads to 100 per worker, the division will require 1.00 Social Service Worker FTE to case manage the new eligibles as a result of this legislation (72 clients/100 = .72).

Phase II - The second phase, which begins July 1, 2009, will add an additional 45,154 individuals to the program. Again, applying the .17% rate, DSDS estimates an additional 77 individuals would access personal care services (45,154 X .0017 = 76.76). Based on the caseload standard of 100 per worker, the division will require 1.00 additional Social Service Worker FTE for a total of 2.00 (77 clients /100 = .77).

Phase III - Upon implementation of the third phase on January 1, 2011, an additional 26,724 adults would gain eligibility under the program. Applying the .17% personal care utilization rate, an additional 45 individuals would access this care (26,724 X .0017 = 45.43). Based on the standard caseload of 100 per FTE, DSDS assumes these individuals could be absorbed into current caseloads, so no additional FTE would be needed for this phase.

Phase IV - Phase IV, which begins January 1, 2012, would add 23,221 adults. At the .17% utilization rate, 39 additional individuals would be accessing personal care services (23,221 X .0017 = 39.48). Based on the standard caseload of 100 per FTE, DSDS assumes these individuals could be absorbed into current caseloads, so no additional FTE would be needed for this phase.

Phase V - Upon implementation of Phase V on January 1, 2013, the addition of 47,353 additional adults at the .17% personal care utilization rate would result in an additional 81 clients accessing these services (47,353 X .0017 = 80.5). These additional clients would result in the need for 1.00 Social Service Worker FTE (81 clients/100 = .81).

Phase VI - On January 1, 2014, 16,514 adults will be added to the program. Based on the .17% rate, another 28 clients will access personal care services (16,514 X .0017 = 28.07). DSDS assumes these individuals could be absorbed into current caseloads, so no additional FTE would be needed for this phase.

The blended Federal participation rate of 54 percent GR and 46 percent Federal was applied to this cost estimate for Personal Services and Expense and Equipment.

ASSUMPTION (continued)

Social Service Worker duties include the responsibility for investigation of hotlines, eligibility determination and authorization of state-funded in-home services, and care plan management.

Currently, the ratio of Home and Community Area Supervisors (HCSAS) is one supervisor for every ten Social Service Worker (SSW) FTE. Therefore, since this legislation will only require 3.00 SSW FTE in total, DSDS will not request any additional supervisors or clerical staff and will absorb those duties with existing staff.

Division of Administration:
The additional requirements of the legislation would require the Office of General Counsel to promulgate rules for the new programs, perform contract/grant review, provide consultations, ensure adequate reporting requirements, and review of information to be disclosed. Due to this increase in workload, the OGC will need two additional mid-level staff attorneys.

Officials from the **Department of Insurance, Financial Institutions & Professional Registration** assume the Department will require one Planner II to implement the Start-up Grants for Non-profit Broker Organizations. The Planner II will be responsible for administering the grant process. The position will also participate in creating eligibility, rating and selection criteria and rule development. It is assumed the Planner II will be funded by General Revenue.

The Department will need appropriation of $100,000 from General Revenue to distribute the start-up grants.

The Department believe existing staff can implement other provisions of the proposal impacting the Department. However, if the workload is such to require additional staff, additional staff and appropriation will be requested through the budget process.

According to the Missouri Health Insurance Pool, while there could be a broadening of eligibility to the pool, the cost of the preexisting changes on pool costs is unknown and would depend upon the number of applications processed with a preexisting condition exclusion.

Officials from the **Department of Social Services - Human Resource Center** assume the proposal would have no fiscal impact on their agency.

Officials from the **Department of Social Services - Division of Legal Services (DSS-DLS)** estimates that 10% of participants request hearings on an annual basis. Thus, for each year the

amount of hearings added would be:

ASSUMPTION (continued)

FY09 0
FY10 329
FY11 134
FY12 116
FY13 237
FY14 83

It is assumed that a benefits hearing officer can handle 900 hearings per year. Therefore, it is assumed that by full implantation in FY14, a fiscal impact of 1 hearing officer. It is also assumed that any rulemaking that would need to be done would be handled by the MO HealthNet Division and should be reflected in their fiscal note.

Oversight assumes the DSS-DLS could absorb one hearing officer FTE.

Officials from the **Department of Social Services - Division of Youth Services (DSS-DYS)** states since Section 167.720 is not effective until July 1, 2011, thus the Division assumes zero fiscal impact through FY11. The Division will require 12 Academic Teacher III FTE's for FY12.

Officials from the **Department of Social Services - Research and Evaluation** state in addition to obtaining information from ITSD, Research and Evaluation Unit anticipates it will be called upon to supply data to the Department of Health and Senior Services, due to sections 191.1300 to 191.1324. This would involve writing computer programs to retrieve that data, manipulating the data into a format for transfer to the information center, interpreting the data, and maintaining those programs over time. Since the data in the information center will need to be updated periodically, Research and Evaluation anticipate this would be an ongoing responsibility.

In recent years there has been increasing demand for Medicaid related data. The Research and Evaluation Unit cannot meet additional requests for information in that area without additional staff resources. Therefore, Research and Evaluation Unit anticipates the need for one additional research analyst III to handle the task created by these sections.

Officials from the **Department of Social Services - Information Technology Services Division (DSS-ITSD)** assumes the following fiscal impact to the Division:

Legacy Costs: Contractors: 7896 hours X $75 per hours = $592,200
FAMIS Costs: Contractors: 1360 hours X $89 per hours = $121,040
Total = $713,240

ASSUMPTION (continued)

Section 191.1300-191.1324 DSS-ITSD states most healthcare payment information will come from Infocrossing (IFOX). IFOX processes all MO HealthNet claims for services. IFOX provides interface/extract programs when required. DSS Systems that may provide information include FAMIS, FACES, Alternative Care, Medical Services, IM, and Youth Services.

FAMIS gave an estimate of 2000 hours for an interface or extract program at a rate of $89 per hour for a total cost of $178,000.

The other systems gave an estimate of 320 hours per program at $75 per hour for a total cost of $24,000 per program (2 programmers for one month). 2 programs x 4 systems x $24,000 = $192,000

The Medical Services team would need a contractor to do the programming. They would write programs that read the Medicaid claims files and categorize the expenses, service types, etc. Some of the info would have to be obtained from the MMIS fiscal agent. Information would have to be obtained from individual providers (e.g. average charge, average net revenue per adjusted day, cost per patient day, etc.) 640 hours for two programs.

Assume two extracts per system.

FAMIS:	2 programs x $178,000 =	$356,000
	2 programs x $24,000 =	$48,000
	Total	$404,000

Accounting Splits: IM/Medicaid is 50% GR and 50% FF and FAMIS is 76% GR and 24% FF.

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

Based on information gathered from 2006 Census Bureau, and if funds were appropriated to cover this at 100%, FSD has determined there would be 268,272 new participants for this program. These participants would be phased in over a period of six years, as outlined below.

The FSD fiscal note is based on determining the income eligibility only. The cost to manage the health care accounts, determining the amount of the cost share for each person, and determining at which point benefits will become available after the cost share is met will be funded through MO HealthNet Division's fiscal note and budget.

ASSUMPTION (continued)

To manage the new caseload, FSD will use a variety of methods, such as a call center or other automated services. Below is an estimate of the cost to implement with staff and the cost to implement without staff by implementing a call center and investing in technology such as on-line applications.

PHASE I:
The first phase, to be implemented 7/1/08, would provide health care for 54,500 custodial parents. These are custodial parents already known to FSD as their children are currently receiving MO HealthNet benefits. FSD would not see an increase in caseload size due to these participants.

FSD estimates FAMIS cost of 3000 hours @ blended rate of $89/hour to coordinate with the Missouri Health cabinet to engage in any activities that will implement improved collaboration of agencies in order to create, manage, and promote coordinated policies, programs and service-delivery systems that support improved health outcomes. Total FAMIS cost estimated $267,000 (3000 hours x $89/hour). This cost would be incurred as a one-time cost for the first phase.

PHASE II:
The second phase, to be implemented 7/1/09, would provide health care for 32,876 non-custodial parents under 100% FPL.

Based on 32,876 additional cases, and a 243 caseload standard, FSD would need 135 new Eligibility Specialists (32,876/243 = 135).

On a 10-1 ratio, Eligibility Specialist to Eligibility Supervisor, FSD would need 14 new Eligibility Supervisors (135/10 = 13.5, rounded up to 14).

On a ratio of 6-1 Eligibility Specialist/Eligibility Supervisor to Clerical Staff, we would need an additional 25 clerical staff, with 19 OSA and 6 SOSA. (135+ 14 = 149 ÷ 6 = 24.83, rounded up to 25. 29 x 75% = 22 OSA; 29 - 22 = 7 SOSA.

Total new FTE for 2nd phase: 135 + 14 + 25 = 174

PHASE III:
The third phase, to be implemented 1/1/2011, would provide health care to 26,724 adults. FSD anticipates that 50% of these would be custodial parents and known to FSD. 26,724 x 50% = 13,362. There would be 13,362 new cases.

ASSUMPTION (continued)

Based on 13,362 additional cases, and 243 caseload standard, FSD would need 55 new Eligibility Specialists (13,362 /243 = 54.98, rounded up to 55).

On a 10-1 ratio, Eligibility Specialist to Eligibility Supervisor, FSD would need 6 new Eligibility Supervisors (55/10 = 5.5, rounded up to 6).

On a ratio of 6-1 Eligibility Specialist/Eligibility Supervisor to Professional Staff, we would need an additional 16 professional support staff, with 12 OSA and 4 SOSA. (55 + 6 = 61 ÷ 6 = 10.16 rounded down to 10. 10 x 75% = 7 OSA; 10-7 = 3 SOSA.

Total new FTE for 3rd phase: 55 + 6 + 10 = 71

PHASE IV:
The fourth phase, to be implemented 1/1/2012, would provide health care to 23,221 adults. FSD anticipates 50% of these would be custodial parents and known to FSD. 23,221x 50% = 11,610.5. There would be 16,611 new cases.

Based on 11,611 additional cases, and 243 caseload standard, FSD would need 48 new Eligibility Specialists (11,611/243 = 48).

On a 10-1 ratio, Eligibility Specialist to Eligibility Supervisor, FSD would need 7 new Eligibility Supervisors (48/10 = 4.8, rounded up to 5).

On a ratio of 6-1 Eligibility Specialist/Eligibility Supervisor to Professional Staff, we would need an additional 14 professional support staff, with 11 OSA and 3 SOSA. (48 + 5 = 53 ÷ 6 = 8.833 Rounded to 9 9 x 75% = 7 OSA; 9-7 = 2 SOSA.

Total new FTE for 4th phase: 48 + 5 + 9 = 68

PHASE V:
The fifth phase, to be implemented 1/1/2013, would provide health care to 47,353 adults. FSD anticipates 50% of these would be custodial parents and already known to FSD. 47,353 x 50% = 23,677. There would be 23,677 new cases.

Based on 23,677additional cases, and 243 caseload standard, FSD would need 97 new Eligibility Specialists.

On a 10-1 ratio, Eligibility Specialist to Eligibility Supervisor, FSD would need 10 new

ASSUMPTION (continued)

Eligibility Supervisors (97/10 = 9.7).

On a ratio of 6-1 Eligibility Specialist/Supervisor to Professional Staff, we would need an additional 18 professional support staff, with 14 OSA and 4 SOSA. (97 + 10 ÷ 6 = 17.8. Rounded up to 18 x 75% = 14 OSA; 18-14 = 4 SOSA.

Total new FTE for the 5th phase: 97 + 10 + 18 = 125

PHASE VI:
The sixth phase, to be implemented 1/1/2014, would provide health care to 16,514 adults. FSD anticipates 50% of these would be custodial parents and known to FSD. 16,514 x 50% = 8,257. There would be 8,257new cases.

Based on 8,257additional cases, and 243 caseload standard, FSD would need 34 new Eligibility Specialists.

On 10-1 ratio, Eligibility Specialist to Eligibility Supervisor, FSD would need 3 new Eligibility Supervisors (34/10 = 3.4, rounded down to 3).

On a ratio of 6-1 Eligibility Specialist/Eligibility Supervisor to Professional Staff, we would need an additional 10 professional support staff, with 8 OSA and 2 SOSA. (34+ 3 ÷ 6 = 6.16 rounded down to 6. 10 x 75% = 5 OSA; 6-5 = 1 SOSA.

Total new FTE for the 6th phase: 34 + 3 + 6 = 43

Total Cost:
The total cost by phase by fiscal year if implemented with staff or staff equipment is $267,000 for FY09, $9,714,777 for FY10 and $10,893,089 for FY11.

However, the Division believes that with the implementation of a call center at $6,078,049 annually with a one-time start-up cost in FY 09 of $1,487,069 and investing 20% of the staffing cost into technology, the Division can absorb these cases with existing staff. Therefore the

Division is projecting the following fiscal: $1,754,069 for FY09, $8,021,005 for FY10 and $8,256,667 in FY11.

ASSUMPTION (continued)

Officials from the **Department of Social Services -MO HealthNet Division (DSS-MHD)** states the following:

Section 26.853 Missouri Health Cabinet:
It is assumed that the DSS will provide equipment and expense funds in the amount of $750,000 annually. These funds will cover the cost to contract any data assistance, surveys, research and reporting requirements of the Cabinet.

Section 191.1250 to 191.1277 Telehealth:
MHD currently uses Telehealth. No increased costs are anticipated due to this provision.

Section 191.1300 to 191.1324 Comprehensive Health Information System:
MHD assumes the Division will provide information to the Missouri Center for Health Information. The estimate of the impact of providing adhoc reporting is $1,000 per month or $12,000 per year. Expenditures for administration and health care technology earn 50% federal financial participation with a 50% state match.

Oversight assumes the MHD could absorb the costs of providing adhoc reporting related to these sections.

Sections 197.850 to 197.880 Hospitals and Ambulatory Surgical Centers:
There will be no fiscal impact in the three years of this fiscal note but the impact will begin in FY 2012 at a cost that is unknown but greater than $100,000 annually.

Section 208.005 Preventive Benefits:
The MHD currently provides coverage for these benefits therefore there will be no fiscal impact.

Section 208.149 Preventable Medical Errors
This section prohibits the MHD from reimbursing providers for the treatment of preventable errors. It is assumed that the provider will not be able to bill the injured patient for the preventable medical error. In addition, MHD must compile a list of preventable medical errors.

It is assumed that MHD's policy will mirror Medicare's policy.

In order to identify the claims that are for preventable medical errors the MHD will either develop and implement an in-house process, contract out the process or develop a method that is a combination of these methods whichever is most cost efficient.

ASSUMPTION (continued)

An in-house process would require the MMIS section of MHD to coordinate with the MHD fiscal agent to program the claims payment system to deny payment for claims that should not be paid. There will be unknown programming costs for the fiscal agent.

In addition, programming will be needed to identify and report suspect claims that were not denied based on the new edits. The report would be reviewed by the Program Integrity Unit (PIU) to identify additional claims that were not identified by the edits. There would be a need for one additional Nurse III staff in PIU for this function.

If this process is contracted out MHD assumes the fee would be less than $500,000 based on other contracts that provide similar services.

The exact system that MHD will use is not known and the potential cost savings is not known. Therefore, the estimated cost will be a range of $100,000 to $500,000.

Section 208.152.1(19) Therapy Services and Electronic Prior Authorization System:
Cost for this section includes the program cost annually plus a one time cost of $100,000 to modify the information in the existing prior authorization system to include therapy services. FY09 (10 months) $6,078,210 ($2,237,389 GR); FY10 $7,496,669 ($2,759,524 GR); FY11 $7,834,019 ($2,883,702 GR).

Total cost for this legislation excluding Insure Missouri (Section 208.1303) is:
FY09 $6,928,210 to $7,328,210 ($2,649,199 to $2,796,439 GR); FY10 $8,346,669 to $8,746,669 ($3,171,334 to $3,318,574 GR); FY11 $8,684,019 to $9,084,019 ($3,295,512 to $3,442,752 GR).

Section 208.1303 - 208.1345 Insure Missouri:

Number of Participants - This legislation provides health care coverage for adults up to 225% of the federal poverty level (FPL). Custodial Parents Under 100% of FPL - 54,500; Noncustodial Parents Under 100% of FPL - 32,876; Adults from 100% to 125% of FPL - 26,724; Adults from

125% to 150% of FPL - 23,221; Adults from 150% to 200% of FPL - 47,353; and Adults from 200% to 225% of FPL - 16,514.

Custodial parents below 100% of the FPL were determined from the number of parents who had earned income with children covered by MO HealthNet for Kids. The remaining participants are based on 2006 Census Bureau estimates of the number of uninsured in Missouri that were working. Approximately 53% of the uninsured are estimated to be childless adults. To determine the number of childless adults below 100% of the FPL, the Census Bureau estimate of working uninsured below 100% of the FPL was multiplied by 53%. The other categories of adults are based on actual Census Bureau estimates for each of the percent of poverty ranges. Total participants are 201,188.

Calculation of Costs - Costs are based on a distribution of claims by size of claim. Average claim amounts for each distribution group were multiplied by the percentage distribution and the number of estimated participants. Claim amounts were reduced to reflect the provision of preventive care to the participant. The proposal allows for the first $500 of preventive care to be provided at no cost to the participant. MHD used the average claim amount of $253 from the claim grouping "less than $500". It was assumed due to the low cost, these claims represented preventive care. It was further assumed that on average, not all participants would use the full $500 and the $253 represented a good estimate of preventive care.

An example of the calculation using the $500 to $1,000 claim group follows:

- People in this group had 11.71% of all claims.
- The average claim for this group was $799.
- When reduced by the cost of preventive care, the remaining cost of $546 was multiplied by each participant's group.
- This means the formula is: 54,500 custodial parents x 11.71% x $546 = $3,483,926 in cost to be shared between the insured and the state. The per member per year cost for both the insured and the state combined is $3,896, or $325 per month.

Distribution of Costs between Insured and State - Custodial parents below 100% of the FPL contribute to their cost of care through co-pays. Co-pays of $25 per year were assumed. Childless adults below 100% of the FPL are required to contribute 1% of the individual's annual income. All other adults above 100% of the FPL are required contribute to a Health Care Account based on the individuals annual income range. The maximum contribution is $1,000 per year. If the participant's required contribution is less than the $1,000 maximum, the state will make up the difference. The contribution by the participant is based on the lowest percentage of poverty for each group.

Total Cost - Costs are shown cumulatively based on the implementation dates including 6.15% inflation per year. The inflation is based on the Center for Medicare and Medicaid National Health Expenditure Index. The following take-up rates were used 1) custodial parents below 100%--100% take-up, 2) childless adults below 100%--85% take-up and 3) all other categories-65% take-up.

The cost to the insured has been reduced by the amount of SCHIP premium collections. The proposal allows the insured to reduce the contribution to the Health Care Account by payments made to MO HealthNet, SCHIP and Medicare. This will require the offset for the SCHIP premiums to be paid by the state. No payments were considered for MO HealthNet or Medicare. The cost of the insured has also been adjusted to recognize the federal 5% of income cost sharing limit. When determining the annual contribution to the health care account there were three scenarios considered: 1) the household has one adult, 2) the household has two adults and one adult is uninsured, and 3) the household has two adults and both are uninsured. For the first two categories the 5% limit is not applicable. However, for households with two uninsured adults, two separate contributions to the health care account would, in some cases, exceed the federal 5% limit. The cost estimate assumes 32.1% of the working uninsured with a health care account are in a household of one. For households with two adults, 39.6% had one uninsured adult. In 28.3% of the households, both adults were uninsured. The distribution of two-adult households is based on a 1996 Census Bureau medical expenditure panel survey (MEPS). The source of the state share is a combination of General Revenue and Federal Reimbursement Allowance dollars.

The fiscal impact is $210,944,970 in FY09, $358,590,796 in FY10 and $437,258,329 in FY11 and an unknown cost for the addition of pregnant women.

FISCAL IMPACT - State Government	FY 2009 (10 Mo.)	FY 2010	FY 2011
GENERAL REVENUE FUND			
Costs - Department of Mental Health			
Program Costs	(Unknown)	(Unknown)	(Unknown)
Total Costs - DMH	(Unknown)	(Unknown)	(Unknown)
Costs - Department of Revenue			
Personal Services	($182,557)	($225,641)	($232,410)
Fringe Benefits	($80,727)	($99,778)	($102,772)
Equipment and Expense	($50,234)	($8,740)	($9,001)
Total Costs - DOR	($313,518)	($334,159)	($344,183)

FTE Change - DOR	10 FTE	10 FTE	10 FTE
Costs - Missouri Consolidated Health Care Plan			
Preventive Services Costs	(Unknown but Greater than $100,000)	(Unknown but Greater than $100,000)	(Unknown but Greater than $100,000)
FISCAL IMPACT - State Government (continued)	FY 2009 (10 Mo.)	FY 2010	FY 2011
Costs - Department of Health and Senior Services			
Personal Services	($216,623)	($285,689)	($294,260)
Fringe Benefits	($98,044)	($129,303)	($133,182)
Equipment and Expense	($684,079)	($167,515)	($172,541)
Program Costs	($5,000,000)	($5,000,000)	($5,000,000)
Total Costs - DHSS	($5,998,746)	($5,582,507)	($5,599,983)
FTE Change - DHSS	7.08 FTE	7.08 FTE	7.08 FTE
Costs - Department of Insurance, Financial Institutions & Professional Registration			
Personal Services	($32,249)	($39,860)	($41,056)
Fringe Benefits	($14,261)	($17,626)	($18,155)
Equipment and Expense	($4,857)	($3,708)	($3,818)
Total Costs - DIFP	($51,367)	($61,194)	($63,029)
FTE Change - DIFP	1 FTE	1 FTE	1 FTE
Costs - Department of Social Services			
Personal Services - DYS	$0	$0	($471,471)
Fringe Benefits - DYS	$0	$0	($208,485)
Equipment and Expense - DYS	$0	$0	($83,427)
Personal Service - R&E	($22,565)	($27,902)	($28,739)
Fringe Benefits - R&E	($9,978)	($12,338)	($12,708)
Equipment and Expense - R&E	($742)	($216)	($223)
Program Costs - ITSD	($929,558)	$0	$0
Program Costs - FSD	($957,680)	($4,340,120)	($4,457,951)
Program Costs - MHD	($2,649,199 to $2,796,439)	($3,171,334 to $3,318,574)	($3,295,512 to $3,442,752)

Program Costs - MHD Insure Missouri	($46,800,000)	($46,800,000)	($46,800,000)
Total Costs - DSS	($51,369,722 to $51,516,962)	($54,351,910 to $54,499,150)	($55,358,516 to $55,505,756)
FTE Change - DSS	.7 FTE	.7 FTE	12.7 FTE

FISCAL IMPACT - State Government (continued)	FY 2009 (10 Mo.)	FY 2010	FY 2011
ESTIMATED NET EFFECT ON GENERAL REVENUE FUND	**(Unknown but Greater than $57,833,353)**	**(Unknown but Greater than $60,429,770)**	**(Unknown but Greater than $61,465,711)**
Estimated Net FTE Change for General Revenue Fund	18.78 FTE	18.78 FTE	30.78 FTE

TOBACCO USE PREVENTION, CESSATION AND ENFORCEMENT TRUST FUND

Income - Department of Health and Senior Services			
Revenue from Strategic Contribution Payments	$5,000,000	$5,000,000	$5,000,000
Costs - Department of Health and Senior Services			
Personal Services	($70,049)	($86,160)	($88,314)
Fringe Benefits	($31,704)	($38,996)	($39,976)
Equipment and Expense	($4,871,791)	($4,842,303)	($4,838,355)
Program Costs	($26,456)	($32,541)	($33,355)
Total Costs - DHSS	($5,000,000)	($5,000,000)	($5,000,000)
FTE Change - DHSS	2 FTE	2 FTE	2 FTE

ESTIMATED NET EFFECT ON TOBACCO USE PREVENTION, CESSATION AND ENFORCEMENT TRUST FUND	**$0**	**$0**	**$0**
Estimated Net FTE Change for Tobacco Use Prevention, Cessation and Enforcement Fund	2 FTE	2 FTE	2 FTE
FISCAL IMPACT - State Government (continued)	FY 2009 (10 Mo.)	FY 2010	FY 2011
MO HEALTHFINDER FUND			
Income - Department of Health and Senior Services			
Transfer-in from GR & Fees	Unknown but Greater than $14,373,538	Unknown but Greater than $14,493,616	Unknown but Greater than $14,658,645
Costs - Department of Health and Senior Services			
Personal Services	($2,286,679)	($2,826,335)	($2,911,125)
Fringe Benefits	($1,034,951)	($1,279,199)	($1,317,750)
Equipment and Expense	($1,188,284)	($320,643)	($330,262)
Program Costs	($863,624)	($1,067,439)	($1,099,508)
Program Costs - ITSD	(Unknown but Greater than $9,000,000)	(Unknown but Greater than $9,000,000)	(Unknown but Greater than $9,000,000)
Total Costs - DHSS	(Unknown but Greater than $14,373,538)	(Unknown but Greater than $14,493,616)	(Unknown but Greater than $14,658,645)
FTE Change - DHSS	68 FTE	68 FTE	68 FTE
ESTIMATED NET EFFECT ON MO HEALTHFINDER FUND	**$0**	**$0**	**$0**

Estimated Net FTE Change for MO Healthfinder Fund	68 FTE	68 FTE	68 FTE

FISCAL IMPACT - State Government (continued)	FY 2009 (10 Mo.)	FY 2010	FY 2011
HEALTH TRANSFORMATION FUND			
Income - Department of Health and Senior Services			
Gifts, Donations, Transfers & Appropriated Funds	Unknown	Unknown	Unknown
Costs - Department of Health and Senior Services			
Program Costs	(Unknown)	(Unknown)	(Unknown)
ESTIMATED NET EFFECT ON HEALTH TRANSFORMATION FUND	**$0**	**$0**	**$0**
MISSOURI FREE CLINICS FUND			
Income - Department of Health and Senior Services			
Transfer from General Revenue	$500,000	$0	$0
Costs - Department of Health and Senior Services			
Personal Services	($30,924)	$0	$0
Fringe Benefits	($13,996)	$0	$0

Equipment and Expense	($443,401)	$0	$0
Program Costs	($11,679)	$0	$0
Total Costs - DHSS	($500,000)	$0	$0
FTE Change - DHSS	1 FTE	1 FTE	1 FTE
ESTIMATED NET EFFECT ON MISSOURI FREE CLINICS FUND	**$0**	**$0**	**$0**
Estimated Net FTE Change for Missouri Free Clinics Fund	1 FTE	1 FTE	1 FTE
FISCAL IMPACT - State Government (continued)	FY 2009 (10 Mo.)	FY 2010	FY 2011
FEDERAL REIMBURSEMENT ALLOWANCE FUND			
Costs - Department of Social Services			
Program Costs - MHD Insure Missouri	(Unknown but Greater than $31,249,639)	(Unknown but Greater than $85,878,594)	(Unknown but Greater than $114,985,582)
ESTIMATED NET EFFECT ON FEDERAL REIMBURSEMENT ALLOWANCE FUND	**(Unknown but Greater than $31,249,639)**	**(Unknown but Greater than $85,878,594)**	**(Unknown but Greater than $114,985,582)**
FEDERAL FUNDS			
Income - Department of Health and Senior Services			
Federal Assistance	$36,715	$66,404	$68,398
Income - Department of Social Services			
Federal Assistance	Unknown but Greater than $138,105,210	Unknown but Greater than $234,785,760	Unknown but Greater than $284,677,828
Losses - Department of Mental Health			
Loss of Federal Funding	(Unknown)	(Unknown)	(Unknown)

Costs - Department of Health and Senior Services			
Personal Services	($12,366)	($30,569)	($31,486)
Fringe Benefits	($5,597)	($13,836)	($14,251)
Equipment and Expense	($14,082)	($10,454)	($10,769)
Program Costs	($4,670)	($11,545)	($11,892)
Total Costs - DHSS	($36,715)	($66,404)	($68,398)
FTE Change - DHSS	.92 FTE	.92 FTE	.92 FTE
FISCAL IMPACT - State Government (continued)	FY 2009 (10 Mo.)	FY 2010	FY 2011
Cost - Department of Social Services			
Personal Services - R&E	($9,671)	($11,958)	($12,317)
Fringe Benefits - R&E	($4,276)	($5,288)	($5,446)
Equipment and Expense - R&E	($318)	($93)	($95)
Program Costs - ITSD	($120,214)	$0	$0
Program Costs - FSD	($796,389)	($3,680,885)	($3,798,716)
Program Costs - MHD	($4,279,011 to $4,531,771)	($5,175,335 to $5,428,095)	($5,388,507 to $5,641,267)
Program Costs - MHD Insure Missouri	(Unknown but Greater than $132,895,331)	(Unknown but Greater than $225,912,201)	(Unknown but Greater than $275,472,747)
Total Costs - DSS	(Unknown but Greater than $138,105,210)	(Unknown but Greater than $234,785,760)	(Unknown but Greater than $284,677,828)
FTE Change - DSS	.3 FTE	.3 FTE	.3 FTE
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**(Unknown)**	**(Unknown)**	**(Unknown)**
Estimated Net FTE Change for Federal Funds	1.22 FTE	1.22 FTE	1.22 FTE
FISCAL IMPACT - Local Government	FY 2009 (10 Mo.)	FY 2010	FY 2011

POLITICAL SUBDIVISIONS

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Income - Community-Based Groups	$3,500,000	$3,500,000	$3,500,000
Income - School Districts	$4,000,000	$4,000,000	$4,000,000
Income - County Law Enforcement	$3,000,000	$3,000,000	$3,000,000
ESTIMATED NET EFFECT ON POLITICAL SUBDIVISIONS	**$10,500,000**	**$10,500,000**	**$10,500,000**

FISCAL IMPACT - Small Business

Small businesses that currently provide insurance for their employees may opt to discontinue that provision with the availability of Insure Missouri. Also, small businesses that are health care providers may see a decrease in the number of delinquent accounts and an increase in the amount of reimbursement received, as more Missourians are able to obtain coverage through the program.

Health care facilities licensed under Chapters 197 and 198 that meet the criteria for as a small business could incur costs associated with submitting the data required under proposed section 191.1321. If individual health care agencies, physician practices, dental practices, ambulatory surgical centers, nursing homes or pharmaceuticals are required to report health care information, this could have an impact on their operations as well.

Small hospitals could also incur costs associated with reporting reportable incidents to the patient safety organization and completing the required root cause analysis.

Small businesses could qualify for the credits and deductions established in this legislation.

FISCAL DESCRIPTION

The proposed legislation establishes the Missouri Health Transformation Act of 2008.

MINIMUM HEALTH PROMOTION STANDARD FOR STATE BUILDINGS:
This legislation requires the Office of Administration, in consultation with the Department of Health and Senior Services to submit a report to the Governor and General Assembly by December 31 2008, detailing the opportunities for the state to implement a minimum health promotion standard for construction or substantial renovation of a state building. SECTION 8.365

HEALTH CABINET AND HEALTH POLICY COUNCIL:
This legislation creates the Missouri Health Cabinet. The cabinet shall ensure that the public policy of the state relating to health is developed to promote interdepartmental collaboration and program implementation in order that services designed for health are planned, managed, and delivered in a holistic and integrated manner to improve the health of Missourians.

The cabinet is created in the executive office of the Governor and shall meet for its first organizational session no later than October 1, 2008. Thereafter the cabinet shall meet at least six times each year in the different regions of the stats in order to solicit input from the public. The cabinet shall consist of seven members, including the Governor, the director of the

FISCAL DESCRIPTION (continued)

Departments of Health and Senior Services, Mental Health, Insurance, Financial Institutions and Professional Registration and the Commissioner of Education. The President Pro Tem of the Senate, the Speaker of the House, the chief justice of the Supreme Court, the Attorney General, the Commissioner of the Office of Administration and the Director of Agriculture, or their appointed designees shall serve as ex officio members of the cabinet.

The Governor shall appoint a Health Policy Council to assist the cabinet in its tasks. The council shall replace the MO HealthNet Oversight Committee and the State Boards of Health and Senior Services, which are repealed under the legislation. The members of the council shall consist of representatives from the health care or health policy field. SECTIONS 26.850 TO 26.856

REPORT ON SHIFTING DEMOGRAPHICS:
The Lieutenant Governor, in his or her capacity as the senior advocate for the state, shall coordinate with all the directors of the departments in this state to review their major policies, programs, and structures in light of the state's increasingly older and more diverse population. A policy brief shall be submitted to the Governor and General Assembly by July 1, 2009, and shall highlight critical functions or issue areas that would be affected by shifting demographics and how such issues should be addressed within the next ten years. SECTION 26.900

TAX CREDITS AND DEDUCTIONS:
This legislation increases the amount of tax credits available for taxpayers who modify their home to be accessible for disabled people who reside with such taxpayer. Under current law, up to one hundred thousand dollars in tax credits remaining unused under the rebuilding communities tax credit program are allocated for use by taxpayers who modify their homes for disabled persons residing with such taxpayers. This legislation increases the amount of available tax credits by allocating all unused tax credits under the rebuilding communities tax credit program for use by taxpayers who modify their homes for disabled persons residing with such

taxpayers. The rebuilding communities tax credit program is capped at ten million dollars annually. Constructing additional rooms in the dwelling or a new structure on the property are added as a new eligible cost for which the tax credit may be claimed. SECTIONS 135.535 AND 135.562

This legislation provides an income tax deduction in the amount equal to 100% of the premium paid by the taxpayer during the taxable year for high deductible health plans established and used with a health savings account under the applicable provisions of the Internal Revenue Code to the extent the amount is not deducted on the taxpayer's federal income tax return for that taxable year. SECTIONS 1143.116

FISCAL DESCRIPTION (continued)

HEALTH TRANSFORMATION FUND:
A Health Transformation Fund was created for the establishment of pilot projects in the greater St. Charles and southeast bootheel areas of the state. The pilot projects shall have the involvement of the local community health coalition to establish new approaches to expand coverage for the uninsured population in the respective communities and to create healthier populations through a single comprehensive health care plan. The program shall be administered by the Department of Health and Senior Services and shall have a six-year sunset. SECTION 191.845

MISSOURI HEALTHY WORKPLACE RECOGNITION PROGRAM:
This legislation requires the Department of Health and Senior Services to develop the Missouri Healthy Workplace Recognition Program for the purpose of granting official state recognition to employers with more than fifty employees for excellence in promoting health, wellness, and prevention. The criteria for awarding such recognition shall include at a minimum whether the employer offers workplace wellness programs; incentives for healthier lifestyles; opportunities for active community involvement and exercise, and encouragement of well visits with health care providers. SECTION 191.1025

INTERNET WEB-BASED PRIMARY CARE ACCESS PILOT PROJECT:
This legislation requires the Department of Health and Senior Services to award a grant to implement an internet web-based primary care access pilot project designed as a collaboration between private and public sectors to connect, where appropriate, a patient with a primary care medical home, and schedule patients into available community-based appointments as an alternative to non-emergency use of the hospital emergency room. The criteria for the grant are specified in the act. SECTION 191.1200

TELEHEALTH:
This legislation expresses the state's recognition of the delivery of health care via telehealth as a safe, practical and necessary practice in the state. By January 1, 2009, the Department of Health and Senior Services shall promulgate quality control rules to be used in removing and improving the service of telehealth practitioners. SECTIONS 191.1250 to 191.1277

COMMUNITY AND FAITH-BASED ORGANIZATIONS:
This legislation requires the Office of Minority Health to solicit proposals from such community programs and organizations to develop solutions regarding health and wellness SECTIONS 192.083

FISCAL DESCRIPTION (continued)

MISSOURI FREE CLINICS FUND:
This legislation creates the "Missouri Free Clinics Fund" to be administered by the Department of Health and Senior Services for use by clinics in the Missouri free clinics association to increase their infrastructure and bolster their sustainability in order to serve a greater number of people in a more effective manner. For a one-time funding appropriation of 500,000 dollars from the General Assembly, the Department shall disburse funds via contracts in accordance with applicable guidelines, policies, and requirements established by the department. SECTION 192.990

TOBACCO USE PREVENTION, AND CESSATION FUND:
This legislation creates the tobacco use prevention and cessation fund. Beginning fiscal year 2009, payments received from the strategic contribution fund will be deposited into the newly created fund to be used to fund tobacco prevention and cessation programs. SECTION 196.1200

ADVERSE HEALTH EVENTS:
This legislation requires hospitals to report whenever they have a "serious reportable event in health care," as identified by the National Quality Forum. Such events include wrong-site surgery, retention of a foreign object in a patient after surgery, and death or serious disability associated with medication error.

The initial report of the event shall be reported to the patient safety organization no later than the close of business on the next business day following discovery of the incident. The initial report shall include a description of immediate actions taken by the hospital to minimize the risk of harm to patients and prevent reoccurrence. Within 45 days after the event occurred, the hospital shall submit to the patient safety organization a root cause analysis and a prevention plan.

The patient safety organization shall publish an annual report to the public on reportable

incidents. The report shall show the number and rate per patient encounter by region and by category of reportable incident and may identify reportable incidents by type of facility.

MO HEALTHNET:
Current law as to MO HealthNet eligibility was modified to reflect changes for custodial parents under 100 percent of the federal poverty level and how subject to appropriation certain earned income shall be disregarded for these participants. Individuals eligible due the disregard provision who are at least 19 years of age and less than 65 years of age shall receive health care coverage under the Insure Missouri plan, unless they are dual Medicare and Medicaid eligible or pregnant. SECTION 208.145

FISCAL DESCRIPTION (continued)

The Professional Services Payment Committee shall be required to review and make recommendations to the MO HealthNet Division regarding standards and policies for denying payment to a health care provider for treatment costs associated with preventable errors. SECTION 208.149

Prescribed medically necessary therapy services, including physical, occupational, and speech therapy, shall be covered under the Mo HealthNet program. SECTION 208.152.

This legislation grants the MO HealthNet Division authority to collect from third party payers through subrogation of claims. SECTION 208.215

This legislation also establishes the Insure Missouri program to administered by the Department of Social Services. SECTIONS 208. 1300 to 208.1345

PREVENTIVE SERVICES:
Beginning July 1, 2009, the Missouri consolidated health care plan shall include, as part of its covered benefits, all of the preventive benefits recommended by the federal U.S. Preventive Services Task Force. SECTIONS 103.185

HEALTH INSURANCE:
The Department of Insurance, Financial Institutions and Professional Registration shall administer a grant program to assist the start-up of non-profit broker organizations. Eligible participants shall apply to the Department for a grant, using a competitive application process prescribed by the Department. The Department shall award grants not to exceed twenty-five thousand dollars per applicant, with the maximum cumulative total of grants issued per fiscal

year not to exceed one hundred thousand dollars. The Department shall establish eligibility and give preference to applicants who demonstrate the ability to enhance representation of low-cost health insurance coverage models in the market. This program shall expire in years unless re-authorized by the General Assembly. SECTION 376.025

Under this legislation, health carriers are allowed to include wellness and health promotion programs, condition or disease management programs, health risk appraisals programs, and similar provisions in high deductible health plans or policies that comport with federal requirements, provided that such wellness and health promotion programs are approved by the Department of Insurance, Financial Institutions and Professional Registration. SECTION 376.685

FISCAL DESCRIPTION (continued)

This legislation modifies the provisions of Missouri's high risk pool to provide that the twelve-month preexisting condition exclusion period shall not apply for coverage if the person applying for pool coverage has at least three months of uninterrupted prior insurance coverage, so long as the application for pool coverage is made not later than sixty-three days following the loss of such health insurance coverage. SECTION 376.986

Under this legislation, the director of Insurance, Financial Institutions and Professional Registration is authorized to allow health reimbursement arrangement only plans that encourage employer financial support of health insurance or health related expenses recognized under the rules of the Internal Revenue Service to be approved for sale in connection with or packaged with individual health insurance policies otherwise approved by the director. SECTION 376.1600

The director shall study and recommend to the General Assembly changes to remove any unnecessary application and marketing barriers that limit the entry of new health insurance products into the Missouri market. The director shall examine state statutory and regulatory requirements along with market conditions which create barriers for the entry of new health insurance products and health insurance companies. The director shall also examine proposals adopted in other states that streamline the regulatory environment to make it easier for health insurance companies to market new and existing products. The director shall submit a report of his or her findings and recommendations to each member of the General Assembly no later than January 1, 2009. SECTION 376.1618.

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

Budget and Planning Division
Office of the Attorney General
Department of Agriculture
Department of Higher Education
Office of Administration
Department of Economic Development
Department of Elementary and Secondary Education
Department of Insurance, Financial Institutions & Professional Registration
Department of Mental Health
Department of Natural Resources
Department of Corrections
Department of Health and Senior Services
Department of Labor and Industrial Relations
Department of Revenue
Department of Social Services
Department of Public Safety
Missouri Governor's Office
Missouri Senate
Missouri Consolidated Health Care Plan
Legislative Research-Oversight Division
Office of the Lieutenant Governor
Missouri House of Representatives

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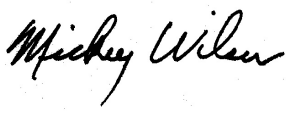
Department of Highways and Transportation



Mickey Wilson, CPA
Director
April 14, 2008

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