COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 5381-03
Bill No.: SB 739
Subject: Medicaid; Health Care; Social Services Department; Health Department; Mental Health Department
Type: Original
Date: February 20, 2014

Bill Summary: This proposal modifies provisions relating to the MO HealthNet program.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
General Revenue	(Could exceed $48,184,173)	(Could exceed $68,208,577)	(Could exceed $70,419,126)
Total Estimated Net Effect on General Revenue Fund	**(Could exceed $48,184,173)**	**(Could exceed $68,208,577)**	**(Could exceed $70,419,126)**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
Joint Contingency*	$0	$0	$0
Various Other State Funds	($13,990,220)	($14,503,998)	($15,113,165)
Total Estimated Net Effect on Other State Funds	**($13,990,220)**	**($14,503,998)**	**($15,113,165)**

*** Transfers-in and expenses net to $0.**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 40 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
Federal	(Greater than $22,500,000)	(More than $45,000,000)	(More than $45,000,000)
Total Estimated Net Effect on All Federal Funds	**(Greater than $22,500,000)**	**(More than $45,000,000)**	**(More than $45,000,000)**

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2015	FY 2016	FY 2017
General Revenue	5.5	5.5	5.5
Federal	4.5	4.5	4.5
Total Estimated Net Effect on FTE	**10**	**10**	**10**

☒ 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 2015	FY 2016	FY 2017
Local Government	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

§208.010 - Asset limits

Officials from the **Department of Social Services (DSS) - MO HealthNet Division (MHD)** state the MHD expects a fiscal impact because of changes to the resource limits. Higher costs will result from one group of Medicaid eligibles who currently receive limited medical benefits but will receive full Medicaid benefits under this legislation. New eligibles are also expected to enter the Medicaid program because of the change in eligibility rules.

The populations that are being proposed for full medical assistance are Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB).

There are a total of 8,174 new cases composed of 6,274 new cases (1,005 rejections + 133 closings + 5,136 unknown population) plus 775 QMBs and 1,125 SLMBs that will receive benefits as a result of increasing the asset limits.

The total costs for the new cases are:

FY 15 (10 months): $125,385,999 (Federal $79,112,296; GR $30,540,644; Other $15,733,059);
FY 16: $156,782,654 (Federal $98,922,016; GR $38,188,021; Other $19,672,617);
FY 17: $163,367,525 (Federal $103,076,740; GR $39,791,918; Other $20,498,867).

Officials from the **DSS - Family Support Division (FSD)** state the FSD has determined there would be a total of 8,174 new cases for MO HealthNet for the Aged, Blind, and Disabled (MHABD) program(s) if the resource limits are increased as proposed. The FSD arrived at 8,174 new cases in this manner:

> In FY 13, the FSD rejected 7,433 MO HealthNet (MHN) applications due to resources. Of these rejected applications, 5,622 were rejected for all FSD MO HealthNet programs. The remaining 1,811 (7,433-5,622) cases were eligible for Qualified Medicare Beneficiary (QMB)/Specified Low-income Medicare Beneficiary (SLMB) benefits, which have higher resource limits, and are included in the QMB/SLMB population below. The FSD estimates that 1,005 of the 5,622 applications rejected for all FSD MO HealthNet programs would be eligible if the resource limit was increased.
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> In FY 13, the FSD closed 1,137 MO HealthNet for the Aged, Blind, and Disabled cases due to resources. Of these closed cases, 267 were not eligible for other MHN programs. The remaining 870 cases (1,137-267) were eligible QMB/SLMB and are included in the QMB/SLMB population below. The FSD estimates that 133 of the 267 cases closed and not eligible for other MHN programs would be eligible if the resource limit was increased.

ASSUMPTION (continued)

The FSD would also see an increase in MHN eligibles from the QMB/SLMB population. In SFY13 there was an average of 4,025 QMB persons. Of these, 3,826 live alone and 199 live with a spouse. Of those living alone, 713 would be eligible if the resource limit was increased. Of those living with a spouse, 62 would be eligible.

Total new MHN cases from QMB: 713 + 62 = 775

In FY 13 there was an average of 10,798 SLMB persons. Of these, 9,059 live alone and 1,739 live with a spouse. Of those living alone, 915 would be eligible if the resource limit was increased. Of those living with a spouse, 210 would be eligible.

Total new MHN cases from SLMB: 915 + 210 = 1,125

The FSD anticipates an increase in applications as the result of the increased resource limits. These applications would come from a previously unknown population who currently chooses not to apply due to the current resource limits. According to U.S. Census Bureau data, 51,364 uninsured Missouri individuals, age 19 or above, have a disability. If 10% of these individuals were to apply and be found eligible for MHN benefits, the FSD would see an increase of 5,136 (51,364 x 10%) new MHN cases as the result of the increased resource limits.

Total new cases:

1,005 (rejections)
133 (closings)
775 (QMB)
1,125 (SLMB)
5,136 (unknown population)
8,174 new MHN cases

Officials from the **DSS - Division of Legal Services (DLS)** state section 208.010.2(4) seeks to increase the resource limit for MO HealthNet benefits from $1,000 to $2,000 for single individuals and from $2,000 to $4,000 for married couples living together. Within DLS, only the Hearings Unit would be affected by the proposed changes. Because the proposed legislation increases the asset limit, the population of MO HealthNet participants should also increase. The MO HealthNet Division estimates this asset increase to result in 8,174 additional MO HealthNet participants. The DLS Hearings Unit anticipates that approximately 10 percent of MO HealthNet participants will request a DLS hearing. A DLS administrative hearing officer's caseload is

ASSUMPTION (continued)

presumed to be 900 hearings per year. In FY 2013 there were 18 hearing officers. Therefore, the estimated effect of this provision would be to add 45 hearings per year for each hearings officer (817 ÷ 18), or approximately one extra hearing per week. It is not expected that hearings would increase in such a way that current staffing levels could not effectively absorb the increase in workload. Thus, this provision appears to have a negligible fiscal impact on the Division of Legal Services.

Officials from the **Department of Mental Health (DMH)** state the provisions of this proposal increases the available asset limit for persons age 65 and over and persons with disabilities to $2,000 for single individuals and $4,000 for married couples. The Department of Social Services (DSS) estimates this would add 8,174 new eligibles to the MO HealthNet program. The DMH, estimates 314 of these individuals currently receive Community Psychiatric Rehabilitation (CPR) services and 92 receive substance abuse treatment as non-Medicaid consumers at an annual cost of approximately $318,400. Covering these consumers under MO HealthNet would allow DMH to re-direct state funds currently used for the services to provide additional CPR and substance abuse treatment. There also will be additional individuals with substance use disorders or serious mental illness who would qualify due to the increased asset limit. Costs for CPR and Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) for the additional individuals and the current DMH consumers moving to MO HealthNet are included in the DSS estimate.

Officials from the **Department of Health and Senior Services (DHSS) - Division of Senior and Disability Services (DSDS)** state in section 208.010.2(4) the resource limit increases would result in additional individuals becoming eligible for MO HealthNet without spenddown requirements. Currently, many of those individuals now participate with a spenddown. DHSS defers to the Department of Social Services to determine the fiscal impact for this change in asset limit.

Officials from the **Office of Administration (OA) - Information Technology Services Division (ITSD)/DSS** state section 208.010 of this act modifies the amount of cash, securities or other total non-exempt assets an aged or disabled participant is allowed to retain in order to qualify for MO HealthNet benefits from less than $1,000 to $2,000 for a single person and from $2,000 to $4,000 for a married couple. This would require changes to Family Assistance Management Information System (FAMIS), including:

1. Updating rules table with new resource maximum values will require 1 hour from a state staff member for all environments. This also includes update of technical specification documents.

ASSUMPTION (continued)

2. Projecting 38 hours of effort for unit and systems test by contract staff.
   Assumptions:
   - All effort associated with these changes will be completed in FY 15 (no impact beyond 2015).
   - 39 hours of effort will be completed at the state staff rate of $63.04/hr.

Total Cost: 39 hrs X $63.04 = $ 2,459 (rounded).

The match rate for FAMIS is 50% GR and 50% Federal.

Sction 208.010 2 (2)

This section pays Pregnant Women with income between 133% and 185% of the FPL a subsidy in an amount equal to the premium and co-pays for a health plan they purchase on the Federally-facilitated marketplace.

1. Requires processing of two new Medicaid Eligibility (ME) Codes.
2. Process commercial payments in a manner similar to what is currently done for the Health Insurance Payment Program (HIPP). This applies to a population estimated at 20,000 individuals.
3. This impacted MPW group enrolls through the Federally-facilitated Marketplace. These interfaces would exist through the MO Eligibility Determination and Enrollment System (MEDES) and the Federal Data Services Hub.

Effort and Cost for ITSD:

1. MO HealthNet Systems - Add two Medicaid Eligibility (ME) codes to table that determine match code. Requires one Computer Information Technology Specialist (CITS) I at $25.05 per hour for 8 hours of analysis, coding and unit test plus 8 hours for systems and user acceptance testing. (16 hours X $25.05/hr = $401; rounded).
2. MO HealthNet Systems - Create new COBOL program to create remittance advises (RA's). Can be modeled from FMSHI707 reducing time to four hours for analysis and coding and four hours for testing for one IT-III at a rate of $19.73 per hour (16 hours X $19.73 = $316; rounded).
3. DBA Team - Create new database to store the direct deposit information. This can be modeled after the existing HIPP direct deposit database which reduces effort to 24 hours for one CITS I at a rate of $25.05 per hour (24 hours X $25.05/hr = $601; rounded).

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ASSUMPTION (continued)

4. MO HealthNet Systems - Create new job/proc/program to process and store direct deposit information in the database. Requires one Information Technologist (IT) IV at a rate of $22.34 per hour. Estimating 16 hours for analysis, code and unit test plus 16 hours for system and user acceptance testing, including time to test with mailroom to ensure the aims marks line up they can merge notices with checks. (32 hours X $22.34 = $715; rounded)
5. State Data Center costs are anticipated to be about 13 times higher than the average $68 per month for processing HIPP (for an estimated 20,000 people versus the 1,532 currently enrolled in HIPP). Data Center costs include CPU, storage and print expenses. (13 X $68/month = $884 per month or $10,608 per year).

Total DDI Hours: 88 hours
Total DDI Cost: $2,032.56
Annual Data Center Charges: $10,608 per year

Development costs would occur in FY 15 and data center costs would occur for the last half of FY 15 and for full years thereafter.

GR Expense for FY15
DDI: 10% X $2,032.56 = $204 (rounded)
SDC: 10% X 0.5 years X $10,608 = $530 (rounded)
Total GR Expense = $734 (rounded)

Federal Expense for FY 15
DDI: 90% X 2,032.56 = $1,829 (rounded)
SDC: 90% X 0.5 years X $10,608 = $4,774 (rounded)
Total Federal Expense = $6,603 (rounded)

GR Expense for FY 16 and thereafter
SDC: 10% X $10,608 = $1,061 (rounded)

Federal Expense for FY 16 and thereafter
SDC: 90% X $10,608 = $9,547 (rounded)

§208.151 - Medical Assistance for Needy Persons (MO HealthNet)

Officials from the **DSS - Division of Finance and Administrative Services (DFAS)** state there is an estimated savings for 208.151.2(1) relating to breast and cervical cancer costs.

ASSUMPTION (continued)

Effective July 1, 2015, women with breast or cervical cancer will be eligible for MO HealthNet (MHN) only if they do not have access to employer-sponsored health insurance coverage or subsidized insurance coverage through the health care exchange and have income between 100% and 200% of the federal poverty level (FPL) using the Modified Adjusted Gross Income (MAGI) standard. DSS estimates that 18 eligibles will be affected by this provision, resulting in a savings in FY 16 of $430,988 (Federal $319,664; GR $66,794; various Other State Funds $44,530) and in FY 17 of $449,090 (Federal $333,090; GR $69,600; various Other State Funds $46,400).

DSS - DFAS officials also state for subsection 208.151.2(2) - Pregnant Women, there will be a savings.

Effective July 1, 2015, pregnant women between 138% and 185% of the FPL will be eligible for MHN in the form of a premium subsidy to allow them to enroll in a plan offered by the health care exchange. A pregnant woman is eligible for a premium subsidy equal to the amount of the percentage of income required for premium payments or coinsurance to the pregnant women by federal rule.

DSS estimates this provision will affect 1,239 eligibles and result in a savings beginning in FY 2016. FY 16 savings are estimated to be $10,602,984 (Federal $6,689,953; GR $2,347,819; various Other State Funds $1,565,213); FY 17 savings are estimated to be $11,048,310 (Federal $6,970,931; GR $2,446,427; various Other State Funds $1,630,952).

Officials from the **DSS - FSD** state for section 208.151.8 that as of November, 30, 2013, there are 63,920 individuals eligible for MO HealthNet for the Aged, Blind, and Disabled (MHABD) program on a spend down basis. Of these, 84% (53,693) are also receiving Medicare and 16% (10,227) are non-Medicare. Only the non-Medicare recipients will need to be notified since Medicare recipients are not eligible for coverage in the exchange. The FSD anticipates mailing a one-time notice to these individuals to notify them of the potential for more cost-effective private insurance and premium tax credits available through the health care exchange. The FSD anticipates a one-time cost of $4,193 (10,227 x $0.41 postage cost) to mail the initial one-time notice. These costs have a 50% federal match rate ($2,097 Federal; $2,096 General Revenue).

Notification for new MHABD spend down participants will be added to other required notifications mailed when a participant is approved for or changed to spend down eligibility.

Oversight assumes the DSS - FSD can absorb the minimal mailing costs associated with these provisions of the proposal.

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ASSUMPTION (continued)

Officials from the **DSS - DLS** state section 208.151.2 proposes to limit Medicaid eligibility for Breast and Cervical Treatment, Blind Pension, Pregnant Women, and Infant subgroups. This provision appears to have no fiscal impact on the DLS.

§208.186 - Substance Abuse Assessments

Officials from the **DSS - Children's Division (CD)** state it is unknown how many MO HealthNet participants may receive an assessment based on this provision. MO HealthNet may already pay for a limited number of these assessment in the normal course of treatment; however, it is likely that the number of assessments will increase. The CD assumes an unknown fiscal impact.

Officials from the **DSS - Division of Youth Services (DYS)** state it is unknown how many MO HealthNet participants may receive an assessment based on this provision. MO HealthNet may already pay for a limited number of these assessment in the normal course of treatment; however, it is likely that the number of assessments will increase. The DYS assumes an unknown fiscal impact.

Officials from the **DSS - DLS** state this section seeks to require mental screenings for individuals convicted of a crime involving drugs and alcohol or child abuse and neglect. No fiscal impact is expected for the DLS.

Officials from the **DMH** state this section requires a MO HealthNet recipient who has been adjudicated guilty of a crime involving alcohol or controlled substance or which was a contributing factor, or is a parent of a child subject to proceedings in a juvenile court, to obtain an assessment by a treatment provider approved by DMH. The language is unclear as to which department or division will fund these assessments or if the cost of the assessment will be paid by the individual. DMH assumes there would be no cost to the DMH for the assessments.

§208.661 - Co-locating Health Clinics on School Property

Officials from the **DSS - MHD** state this legislation requires the DSS to develop incentive programs to encourage Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), or other primary care practices to co-locate on the property of public elementary and secondary schools with fifty percent or more students who are eligible for free or reduced price lunch.

ASSUMPTION (continued)

If the incentive programs consist of grants, the grants could be an MHD fiscal impact. MHD would offset such grants from the costs reported by FQHCs or RHCs when MHD performs their FQHC/RHC Medicaid cost settlements. If MHD amends its regulations to exempt such grants from offset, the fiscal impact to MHD would be greater than if the incentive grants are offset.

Assuming that this legislation is passed, if a school-based clinic becomes certified and approved by federal agencies as an FQHC or RHC site, the site must first be enrolled with Medicare before it can be enrolled as a Medicaid FQHC/RHC site. Due to time required for the enrollment process, there will be no fiscal impact for FY 15. Not knowing who will elect to use this and the utilization makes the fiscal impact for FY 16 and FY 17 unknown.

Oversight is ranging the costs from $0 to (Unknown) for FY 16 and FY 17 because 208.661.4 provides that the provisions of the proposal will be null and void unless and until any waivers necessary are granted by the federal government.

Officials from the **Department of Elementary and Secondary Education (DESE)** state section 208.661 appears to provide the potential for local school districts to gain an incentive; however, any impact cannot be estimated.

Officials from the **DHSS - Division of Regulation and Licensure (DRL)** state there are approximately 384 RHCs in the state currently. DHSS does not believe established RHCs would relocate in order to co-locate with a school. Due to the fact that DHSS no longer performs initial RHC Medicare surveys except in very limited situations and most new RHCs, if any, that would result from the proposed legislation, would go through the Accrediting Organization's (AO) accreditation process, DRL is considering this fiscal note to be no impact for this section.

§208.662 - Show-Me Healthy Babies

Officials from the **DSS - DMH** state section 208.662.1 creates the "Show-Me Healthy Babies Program" which would provide medical coverage to unborn children through the Children's Health Insurance Program (CHIP).

Section 208.662.2 sets the income eligibility of the program at no more than 300% of the federal poverty level (FPL), subject to appropriations.

Section 208.662.3 states that medical coverage would be limited to prenatal care and pregnancy-related services that benefit the health of the unborn child and that promote healthy labor, delivery, and birth.

ASSUMPTION (continued)

The Family Support Division (FSD) assumes that 1,844 unborn children will be enrolled. This is the number of Medicaid for Pregnant Women (MPW) who were denied coverage for income between 185% and 300% of Federal Poverty Level (FPL). MHD assumes that pregnant women will be enrolled, and not actually the unborn child. MHD further assumes that the coverage would be similar to the current coverage for the MPW population, which could include other medical issues for the mother that could affect the unborn baby (for example, diabetes or an infection). The cost per member per month (PMPM) for the MPW population is $579.11. Total cost for a year would be $12,814,546 (1,844 x $579.11 x 12). There may be some additional unknown costs for programming, so that this new category of aid can be identified.

Section 208.662.4 requires the DSS to set up a presumptive eligibility procedure for enrolling an unborn child.

FSD currently has presumptive eligibility procedures in place.

Section 208.662.5 states that coverage for the child shall continue for up to one year after birth. MHD currently covers children age 0 - 1 between 185% - 300% of FPL under the CHIP program. This would have no additional fiscal impact on MHD.

Section 208.662.6 requires coverage for the mother to continue through the last day of the month that includes the sixtieth day after the pregnancy ends. Coverage for the mother shall be limited to pregnancy-related and postpartum care.

These costs would be included in the yearly cost of the MPW population.

Section 208.662.7 defines the ways that the DSS may provide coverage. These include paying the health care provider directly or through managed care; a premium assistance program; a combination of the two; or a similar arrangement.

MHD assumes a one-time cost for managed care rate development of $50,000.

Section 208.662.8 requires the department to provide information about the Show-Me Healthy Babies Program to maternity homes, pregnancy resource centers, and similar agencies and programs in the state. It also states the department shall consider allowing such agencies to assist in enrollment and presumptive eligibility and verification of the pregnancy.

Section 208.662.9 requires the DSS to submit a state plan amendment or seek necessary waivers within sixty days after the effective date of this section to United States Department of Health and Senior Services.

ASSUMPTION (continued)

MHD currently has a state plan amendment for CHIP. MHD assumes that it could submit this new state plan amendment with existing staff.

Section 208.662.10 requires the DSS to prepare and submit a report on cost savings and benefits at least annually.

MHD assumes that it would contract this service out at a cost of $40,000 per year.

Section 208.662.11 states that the Show-Me Healthy Babies Program shall not be deemed an entitlement program, but instead shall be subject to federal allotment or appropriations and matching state appropriations.

Section 208.662.12 states that the state is not obligated to continue this program if the allotment or payments from the federal government end or are not sufficient to operate the program, or if the general assembly does not appropriate funds for the program.

MHD assumes that if the waiver were not approved or if state match were not appropriated, that this program would cease to exist.

Section 208.662.13 states that nothing in this section shall be construed as expanding MO HealthNet or fulfilling a mandate imposed by the federal government or the state.

Total costs for the program, would be $12,814,546 in FY 13 for the unborn population plus $40,000 per year for reporting, a one-time rate development cost of $50,000, and a one-time unknown cost for programming in FY15. It is also assumed that the unborn cost in FY 15 will only be for a 10-month period. A 2.9% medical inflation was added to the FY 13 program costs for FY 14 and FY 15 to arrive at the FY 15 cost. An additional 2.9% medical inflation cost was added to FY 16 and FY 17. The federal match for CHIP services is 74.170%. Rate development, reporting and programming costs would receive a federal match rate of 50%.

FY15 (10 months): $0 to > $11,397,139 (GR > $2,965,634; Federal > $8,431,505);
FY16: $0 to $14,002,055 (GR $3,626,399; Federal $10,375,656); and
FY17: $0 to $14,406,954 (GR $3,730,984; Federal $10,675,970).

This program is subject to appropriations.

Officials from the **DMH** state this section establishes the "Show-Me Healthy Babies Program" under the Children's Health Insurance Program (CHIP) to provide coverage to unborn children whose mothers are uninsured and have income up to 300% of the federal poverty level (FPL).

ASSUMPTION (continued)

DMH currently serves consumers in Alcohol and Drug Abuse (ADA) and CPR programs that are not eligible for MO HealthNet that would qualify in this new program. There also will be additional individuals with substance abuse disorders and serious mental illness who would qualify under this new program. Costs for CPR and CSTAR services are included in the DSS estimate.

Officials from the **Office of Administration - Commissioner's Office** state that due to the possible duplication of services, and the differences between services provided, it is unknown at this time how the Alternatives-to-Abortions (A2A) program would be impacted if this proposal passes.

Officials from the **OA - ITSD/DSS** provide the following assumptions:

MHD indicated they would require the establishment of at least one new Medicaid Eligibility (ME) code, coding to possibly enroll a participant in a managed care plan, passing eligibility to WIPRO (the DSS contractor) from the Family Assistance Management Information System (FAMIS), and review the Health Insurance Premium Payment (HIPP) coding.

In addition, MMIS would require the establishment of at least one new ME code, development of new reports, and additional tracking of participants. The required systems work would be done by WIPRO.

MHD Estimates:

Activities	Estimated Hours
Analysis/Design/Create/Modify Specs	100
Coding	160
Testing	40
Total	300 hrs

300 hours X $63.04/hr = $ 18,912

Match rate is 50% General Revenue and 50% Federal.

§208.670 - Telehealth

Officials from the **DSS - MHD** assumes that out-of-state health care providers must enroll with MO HealthNet and must only provide the distant site service, and a Missouri provider must initiate the contact as the originating site. MO HealthNet assumes that a specialist (including

ASSUMPTION (continued)

hospitalist) would not be able to admit or serve as an attending provider via telehealth services. MO HealthNet also assumes that all other requirements for Telehealth service, established in 13 CSR 70-3.190, will be followed.

MO HealthNet does not anticipate a fiscal impact.

§208.950 - Aged and Disabled Included in Managed Care

Officials from the **DHSS - DSDS** state that Section 208.950.4, the exemption from managed care programs for the elderly and disabled MO HealthNet participants is repealed. This means these individuals (unless they are in skilled nursing facilities) could be moved into a managed care plan rather than remaining fee-for-service participants. DSDS cannot determine the fiscal impact of this repeal since the design of the managed care structure has yet to be determined

§208.952 - Joint Committee on MO HealthNet

Officials from the **Missouri Senate** state the proposal will have no fiscal impact to the Missouri Senate. However, the language of the proposal establishing a joint committee to study Medicaid issues will likely have a fiscal impact ranging from $75,000 to $165,000. This estimate is based on current appropriations (rounded) for the Joint Committees: Education, $75,000; Administrative Rules, $124,000; and Retirement Systems, $165,000.

Oversight will transfer funds from the General Revenue Fund to the Joint Contingency Fund, ranging from $75,000 to $165,000, to cover the expenses of the Joint Committee on MO HealthNet. Oversight assumes expenditures will equal funds transferred-in and will net to $0.

Officials from **DESE** state depending on the actions of the committee, there could be a cost to the department.

DESE will have access to some state information through the MO Health Information Network exchange. However, DESE does not collect the data required through this proposal, especially at the district level. DESE can capture districts' Medicaid revenue at the end of the year through the Annual Secretary of the Board Report (ASBR), but it has no way to project future costs and growth for each school. Costs are unknown.

Oversight assumes MO HealthNet growth projections, including enrollment growth categorized by population and geographic area will be primarily the responsibility of the DSS and the DESE will have minimal costs associated with this provision of the proposal.

ASSUMPTION (continued)

Officials from the **DSS - MHD** state the compensation for the Joint Committee on MO HealthNet shall be paid from the joint contingent fund or jointly from the senate and house contingent funds until an appropriation is made; therefore, there will be no fiscal impact to MHD

§208.990 - Parent and Caretaker Relative MO HealthNet Coverage

Officials from the **DSS - FSD** state for section 208.990.6 that parents or caretaker relatives are currently not eligible to receive MO HealthNet for Families benefits unless there is also an eligible child in the household.

Federal law found at 42 USC 1396(a) sets forth the criteria for who must be covered under a state's Medicaid plan. If individuals applying for Medicaid meet the criteria set forth in federal law, states must cover those individuals. Adding a requirement for participants of the MO HealthNet for Pregnant Women or Uninsured Women Health Services programs that dependent children living with the participant receive MO HealthNet or CHIP benefits, or be enrolled in minimum essential coverage would be adding an eligibility requirement that is not in federal law. The United States government may impose sanctions against states that do not comply with federal Medicaid law. These sanctions may include disallowances and the loss of all or a portion of federal financial participation in the Medicaid program, however this is unknown.

Due to the change in organization structure and the new eligibility system, the FSD assumes existing staff will be able to maintain any changes in applications and caseload sizes as a result of the changes proposed under Section 208.010.2(4).

The FSD assumes existing Central Office Program Development Specialists in the Policy Unit will be able to complete necessary policy and/or forms changes.

The FSD assumes OA-ITSD will include the Family Assistance Management Information System (FAMIS)/Missouri Eligibility Determination and Enrollment System (MEDES) programming costs for the system changes as well as the system generated notice needed to implement provisions of this proposal in their fiscal note response.

§208.991 - Definitions and MO HealthNet Eligible Persons

Officials from the **DHSS - DSDS** state this section defines terms including "medically frail" and adds MO HealthNet coverage for those meeting that definition. Since the screening process would have to be developed, DSDS cannot provide an estimate of the number of individuals that would be eligible under this definition, or an estimate of the cost of services for those individuals.

ASSUMPTION (continued)

Officials from the **DSS - DFAS** state section 208.997 requires the MO HealthNet Division (MHD) to develop a Health Care Homes Program for individuals who are deemed medically frail. Medically frail is defined in subdivision 208.991.1(7).

§208.997 - Health Care Homes Program

Officials from the **DSS - DFAS** state MHD must implement a "Health Care Homes Program" to transition from the fee-for-service program to an accountable care organization under 208.1503. The health care homes model is a provider-directed care coordination program for the medically frail. It provides payment to primary care clinics for MO HealthNet participants. This section is effective January 1, 2015. Therefore, the first year impact is roughly half of that of the impact for FY 16 and FY 17.

It is assumed there will be an unknown cost if the intent of the legislation is to have all individuals in an Accountable Care Organization (ACO) also in a health home. The health home infrastructure and level of care management is cost prohibitive for some Aged, Blind and Disabled participants whose care may be managed through other, less intense, models.

There will be an unknown savings if the intent of the proposal is to have only medically frail participants in a health home.

Since the intent of the proposal is unclear, **Oversight** will range the impact of this section from (Unknown) costs to Unknown savings for all fiscal years.

Officials from the **DSS - MHD** state MHD is already covering the Behavior Assessment CPT codes (§208.997.4), so there is no fiscal impact for this subsection.

Officials from the **DHSS - Division of Community and Public Health (DCPH)** state this section poses an unknown impact to the Healthy Children and Youth (HCY) and Medically Fragile Adult Waiver (MFAW) programs. This section directs MO HealthNet to develop and implement a "Health Care Homes Program" as a provider-directed care coordination program for individuals who are deemed medically frail and who shall be transitioned from the fee-for-service program to an accountable care organization.

Section 208.997.3 indicates that the health care home for these recipients may also be the provider of home and community based services received by these recipients. Currently, the Bureau of Special Health Care Needs (SHCN) provides service coordination for recipients for MO HealthNet's HCY and MFAW Programs. These program participants appear to meet the definition of medically frail in the legislation and are fee-for-service recipients. Through service

ASSUMPTION (continued)

coordination functions, SHCN service coordinators assess and authorize the home and community based services to be provided to program participants by other providers. It is unclear in the legislation if authorization of home and community based services would remain a function of SHCN separate from the care coordination to be provided by the accountable care organizations. Current structure enables SHCN to be an objective third party assessor in assessing and authorizing services for the HCY and MFAW programs.

Officials from the **DHSS - DSDS** state this section establishes health care homes for medically frail individuals and transitions them to managed care settings. Since the design of neither the managed care setting, nor the services covered is defined, DSDS cannot provide a fiscal estimate for this section.

§§208.998 and 208.1503 - Extension of Managed Care Statewide and Accountable Care Organizations

Officials from the **DSS - MHD** state section 208.998 extends the MO HealthNet Managed Care program statewide by January 1, 2015, for all eligibility groups currently enrolled in a managed care plan as of January 1, 2014.

Section 208.998 extends the MO HealthNet Managed Care program statewide by January 1, 2015, for all eligibility groups currently enrolled in a managed care plan as of January 1, 2014.

MO HealthNet would require an additional eight (8) FTE to implement Managed Care statewide. These FTE would include: a Social Services Manager II ($50,088 annually); a Management Analysis Specialist II ($41,016 annually); a Medicaid Unit Supervisor ($41,016 annually); a Program Development Specialist ($39,480 annually); a Correspondence and Information Specialist ($34,092 annually); and three (3) Medicaid Technicians ($31,800 annually, each). MHD assumes that additional rental space would be needed, as there are not eight (8) open cubicles at the Howerton Building. The total cost for staff, fringe and office space for FY15 (10 months) would be $476,102. FY16 costs would be $492,757, and FY17 costs would be $498,187.

If current HMOs are utilized from January 1, 2015 to July 1, 2015, and only new enrollees are sent enrollment packets, the cost for enrollment packets would be $229,000. However, if there was a statewide rebid and open enrollment for all enrollees, the cost for enrollment packets would be $510,140. If a rebid were required, there will be additional activities that would need to take place and it is unlikely that the rebid process could be successfully implemented before January 1, 2015.

ASSUMPTION (continued)

MO HealthNet estimates that there would be an actuarial cost to evaluate the capitation rates in the amount of $100,000.

There would also be a one-time cost for Medicaid Management Information System (MMIS) changes to cover the additional counties and population. The estimated cost for this would be $550,000. This assumes a new region will be created and up to 3 new health plans will be added.

Section 208.998.8.(6) adds pharmacy benefits to the list of services provided by the contracted health plans. However, Section 208.998.2 allows DSS to designate certain health care services be excluded from such health plans if it is determined to be cost effective. Therefore, DSS plans to continue to carve-out pharmacy benefits as this is the most cost-effective option. If pharmacy benefits were covered by the managed care plans there would a loss of pharmacy tax as a funding source.

The cost to administer statewide managed care with the current MO HealthNet population would be as follows:

FY15: $476,101 for Salaries, Fringe and E&E (10 months)
$229,000 minimum for enrollment packets
$100,000 for actuarial costs
$550,000 for MMIS costs
Total: $1,355,101

NOTE: Costs could exceed above amount if rebid is necessary ($510,140 packet cost for enrollees plus additional costs associated with rebidding managed care contracts).

FY 16: $492,757 for Salaries, Fringe and E&E
$229,000 for additional Enrollment Packets
Total: $721,757

FY 17: $498,187 for Salaries, Fringe and E&E
$229,000 for additional enrollment packets
Total: $727,187

FY15 (10 mos.) >= $1,355,101 (GR >= $677,550; Federal >=$677,551);
FY16: $721,757 (GR $360,878; Federal $360,879);
FY17: $727,187 (GR $363,593; Federal $363,594).

ASSUMPTION (continued)

There would be a six-month savings in FY 15 for moving the current fee-for-service population to Managed Care. Savings will be in Federal, GR and Other Funds, including Federal Reimbursement Allowance, Ambulance Federal Reimbursement Allowance and Health Initiatives Fund.

FY 15 (6 months): $12,289,077 (Federal $7,815,605; GR $2,730,633; Other Funds $1,742,839);
FY 16: $25,094,295 (Federal $15,959,466; GR $5,575,953; Other Funds $3,558,876)
FY 17: $26,148,256 (Federal $16,629,764; GR $5,810,142; Other Funds $3,708,350)

The number of eligibles affected is:

Adults: 26,184
Pregnant Women: 9,364
Children: 153,306
Children - 100% State Benefit (DYS and CD): 184
Children - CHIP (at the enhanced match rate): 15,547
Total: 204,585

DSS assumes a 3% cost savings as a result of moving these recipients from fee-for-service to managed care.

Officials from the **DSS - DFAS** state the current fee-for-service population being moved to Accountable Care Organizations (ACOs) does not begin until January 1, 2015. DSS used a shared risk model to estimate costs because no data exists for a full risk model.

An analysis completed in 2010 found that HMO managed care for the Aged, Blind and Disabled (ABD) population would save no more than $14.5 million GR annually. It is assumed an HMO would yield maximum savings and an ACO something less. Paying a provider a risk-based rate requires that rate to be actuarially sound; the GR cost of each 1% increase in the ABD population FY 13 costs for non-institution care is $15 million GR annually.

DSS assumes unknown costs for this provision of the proposal.

Officials from the **DSS - DLS** state the language of this section proposes to expand the MO HealthNet managed care program statewide by January 1, 2015. The MO HealthNet Division anticipates this change to result in a shift of participants from traditional fee-for-service to managed care coverage, but not a change in the total number of participants. Thus, the DLS should not notice a measurable difference in legal representation or hearings, and so this legislative provision does not appear to have any fiscal impact on the DLS.

ASSUMPTION (continued)

Officials from the **DMH** state sections 208.998 and 208.1503 requires MO HealthNet fee-for-service participants, except for those participants in skilled nursing facilities, to be transitioned into managed care or accountable care organizations. Section 208.1503 also encourages provider rates to include pay-for-performance and to be comparable to commercial rates. It is unclear if these sections of the proposed legislation continue to carve-out DMH care management services (Community Psychiatric Rehabilitation [CPR], Comprehensive Substance Abuse Treatment and Rehabilitation [CSTAR], Targeted Case Management [TCM], and Developmental Disabilities waiver services) from managed care. Therefore, DMH assumes that all DMH fee-for-service participants and care management services will be transitioned into Managed Care or an associated company offer (ACO) program.

Transitioning DMH care management services to a Managed Care or ACO program will place additional pressure on state funds through the loss of DMH funding mechanisms such as the clinic Upper Payment Limit (UPL), Intermediate Care Facility/Developmental Disabilities (ICF/DD) UPL, ancillary administrative, and local tax match dollars, and the loss of these funding mechanisms would not be realized through a net managed care savings. DMH anticipates the loss in excess of $51,000,000 ($6,000,000 General Revenue and $45,000,000 Federal Funds) to the current DMH budget.

Oversight notes the effective date of the extension of managed care statewide and the transitioning into Accountable Care Organizations is January 1, 2015, Therefore, DMH's losses will be for 6 months for FY 15.

Officials from the **DHSS - DCPH** state the proposed legislation modifies the provisions to the MO HealthNet program. These changes would have an unknown impact on the Metabolic Formula Program, the Adult Genetics Program, and Children and Youth with Special Health Care Needs Program because the proposed legislation requires participants eligible for MO HealthNet to enroll in a health care exchange, select a plan and then MO HealthNet will pay in the form of a premium subsidy. It's not stated what the insurance coverage of these plans would entail to determine what the impact would be for the programs. As payer of last resort, these programs may have more or less fiscal responsibility for eligible expenses depending on the number of individuals eligible for MO HealthNet and the coverage of the plans to be subsidized by MO HealthNet under the new provisions.

Officials from the **DHSS - DSDS** state this section (208.1503) provides for the transition of current fee for service participants (except those in nursing facilities) to managed care settings. Since the design of neither the managed care setting, nor the services covered is defined, DSDS cannot provide a fiscal estimate for this section.

ASSUMPTION (continued)

In summary, the details of how the managed care program would work for the elderly and disabled populations have not been defined and there are several factors that are not defined regarding Home and Community Bases Services participants. Therefore, the fiscal impact for the proposed legislation is unknown for DHSS.

Officials from the **Department of Insurance, Financial Institutions and Professional Registration (DIFP)** state Section 208.1503.1 of this proposal creates "Accountable Care Organizations (ACOs)"; Section 208.1503.2 requires that the "ACOs shall be full-risk bearing entities..."

Under current provisions of law (§375.012.1(4)) as full risk bearing entities, these ACOs would appear to need to be licensed as a Health Maintenance Organization (HMO) or a Life and Health insurer. However, the proposed law does not define licensing requirements or put forth any regulatory standards. If the intent is to regulate ACOs as a licensed insurer, one (1) Financial Analyst Specialist FTE for processing and approving the licensure, as well as ongoing monitoring, would be necessary. It is estimated that there would be 8 to 10 such entities needing to be regulated.

DIFP estimates costs to the General Revenue (GR) Fund for FY 15 of $61,352; FY 16 costs of $64,811; and FY 17 costs of $65,516.

Officials from the **OA - Division of Purchasing and Materials Management (DPMM)** state sections 208.998.4(1) and 208.998.4(2) of the proposal could hinder the competitive process if potential bidders determine the evaluation and contractual stipulations are too restrictive and decide they will not bid. This could result in higher prices and less medical care options for the clients of DSS. The proposal will have no fiscal impact on the DPMM.

Officials from the **OA - ITSD/DSS** provide the following assumptions:

Expand Managed Care program statewide:

1. There are currently three Managed Care Regions covering the central portion of the state from Kansas City to St. Louis.
2. Four new regions would be added to cover the northern and southern areas of the state.
3. Assumes there may be up to three new health plans.
4. MEDES would have to create Managed Care records for seven regions instead of three and create records for an estimated 641,000 enrollees. Currently there are about 410,000 enrollees.

ASSUMPTION (continued)

ITSD Effort and Cost:

1. MO HealthNet Systems - Modify batch subroutine that identifies the Managed Care region the participant resides in. MEDES would call this subroutine to when creating the Managed Care file to be processed by MHN Systems. One Information Technologist (IT) III would be assigned to this task at a rate of $19.73 per hour. Estimating 8 hours for analysis, code and unit test plus 20 hours for systems integration testing with MEDES and UAT with FSD and MHD. (28 hours X $19.73/hr = $552; rounded);

2. MO HealthNet Systems - Modify COBOL modules with reassignment logic to enroll the participant in the same health plan in a different region if the plan exists in both regions. A Computer Information Technologist Specialist (CITS) I would be assigned to this task at a rate of $25.05 per hour. Estimating 8 hours for analysis, coding and unit test plus 20 hours for integration testing with MEDES and UAT with FSD and MHD. (28 hours X $25.05/hr = $701; rounded);

3. Server Applications Team - Modify Managed Care Online Enrollment application to add the new regions and the health plans available in each region. This task would be assigned to a CITS II at a rate of $29.88 per hour. Estimating 16 hours for analysis, coding and unit test plus 24 hours for systems and user acceptance testing. (40 hours X $29.88 per hour = $1,195; rounded);

4. MO HealthNet Systems - Modify programming for approximately 10 reports for new health plans and add new health plans to the provider database. Estimating 40 hours for analysis and coding plus an additional 24 hours of effort to test which includes set up of test JCL and execution of jobs. An Information Technologist (IT) IV would be assigned at a rate of $22.34 per hour. (64 hours X $22.34/hr = $1,430; rounded);

5. Data Center costs for operating Managed Care currently average about $1,900 per month for CPU, storage and print costs. Extrapolating based on a 56% increase in participants in Managed Care, processing costs should increase by $1,064 per month (56% of$1,900) or $12,768 per year.

Total Development Hours: 160
Total Development Cost: $3,879 (rounded)
Expected Increase in Data Center Charges: $12,768 per year.

Development costs would occur in FY 15 and data center costs would occur for the last half of FY 15 and for full years thereafter.

HWC:LR:OD

ASSUMPTION (continued)

GR Expense for FY 15
DDI: 10% X $3,878.80 = $388 (rounded)
SDC: 10% X .5 years X $12,768 = $638 (rounded)
Total GR Expense = $1,026 (rounded)

Federal Expense for FY 15
DDI: 90% X 3,878.80 = $3,491 (rounded)
SDC: 90% X 0.5 years X $12,768 = $5,746 (rounded)
Total Federal Expense = $9,237 (rounded)

GR Expense for FY 16 and thereafter
SDC: 10% X $12,768 = $1,277 (rounded)

Federal Expense for FY 16 and thereafter
SDC: 90% X $12,768 = $11,491 (rounded)

FY 15 Total Costs:	GR	Federal	Total
208.010	$1,229	$1,229	$ 2,458
208.010.2	734	6,603	7,337
208.662	Unknown > 9,456	Unknown > 9,456	Unknown > 18,912
208.998.1	1,026	9,237	10,263
	Unknown > $12,445	Unknown > $26,525	Unknown > $ 38,9707

FY16 and after Costs:	GR	Federal	Total
208.010.2	$1,061	$9,548	$10,608
208.998.1	1,277	11,4910	12,768
	$2,338	$21,038	$23,376

§208.999 - Urgent Care Clinics

Officials from the **DSS - MHD** assumes that, if established, the urgent care clinics will provide the state match and the Centers for Medicare and Medicaid Services (CMS) will recognize the match. The federal cost is unknown. It is assumed that there will be no fiscal impact to the state, even though the federal funds may "pass through" state accounts.

The provisions of this section are subject to appropriations.

ASSUMPTION (continued)

§208.1500 - Managed Care Data and Network Adequacy Requirements

Officials from the **DSS - MHD** state the proposed legislation establishes additional reporting requirements for the health plans. It is assumed that the capitation rates would increase at least $100,000 for the health plans' additional administrative expenses. MHD's actuary assumes that the actuarial cost to evaluate this program change to the managed care capitation rates will be no more than $25,000.

MHD already reports some of the information required by this legislation, but not all of it, and it is not reported in the detailed format required nor is it compiled and published quarterly. In order to meet these requirements, MHD would need one additional staff at the Management Analysis Specialist II level ($41,016 annually), to collect, compile, analyze and report the data on a quarterly basis. It is assumed that FY 15 would be for 10 months and include office/cubicle set up costs. In FY 15, the cost for Personal Services, Fringe and Expense and Equipment would be $63,764. In FY 16 and FY1 7 the cost would be $66,748 and $67,481, respectively.

FY 15: >$188,764 (GR >$81,287; Federal >$ 107,477);
FY 16: >$166,748 (GR >$70,279; Federal > $96,469);
FY 17: >$167,481 (GR >$70,645; Federal > $96,836).

Various Sections - Long-Term Savings

Officials from the **DSS - DFAS** state there is a long-term fiscal impact for Subsections 208.151.2(3), 208.631.3 and 208.631.4, which are not effective until October 1, 2020 (FY 2020):

- Savings from newborns above 138% FPL; (affects 1,054 infants).

- Savings from children in Children's Health Insurance Program (CHIP) families with incomes above 138% FPL; affects 41,490 children. In 2012 60% of the CHIP caseload was above 138% FPL. Beginning in January, 2014, children age 6 to 8 became Medicaid eligible; prior to that they were in the CHIP, no premium category. DSS still claims the CHIP match on these children, but they are now a mandatory population. DSS just looked at the CHIP population above 138%.

- Savings from children in CHIP families with incomes between 133% FPL and 185% FPL (affects 15,427 children).

ASSUMPTION (continued)

Bill as a whole:

Officials from the **Office of Secretary of State (SOS)** state many bills considered by the General Assembly include provisions allowing or requiring agencies to submit rules and regulations to implement the act. The Secretary of State's office is provided with core funding to handle a certain amount of normal activity resulting from each year's legislative session. The fiscal impact for this fiscal note to the SOS for Administrative Rules is less than $2,500. The SOS recognizes this is a small amount and does not expect that additional funding would be required to meet these costs. However, it is also recognized that many such bills may be passed by the General Assembly in a given year and that collectively the costs may be in excess of what the office can sustain within its core budget. Therefore, the SOS reserves the right to request funding for the cost of supporting administrative rules requirements should the need arise based on a review of the finally approved bills signed by the governor.

Officials from the **Joint Committee on Administrative Rules (JCAR)** state the legislation is not anticipated to cause a fiscal impact to JCAR beyond its current appropriation.

Officials from the **Missouri House of Representatives (MHR)** assume the proposal will have no fiscal impact on their organization. The MHR assumes House member expenses related to participation in the permanent Joint Committee on MO HealthNet will be covered by the Senate's Joint Contingent Expenses appropriation or absorbed.

Officials from the **Special School District (SSD)** state the proposed legislation is not expected to have a material fiscal impact on the SSD. Under 208.631.3, the number of children qualifying for Medicaid coverage would decline, which could result in a reduction in Federal Medicaid reimbursement to the district, but that is not anticipated to happen until the year 2020.

Officials from the **Office of State Courts Administrator** and the **Department of Revenue** each assume the proposal would not fiscally impact their respective agencies.

FISCAL IMPACT - State Government	FY 2015 (6 Mo.)	FY 2016	FY 2017
GENERAL REVENUE FUND			
Savings - DSS (§208.151.2(1) and (2))			
Reduction in breast and cervical cancer expenditures	$0	$66,794	$69,600
Reduction in pregnant women expenditures	$0	$2,347,819	$2,446,427
Savings - DSS-MHD (§208.998)			
Program savings for statewide managed care implementation - current rates	$2,730,633	$5,575,953	$5,810,142
Total All Savings - DSS	$2,730,633	$7,990,566	$8,326,169
Costs - DSS-MHD (§208.010.2(4))			
Increase in program costs resulting from an increase in asset limits	($30,540,644)	($38,188,021)	($39,791,918)
Costs - DSS-DYS (§208.186)			
Increase in substance abuse assessments	(Unknown)	(Unknown)	(Unknown)
Costs - DSS-CD (§208.186)			
Increase in substance abuse assessments	(Unknown)	(Unknown)	(Unknown)
Cost - DSS-MHD (§208.661)			
Grant expenditures	$0	$0 to (Unknown)	$0 to (Unknown)
Costs - DSS-MHD (§208.662)			
Program expansion, reporting and development expenditures	(Greater than $2,965,634)	($3,626,399)	($3,730,984)
Costs - DSS (§208.997)			
Health care costs for the aged, blind, and disabled	(Unknown) to Unknown	(Unknown) to Unknown	(Unknown) to Unknown

FISCAL IMPACT - State Government	FY 2015 (6 Mo.)	FY 2016	FY 2017
GENERAL REVENUE FUND (cont.)			
Costs - DSS-MHD (§208.998)			
Increase in program costs - commercial rates	($13,283,468)	($27,363,944)	($28,184,862)
High deductible health plans	(Unknown) to Unknown	(Unknown) to Unknown	(Unknown) to Unknown
Therapy services for managed care participants	($217,426)	($447,463)	($460,439)
Total Costs - DSS-MHD	(Could exceed $13,500,894) to Unknown	(Could exceed $27,811,407) to Unknown	(Could exceed $28,645,301) to Unknown
Costs - DSS-MHD (§208.998)			
Personal service costs	($125,404)	($152,051)	($153,572)
Fringe benefits	($63,963)	($77,554)	($78,329)
Equipment and expense	($48,683)	($16,773)	($17,192)
Packets, Actuarial and MMIS	(Could exceed $439,500)	($114,500)	($114,500)
Total Costs - DSS-MHD	(Could exceed $677,550)	($360,878)	($363,593)
FTE Change - DSS-MHD	4 FTE	4 FTE	4 FTE
Costs - DSS-MHD (§208.1500)			
Personal service	($17,083)	($20,713)	($20,920)
Fringe benefits	($8,713)	($10,565)	($10,670)
Equipment and expense	($55,491)	($39,001)	($39,055)
Total Costs - DSS-MHD	($81,287)	($70,279)	($70,645)
FTE Change - DSS-MHD	0.5 FTE	0.5 FTE	0.5 FTE
Costs - DSS (§208.1503)			
ACO shared risk costs	(Unknown)	(Unknown)	(Unknown)

FISCAL IMPACT - State Government	FY 2015 (6 Mo.)	FY 2016	FY 2017
GENERAL REVENUE FUND (cont.)			
Costs - DIFP (§208.1503)			
Personal service	($33,320)	($40,384)	($40,788)
Fringe benefits	($16,995)	($20,598)	($20,804)
Equipment and expense	($11,037)	($3,829)	($3,924)
Total Costs - DIFP	($61,352)	($64,811)	($65,516)
Net FTE Change - DIFP	1.0 FTE	1.0 FTE	1.0 FTE
Costs - DHHS			
Personal service, equipment and expenses, program costs or savings resulting from managed care, health care homes and other changes	(Unknown) to Unknown	(Unknown) to Unknown	(Unknown) to Unknown
Costs - OA			
Alternatives-to-Abortion (§208.662)	Unknown to (Unknown)	Unknown to (Unknown)	Unknown to (Unknown)
Costs - OA-ITSD/DSS			
System programming costs	(Greater than $12,445)	(Greater than $2,338)	(Greater than $2,338)
Total All Costs	(Could exceed $47,839,806)	(Could exceed $70,124,133)	(Could exceed $72,670,295)
Loss - DMH (§§208.998 and 208.1503)			
Reduction in local tax match monies	(Greater than $3,000,000)	(Greater than $6,000,000)	(Greater than $6,000,000)
Transfer-out from General Revenue to Joint Contingency Fund (§208.952)			
Transfer for expenses associated with the Joint Committee on MO HealthNet	($75,000 to $165,000)	($75,000 to $165,000)	($75,000 to $165,000)
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**(Could exceed $48,184,173)**	**(Could exceed $68,208,577)**	**(Could exceed $70,419,126)**
Estimated Net FTE Change on the General Revenue Fund	5.5 FTE	5.5 FTE	5.5 FTE

FISCAL IMPACT - State Government	FY 2015 (6 Mo.)	FY 2016	FY 2017
JOINT CONTINGENCY FUND			
Transfer-in from General Revenue Fund			
Transfer-in to cover expenses of the Joint Committee on MO HealthNet (§208.952)	$75,000 to $165,000	$75,000 to $165,000	$75,000 to $165,000
Costs - Joint Committee on MO HealthNet			
Expenses related to monitoring and reviewing information related to the MO HealthNet program(§208.952)	($75,000 to $165,000)	($75,000 to $165,000)	($75,000 to $165,000)
ESTIMATED NET EFFECT ON THE JOINT CONTINGENCY FUND	**$0**	**$0**	**$0**
OTHER STATE FUNDS (various)			
Savings - DSS (§208.151.2(1) and (2))			
Reduction in breast and cervical cancer expenditures	$0	$44,530	$46,400
Reduction in pregnant women expenditures	$0	$1,565,213	$1,630,952
Savings - DSS-MHD (§208.998)			
Program savings for statewide managed care implementation - current rates	$1,742,839	$3,558,876	$3,708,350
Total All Savings	$1,742,839	$5,168,619	$5,385,702
Costs - DSS-MHD (§208.010.2(4))			
Increase in program costs resulting from an increase in asset limits	($15,733,059)	($19,672,617)	($20,498,867)
ESTIMATED NET EFFECT ON OTHER STATE FUNDS (various)	**($13,990,220)**	**($14,503,998)**	**($15,113,165)**

FISCAL IMPACT - State Government	FY 2015 (6 Mo.)	FY 2016	FY 2017
FEDERAL FUNDS			
Income - DSS-MHD (§208.010.2(4))			
Increase in program reimbursements due to increasing asset limits	$79,112,296	$98,922,015	$103,076,740
Income - DSS-DYS (§208.186)			
Increase in substance abuse assessment reimbursements	Unknown	Unknown	Unknown
Income - DSS-CD (§208.186)			
Increase in substance abuse assessment reimbursements	Unknown	Unknown	Unknown
Income - DSS-MHD (§208.661)			
Increase in program reimbursements	$0	$0 to Unknown	$0 to Unknown
Income - DSS-MHD (§208.662)			
Program expenditure reimbursements	Greater than $8,431,505	$10,375,656	$10,675,970
Income/Savings - DSS (§208.997)			
Increase in/reduced savings for health care costs for the aged, blind, and disabled	(Unknown) to Unknown	(Unknown) to Unknown	(Unknown) to Unknown
Income/Savings - DSS-MHD (§208.998)			
Increase in/reduced savings for high deductible health plans	(Unknown) to Unknown	(Unknown) to Unknown	(Unknown) to Unknown
Income - DSS-MHD (§208.998)			
Increase in program reimbursements	Unknown, could exceed $677,550	Unknown, could exceed $360,878	Unknown, could exceed $363,593
Increase in program reimbursements for commercial rates	$23,742,009	$48,908,539	$50,375,795
Increase in program reimbursements for therapy services for managed care participants	$371,730	$765,019	$787,205
Total Income - DSS-MHD	Could exceed $24,791,289	Could exceed $50,034,436	(Could exceed $51,526,593

FISCAL IMPACT - State Government	FY 2015 (6 Mo.)	FY 2016	FY 2017
FEDERAL FUNDS (cont.)			
Income - DSS-MHD (§208.1500)			
Increase in program reimbursements	Greater than $107,477	Greater than $96,469	Greater than $96,836
Income - DSS (§208.1503)			
ACO shared risk reimbursements	Unknown	Unknown	Unknown
Income - OA-ITSD/DSS			
Increase in program reimbursements	Greater than $26,525	Greater than $21,038	Greater than $21,038
Total All Income	Could exceed $112,469,092	Could exceed $159,449,614	Could exceed $165,397,177
Savings - DSS (§208.151.2(1) and (2))			
Reduction in breast and cervical cancer expenditures	$0	$319,664	$333,090
Reduction in pregnant women expenditures	$0	$6,689,953	$6,970,931
Total Savings - DSS	$0	$7,009,617	$7,304,021
Savings - DSS-MHD (§208.998)			
Program savings for statewide managed care implementation - current rates	$7,815,605	$15,959,466	$16,629,764
Total All Savings	$7,815,605	$22,969,083	$23,933,785
Costs - DSS-MHD (§208.010.2(4))			
Increase in program expenditures due to increasing asset limits	($79,112,296)	($98,922,015)	($103,076,740)
Costs - DSS-DYS (§208.186)			
Increase in substance abuse assessment expenditures	(Unknown)	(Unknown)	(Unknown)

FISCAL IMPACT - State Government	FY 2015 (6 Mo.)	FY 2016	FY 2017
FEDERAL FUNDS (cont.)			
Costs - DSS-CD (§208.186)			
Increase in substance abuse assessment expenditures	(Unknown)	(Unknown)	(Unknown)
Costs - DSS-MHD (§208.661)			
Increase in program expenditures	$0	$0 to (Unknown)	$0 to (Unknown)
Costs - DSS-MHD (§208.662)			
Program expenditures	(Greater than $8,431,505)	($10,375,656)	($10,675,970)
Costs - DSS (§208.997)			
Health care costs for the aged, blind, and disabled	(Unknown) to Unknown	(Unknown) to Unknown	(Unknown) to Unknown
Costs/Loss - DSS (§208.997)			
Increased/decreased reimbursements for health care costs for the aged, blind, and disabled	(Unknown) to Unknown	(Unknown) to Unknown	(Unknown) to Unknown
Costs/Loss - DSS-MHD (§208.998)			
Increased/decreased reimbursements for high deductible health plans	(Unknown) to Unknown	(Unknown) to Unknown	(Unknown) to Unknown
Costs - DSS-MHD (§208.998)			
Increase in program expenditures for commercial rates	($23,742,009)	($48,908,539)	($50,375,795)
Increase in program expenditures for therapy services for managed care participants	($371,730)	($765,019)	($787,205)
Total Costs - DSS-MHD	($24,113,739)	($49,673,558)	($51,163,000)

FISCAL IMPACT - State Government	FY 2015 (6 Mo.)	FY 2016	FY 2017
FEDERAL FUNDS (cont.)			
Costs - DSS-MHD (§208.998)			
Personal service costs	($125,404)	($152,051)	($153,572)
Fringe benefits	($63,963)	($77,554)	($78,329)
Equipment and expense	($48,683)	($16,773)	($17,192)
Packets, Actuarial and MMIS	(Could exceed $439,500)	($114,500)	($114,500)
Total Costs - DSS-MHD	(Could exceed $677,550)	($360,878)	($363,593)
FTE Change - DSS-MHD	4 FTE	4 FTE	4 FTE
Costs - DSS-MHD (§208.1500)			
Personal service	($17,083)	($20,713)	($20,920)
Fringe benefits	($8,713)	($10,565)	($10,670)
Equipment and expense	(Greater than $81,681)	(Greater than $65,191)	(Greater than $65,246)
Total Costs - DSS-MHD	(Greater than $107,477)	(Greater than $96,469)	(Greater than $96,836)
FTE Change - DSS-MHD	0.5 FTE	0.5 FTE	0.5 FTE
Costs - DSS (§208.1503)			
ACO shared risk expenditures	(Unknown)	(Unknown)	(Unknown)
Costs - OA-ITSD/DSS			
Increase in program expenditures	(More than $26,525)	(More than $21,038)	(More than $21,038)
Total All Costs	(More than $112,469,092)	(More than $159,449,614)	(More than $165,397,177)
Loss - DSS (§208.151.2(1) and (2))			
Reduction in breast and cervical cancer expenditures reimbursed	$0	($319,664)	($333,090)
Reduction in pregnant women expenditures reimbursed	$0	($6,689,953)	($6,970,931)
Total Loss - DSS	$0	($7,009,617)	($7,304,021)

FISCAL IMPACT - State Government	FY 2015 (6 Mo.)	FY 2016	FY 2017
FEDERAL FUNDS (cont.)			
Loss - DSS-MHD (§208.998) Reduction in program reimbursement for statewide managed care implementation - current rates	($7,815,605)	($15,959,466)	($16,629,764)
Loss - DMH (§§208.998 and 208.1503) Reduction in federal funds	(Greater than $22,500,000)	(Greater than $45,000,000)	(Greater than $45,000,000)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**(Greater than $22,500,000)**	**(Greater than $45,000,000)**	**(Greater than $45,000,000)**
Estimated Net FTE Effect on Federal Funds	4.5 FTE	4.5 FTE	4.5 FTE

FISCAL IMPACT - Local Government	FY 2015 (10 Mo.)	FY 2016	FY 2017
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

This proposal would be expected to have a fiscal impact on small business health care providers.

FISCAL DESCRIPTION

ASSET LIMITS INCREASE FOR MEDICAID (Section 208.010)

This propsal modifies the amount of cash, securities or other total non-exempt assets an aged or disabled participant is allowed to retain in order to qualify for MO HealthNet benefits from less than $1,000 to $2,000 for a single person and from $2,000 to $4,000 for a married couple.

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FISCAL DESCRIPTION (continued)

CHANGES TO WOMEN AND CHILDREN UNDER MO HEALTHNET (Section 208.151.2)

This proposal specifies that beginning July 1, 2015, the eligibility level for MO HealthNet benefits shall be lowered under specified circumstances enumerated in the proposal for participants diagnosed with breast or cervical cancer, pregnant women, and infants under one year of age. The proposal specifies the lower eligibility levels and conditions required for continued coverage under MO HealthNet such as if the person does not have access to employer-sponsored health insurance coverage, premium tax credits or subsidized insurance coverage through an exchange.

Such lowering of eligibility levels shall not occur unless and until: (a) There are federal health insurance premium tax credits available to persons through the purchase of a health insurance plan in a health care exchange, whether federally facilitated, state-based, or operated on a partnership basis. The Director of the Department of Revenue must certify to the Director of the Department of Social Services that health insurance premium tax credits are available, and the Director of the Department of Social Services must notify the Revisor of Statutes; and (b) the federal Department of Health and Human Services grants any necessary waivers and state plan amendments to implement these provisions, federal funding is received for the premium subsidies to be paid, and notice has been provided to the Revisor of Statutes.

ASSESSMENTS FOR DRUG AND ALCOHOL TREATMENT AND JUVENILE COURT SERVICES (Section 208.186.)

Assessments for drug and alcohol treatment shall be made to MO HealthNet participants when drugs or alcohol were contributing factors to any crimes or to any child abuse and neglect allegations. Recommendations of the treatment provider may be used by the court in sentencing. Such recommendations shall also be included in the child's permanency plan in juvenile proceedings, and the court may order the parent or guardian to successfully complete treatment before the child is reunified with the parent or guardian.

CHILDREN'S HEALTH INSURANCE PROGRAM (Section 208.631)

Beginning October 1, 2020, a child eligible for the current Children's Health Insurance Plan (CHIP) shall only remain eligible if, in addition to other requirements, his or her parents do not have access to health insurance coverage for the child through their employment or through a health insurance plan in a health care exchange because the parents are not eligible for a premium subsidy for the child or family through the exchange.

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FISCAL DESCRIPTION (continued)

This change cannot go into effect unless and until federal health insurance premium tax credits are available for children and family coverage to purchase a health insurance plan from a health care exchange and the credits are available for six months prior to the discontinuation of CHIP benefits.

HEALTH CARE ACCESS IN LOW-INCOME PUBLIC SCHOOLS (Section 208.661)

The Department shall develop incentive programs, submit state plan amendments, and apply for necessary waivers to permit rural health clinics, federally-qualified health centers, or other primary care practices to co-locate on the property of public elementary and secondary schools with 50% or more students who are eligible for free or reduced-price lunch. The proposal details the prohibitions on such clinics as well as the parental consent required.

SHOW-ME HEALTHY BABIES PROGRAM (Section 208.662)

This proposal establishes the Show-Me Healthy Babies Program within the Department of Social Services as a separate children's health insurance program for any low-income unborn child. For an unborn child to be eligible for enrollment in the program, the mother of the child must not be eligible for coverage under the Medicaid Program as administered by the state and must not have access to affordable employer-subsidized health care insurance or other affordable health care coverage that includes coverage for the unborn child. The unborn child must be in a family with income eligibility of no more than 300% of the federal poverty level or the equivalent modified adjusted gross income unless the income eligibility is set lower by the General Assembly through appropriations. The proposal delineates all of the parameters of the program.

TELEHEALTH (Section 208.670)

This proposal requires the Department of Social Services to promulgate rules regarding MO HealthNet telehealth to allow for out-of-state health care providers and hospitalists to use telehealth services to address access to care.

JOINT COMMITEE ON MO HEALTHNET (Section 208.952)

This proposal amends the Joint Committee on MO HealthNet to have as its purpose of study the efficacy of the program as well as the resources needed to continue and improve the MO HealthNet program over time. The committee shall receive and obtain information from the departments of Social Services, Mental Health, Health and Senior Services and Elementary and Secondary Education as applicable, regarding the projected budget of the entire MO HealthNet program including projected MO HealthNet enrollment growth, categorized by population and geographic area.

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FISCAL DESCRIPTION (continued)

The committee shall meet at least twice a year. The committee is authorized to hire an employee or enter into employment contracts. The compensation of such personnel and the expenses of the committee.

CARETAKER RELATIVES (208.990)

This proposal prohibits MO HealthNet coverage to a parent or caretaker relative living with a dependent child unless the child is receiving MO HealthNet benefits.

CURRENT MANAGED CARE POPULATION EXTENDED STATEWIDE (208.998)

The Department of Social Services shall seek a state plan amendment to extend the current MO HealthNet managed care program statewide by January 1, 2015, for all eligibility groups currently enrolled in a managed care plan as of January 1, 2014. Such eligibility groups shall receive covered services through health plans offered by managed care entities which are authorized by the Department.

The health plans must resemble commercially available health plans while complying with federal Medicaid Program requirements as authorized by federal law or through a federal waiver. The plans must include cost sharing for out patient services to the maximum extent allowed by federal law and may include other co-payments and provide incentives that encourage and reward the prudent use of the health benefit provided. In addition, the plans must encourage access to care through provider rates that include pay-for-performance and are comparable to commercial rates.

The managed care health plans shall also require all MO HealthNet managed care plans to provide coverage for ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse treatment, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness care, and chronic disease management; pediatric services, including oral and vision care; and any other services required by federal law.

The health plans shall also provide a high-deductible health plan option. Such high deductible health plan must include coverage for benefits as specified by Department rule after meeting a $1,000 deductible; an account, funded by the Department, of at least $1,000 per adult to pay the medical costs for the initial deductible; preventive care, as defined by Department rule, that is not subject to the deductible and does not require a payment of money from the account.

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FISCAL DESCRIPTION (continued)

The managed care health plans shall also offer all participants with chronic conditions, as specified by the Department, an option to be included in an incentive program for MO HealthNet participants who obtain specified primary care and preventive services and who participate or refrain from specified activities to improve the participant's overall health.

A MO HealthNet participant is eligible to participate in only one of either the high deductible health plan or the incentive program for chronic conditions.

MANAGED CARE DATA AND NETWORK ADEQUACY REQUIREMENTS (208.1500)

This proposal requires managed care organizations to provide to the Department of Social Services, and the Department to publicly report, certain information regarding medical loss ratios, total payments to the managed care organization in any form, provider compensation rates, service utilization information, data regarding complaints, grievances and appeals, quality measurements and consumer satisfaction.

The managed care organizations shall also be required to maintain such network adequacy requirements. The proposal details the full list of managed care organization requirements as well as reporting requirements.

CURRENT FEE-FOR-SERVICE POPULATION MOVED TO ACCOUNTABLE CARE ORGANIZATIONS (208.1503 AND 208.950)

Beginning January 1, 2015, the group of participants in the MO HealthNet fee-for-service program as of January 1, 2014, except for those participants in skilled nursing facilities, shall be moved to regionally-based accountable care organizations. An "accountable care organization" or "ACO" shall mean an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of a defined group of MO HealthNet participants. The regional ACOs shall be full-risk bearing entities reimbursed through a global payment methodology developed by the department. Participants under an ACO shall be placed in a health care home.

The Department shall also advance the development of systems of care for medically complex children who are recipients of MO HealthNet benefits by accepting cost-effective regional proposals from and contracting with appropriate pediatric care networks, pediatric centers for excellence, and medical homes for children to provide MO HealthNet benefits when the Department determines it is cost effective to do so. Such entities shall be treated as accountable care organizations.

This act also repeals a provision in Section 208.950 prohibiting care coordination for the aged, blind and disabled MO HealthNet population.

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FISCAL DESCRIPTION (continued)

HEALTH CARE HOMES (208.997)

By January 1, 2015, the MO HealthNet Division shall implement the Health Care Homes Program as a provider-directed care coordination program for MO HealthNet participants who shall be transitioned from the fee-for-service program to an accountable care organization. The program must provide payment to primary care clinics for care coordination for individuals deemed medically frail. Clinics must meet certain specified criteria, including the capacity to develop care plans; a dedicated care coordinator; an adequate number of clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement; and the capability to maintain and use a disease registry.

URGENT CARE CLINICS (208.999)

Subject to appropriations, the Department of Social Services shall develop incentive programs to encourage the construction and operation of urgent care clinics that operate outside normal business hours and are located in or adjoined to emergency room facilities that receive a high proportion of patients who are participating in MO HealthNet to the extent that the incentives are eligible for federal matching funds.

PRIVATE INSURANCE PREMIUM SUBSIDY (208.1506)

Beginning July 1, 2015, any MO HealthNet participant who elects to receive medical coverage through a private health insurance plan instead of through the MO HealthNet program shall be eligible for a private insurance premium subsidy to assist the participant in paying the costs of such private insurance if it is determined to be cost effective by the Department. The subsidy shall be provided on a sliding scale based on income, with a graduated reduction in subsidy over a period of time not to exceed two years.

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 Administration -
    Division of Purchasing and Materials Management
    Information Technology Services Division/DSS
    Commissioner's Office
    Division of Purchasing and Materials Management
Office of State Courts Administrator
Department of Elementary and Secondary Education

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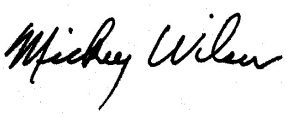
SOURCES OF INFORMATION (continued)

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 -
- Division of Legal Services
- Division of Youth Services
- Family Support Division
- Children's Division
- Division of Finance and Administrative Services
- MO HealthNet Division

Joint Commission on Administrative Rules
Missouri House of Representatives
Missouri Senate
Office of Secretary of State
Special School District



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February 20, 2014

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February 20, 2014

HWC:LR:OD