COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 0497-03
Bill No.: HCS for SCS for SB 230
Subject: Health Care; Medicaid; Social Services Department; Health Department; Mental Health Department
Type: Original
Date: May 5, 2015

Bill Summary: This proposal changes the laws regarding health care.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND				
FUND AFFECTED	FY 2016	FY 2017	FY 2018	Fully Implemented (FY 2021)
General Revenue	($1,104,642)	($1,076,612)	($992,248)	($1,801,691)
Total Estimated Net Effect on General Revenue	**($1,104,642)**	**($1,076,612)**	**($992,248)**	**($1,801,691)**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS				
FUND AFFECTED	FY 2016	FY 2017	FY 2018	Fully Implemented (FY 2021)
MoPHS	(Less than $14,139)	Could exceed $34,927	Could exceed $19,811	(Less than $34,628)
Various Other State Funds	($42,791)	($47,632)	($48,154)	($53,566)
Total Estimated Net Effect on Other State Funds	**(Less than $56,930)**	**(Could be less than $12,705)**	**(Could be less than $28,343)**	**(Less than $88,194)**

Numbers within parentheses: ( ) indicate costs or losses. This fiscal note contains 24 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS				
FUND AFFECTED	FY 2016	FY 2017	FY 2018	Fully Implemented (FY 2021)
Federal*	$0	$0	$0	$0
Total Estimated Net Effect on All Federal Funds	**$0**	**$0**	**$0**	**$0**

*** Income and expenses could exceed $1.6 million annually when fully implemented and net to $0.**

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)				
FUND AFFECTED	FY 2016	FY 2017	FY 2018	Fully Implemented (FY 2021)
General Revenue	12.2	12.2	12.2	12.2
MoPHS	2	2	2	2
Various Other State Funds	0.6	0.6	0.6	0.6
Federal	1.2	1.2	1.2	1.2
Total Estimated Net Effect on FTE	**16**	**16**	**16**	**16**

☒ Estimated Net Effect (expenditures or reduced revenues) expected to exceed $100,000 in any of the three fiscal years after implementation of the act.

ESTIMATED NET EFFECT ON LOCAL FUNDS				
FUND AFFECTED	FY 2016	FY 2017	FY 2018	Fully Implemented (FY 2021)
Local Government	**$0**	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

Oversight was unable to receive agency responses in a timely manner due to the short fiscal note request time. Oversight has presented this fiscal note on the best current information that we have or on prior year information regarding a similar bill. Upon the receipt of agency responses, Oversight will review to determine if an updated fiscal note should be prepared and seek the necessary approval of the chairperson of the Joint Committee on Legislative Research to publish a new fiscal note.

§§191.332 - SCID Newborn Screening

In response to similar legislation (HB 1315), the following agency responses were provided:

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

Division of Community and Public Health
Adding severe combined immunodeficiency (SCID) to the newborn screening panel would result in approximately 20 or more cases per year that would require referral for follow-up and confirmation. However, due to the fact that the testing methodology for SCID is relatively new and based upon recent experience with Lysosomal Storage Disorders, it is recognized that 20 cases per year is the minimum estimated number and the actual referral rate could be significantly higher. Based on this knowledge, it is assumed that the tracking and follow-up of SCID would exceed the current capacity of the newborn screening program.

Due to the nature of SCID, it would not be appropriate to add funding to the existing genetic contracts because newborns referred for follow-up after an abnormal SCID newborn screen would not be seen or followed in the genetic clinics. These newborns would be seen by immunologists and, if necessary, transplant teams. Therefore, the newborn screening program would require one (1) Public Health Senior Nurse ($49,788 annually) to conduct and coordinate all follow-up activities for SCID newborn screening.

The Public Health Senior Nurse responsibilities would include:

- Coordinating and facilitating a SCID Newborn Screening Task Force to advise the program in the implementation of SCID screening;
- Developing any necessary parent educational materials;
- Revising the newborn screening pamphlet;

ASSUMPTION (continued)

- Collaborating with the Missouri State Public Health Laboratory to develop procedures for calling out high risk SCID newborn screening results;
- Collaborating with physicians, nurses, and other medical professionals to ensure all newborns with high risk SCID newborn screen are followed-up appropriately including all necessary evaluations and tests to confirm or rule out a disorder;
- Ensuring all confirmatory results and diagnoses are entered into the Missouri Health Strategic Architecture and Information Cooperative (MOHSAIC);
- Continually evaluate and monitor SCID newborn screening to ensure policies and procedures are in alignment with best practice and evidence-based standards of care; and
- Any additional tasks or duties related to SCID newborn screening.

The newborn screening pamphlet would need to be revised to include information on SCID. This would be a one-time cost of $6,000 to revise and reprint the pamphlet (100,000 pamphlets X $.06 each = $6,000).

State Public Health Laboratory (SPHL):

The State Public Health Laboratory (SPHL) would need to hire one (1) additional FTE Senior Public Health Laboratory Scientist ($41,940 annually) to oversee and maintain newborn screening for SCID.

The job description for Senior Public Health Laboratory Scientist includes:

- Opening daily samples received and assessing for quality and suitability;
- Processing samples into split samples for the SCID testing platforms;
- Comprising work lists, making necessary solutions, and performing instrument preparations;
- Performing the molecular amplification and detection procedures for the presence of T-Cell Receptor Excision Circles (TRECs) to detect SCID;
- Reviewing and interpreting test results, and conducting necessary re-testing of abnormal results;
- Assessing the risk of abnormal results and contacting appropriate genetic referral center for confirmation and follow-up testing.
- Reviewing and approval of daily instrument controls for accuracy;
- Monitoring QC results for shifts and trends, and performing corrective and preventive actions;
- Oversight of instrument performance, maintenance, and troubleshooting;
- Conducting and oversight of regular proficiency testing to assure accuracy and proficiency certifications;
- Training and cross-training new scientists to be proficient in the SCID section;

ASSUMPTION (continued)

- Ordering testing reagents and maintaining good inventory of items necessary for continuation of operations; and,
- Compiling monthly, annual, and as-needed reports for the newborn screening manager.

All laboratory equipment and expense costs associated with SCID testing are based upon vendor quotes for technology currently available. The DHSS assumes the proposal will have a cost to the MoPHS Fund of $656,962 for FY 2016; $758,720 for FY 2017 and $775,127 for FY 2018.

This proposed legislation would require the DHSS to increase the newborn screening fee which will be deposited in the Missouri Public Health Services (MoPHS) Fund. DHSS estimates that the fee will increase by $9.00 when testing is begun with inflationary increases thereafter, as needed. Based on previous years, it is estimated the DHSS will perform 95,640 screens annually - 80,640 will be billed to the submitters and approximately 15,000 will be submitted to Medicaid.

15,000 X $7 (can only claim Medicaid for the lab portion) X 60% (Federal Medical Assistance Percentage rate) = $63,000; 80,640 X $9 = $725,760; total annual income $788,760 ($63,000 + $725,760).

The net estimated fiscal impact to the MoPHS Fund is expected to be $338 for FY 2016; $30,040 for FY 2017; and $13,634 for FY 2018.

Oversight will present DHSS's infant screening revenue and associated costs, including personal service-related costs to FY 2021, when other provisions of this proposal become fully implemented. Oversight assumes no increase in the annual number of newborn screenings performed, the revenue received or the associated lab costs. However, personal service related expenses will have inflationary increases applied. Oversight extrapolated DHSS costs to FY 2021 using a 1% inflationary rate for salary related expenses and a 2.5% inflationary rate for all other costs (the same rates currently used in fiscal note calculations). Fully Implemented Costs present all agency costs to the first year of full implementation of all provisions.

Oversight assumes the provisions of this proposal will take effect on January 1, 2016 when the state employee health insurance plan year goes into effect. In addition, Oversight assumes, based on the Department of Social Services, MO HealthNet response a 1.9% growth rate in Medicaid reimbursements for newborn screening expenses.

Officials from the **Department of Social Services (DSS), MO HealthNet Division (MHD)** stated by January 1, 2016, the Department of Health and Senior Services (DHSS) shall, subject to appropriations, expand the newborn screening requirements in section 191.331 to include severe combined immunodeficiency (SCID), also know as bubble boy disease.

ASSUMPTION (continued)

Currently, newborn screenings are reimbursed by the MHD for the federal portion only. The general revenue portion is included in the DHSS budget.

In FY 2014, the MHD was billed for approximately 15,000 newborn screenings by the State Health Lab. For this calculation, it is assumed the same number of screenings would be billed in FY 2016 as billed in FY 2014.

At this time, the rate for the additional newborn screenings is unknown. Using DHSS' estimates that the rate will be $7.00, the result would be $105,000 ($7 X 15,000 newborn screengins).

Fiscal Impact: Unknown, but at least:

FY 2016 (calculated for 6 months): Total Federal Funds $33,311;
FY 2017 (1.9% trend factor): Total Federal Funds $67,888; and,
FY 2018 (1.9% trend factor): Total Federal Funds $69,178.

Oversight will extrapolate MHD's costs using a 1.9% trend factor to FY 2021, when other provisions of this proposal become fully implemented.

Officials from the **Missouri Department of Transportation (MoDOT)** stated the MoDOT's health plan could have increased costs by adding the screening to its newborn screening charges. The associated charges are unknown, but the anticipated impact is expected to be less than $100,000 annually.

Oversight assumes MoDOT's costs for this additional newborn screening test will be minimal and, therefore, assumes the MoDOT can absorb this potential increase.

Oversight assumes the changes to MoDOT's health insurance plan would be effective January 1, 2016, when the new employee health insurance plan year begins.

Officials from the **Missouri Consolidated Health Care Plan** and the **Missouri Department of Conservation** each assumed the proposal would not fiscally impact their respective agencies.

Officials from the **Department of Public Safety, Missouri State Highway Patrol** defer to the Missouri Department of Transportation (MoDOT), Employee Benefits Section for response on behalf of the Highway Patrol. Please see MoDOT's fiscal note response for the potential fiscal impact of this proposal.

ASSUMPTION (continued)

§§192.020 and 192.667 - Infectious Disease Reporting

In response to similar legislation (HCS HB 1066), the following agency responses were provided:

Officials from the **Department of Social Services (DSS), MO HealthNet Division (MHD)** state MO HealthNet bases hospital reimbursement for a given year on the fourth prior year cost report. Since these requirements would be effective August 28, 2016, any additional cost would begin to be reflected in 2016 or 2017 cost reports. MO HealthNet would use 2016 and 2017 cost reports to establish reimbursement for FY 2020 and FY 2021. Therefore, there would not be a fiscal impact to the MHD for FY 2016, FY 2017, and FY 2018, but starting FY 2020 there could be additional costs. Since the exact requirements for this proposal are not known at this time, MHD can only provide an estimate for these additional costs starting in FY 2020. Per the Bureau of Labor Statistics, the average salary of a Registered Nurse in Missouri in 2013 was $58,040. MHD assumes this proposal will take 25% of a Registered Nurse's time on average per facility. Additionally, the average salary of a Pharmacist in Missouri in 2013 was $114,000 (per salarybystate.org). MHD assumes this proposal will take 25% of a Pharmacist's time on average per facility. Then, assuming this will impact approximately 150 Missouri hospitals, the estimated cost of this proposed legislation could be up to $6,451,500 per year. Furthermore, MHD is prorating this increase in costs to hospitals by the FY 2011 Statewide Mean Medicaid Utilization rate of 32.39%, which was calculated by MHD's Independent Disproportionate Share Hospital (DSH) auditors per DSH reporting requirements. Although this calculation is based on days, it is an estimated way to prorate this cost to Medicaid. Using this percentage, the estimated cost to Medicaid is $2,089,641 ($6,451,500 X 32.39%). Since the requirement is effective for hospitals August 28, 2016, only a portion of the cost would be in FY 2020. 82 hospitals have a cost report year end between August 28 and December 31. The estimated cost for FY 2020 is $1,142,337 ($2,089,641 X 82/150). The estimated cost for FY 2021 is $2,089,641 (fully implemented). The costs will be split approximately 37% GR/63% Federal.

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

§192.667 - Infection reporting
DHSS would have to work with the Office of Administration, Information Technology Services Division (ITSD) to enhance the current MHIRS (Missouri Hospital Infection Reporting System) website to collect any new surgery types and possibly new facility types (e.g., dialysis centers, nursing homes). This would include major revisions to the Annual Registration site. In addition, major modifications to the public and historical reports would be required. DHSS staff will need to develop statistical standards for any new surgery categories and possibly new facility types

ASSUMPTION (continued)

and/or incorporate standards developed by the Center for Medicare and Medicaid Services (CMS). Staff will also be needed to monitor the expanded list of surgery categories to ensure that data is being properly reported and that DHSS is getting valid, accurate data.

To perform Bureau of Health Care Analysis and Data Dissemination (BHCADD) activities in accordance with the above assumptions, BHCADD will need one Research Analyst III ($40,380 annually).

DHSS would also be asked to work with hospitals, Ambulatory Surgical Centers (ASCs) in developing the antimicrobial stewardship program. The DHSS would be tasked with writing an annual report for the state and regions describing incidence, type and distribution. This data would be available from the National HealthCare Safety Network (NHSN) through the Center for Disease Control's Antimicrobial Use and Resistance (AUR) Module.

To perform activities in accordance with the above assumptions, DHSS (either the Bureau of Communicable Disease Control and Prevention or another assigned Bureau) would need one additional Research Analyst III ($40,380,annually).

DHSS provided **Office of Administration (OA), Information Technology Services Division (ITSD)** costs. ITSD assumes every new IT project/system will be bid out because all ITSD resources are at full capacity. A 12-month project time-line was assumed with the first six (6) months focused on analysis, design and development of the functionality necessary to begin collecting and reporting antibiotic use by January 1, 2016, with the remainder of the development and implementation being completed in FY 2017. The project increases the amount of data being collected, stored and reported. Therefore, costs have been included for additional disk space. ITSD assumes costs to the General Revenue Fund of $129,772 for FY 2016; $123,980 for FY 2017; and $27,449 for FY 2018.

Oversight notes the increase in DSS-MHD's costs are not fully implemented until FY 2021. Oversight extrapolated DHSS and OA-ITSD costs to FY 2021 using a 1% inflationary rate for salary related expenses and a 2.5% inflationary rate for all other costs (the same rates currently used in fiscal note calculations) so that Fully Implemented Costs present all agency costs, not just MHD's.

§192.380 - Perinatal Advisory Council

In response to a similar proposal (HB 735), the following response was provided:

Officials from the **Department of Health and Senior Services (DHSS)** state section 192.380.2 creates a Perinatal Advisory Committee (PAC) and directs the DHSS to provide necessary support to the council. In addition, DHSS would be responsible for organizing and hosting

ASSUMPTION (continued)

stakeholder meetings to gather public input to be shared with the PAC. DHSS will need a full time Health Program Representative III ($38,928 annually) to support and staff the 17 member Perinatal Advisory Council appointed by the Governor. Duties of this position include but are not limited to the following:

- Coordinate with Governor's Office to ensure appointments are made according to membership requirements in Section 192.380.2;
- Assisting potential members with the application process;
- Arrange the council meetings, identify locations for the meetings, and prepare agendas and minutes of the meeting as requested by the Council Chair;
- Coordinate the stakeholder input meetings to be held around the state;
- Provide support for the members of the council, performing relevant data inquiries and compilation of information as requested by the Chair or other members;
- Coordinate collaboration with other appropriate agencies and entities needed to administer provisions of the proposed legislation; and
- Creation and dissemination of reports that compiles information reported on all high-risk birth outcomes (Section 192.380.4(4)) and other information that will be used by the PAC to evaluate and monitor the performance of the perinatal system in Missouri (Section 192.380.4(9)).

Additional funds are requested for the reimbursement of travel expenses for PAC members to attend PAC meetings and to attend the stakeholder public input meetings to be held around the state. DHSS assumes the regular meetings will be held monthly for the first year and quarterly thereafter. It is also assumed that there will be four stakeholder meetings around the state (two urban and two rural) and that a maximum of 6 PAC members will attend those meetings. The cost per PAC member to attend these meetings is calculated at $180 per day for lodging, meals, and mileage. The total travel cost for stakeholder meetings in the first year calculates to $4,320 (6 members x 4 meetings x $180). The total cost for PAC regular meetings in the first year is calculated at $36,720 (17 members x 12 meetings x $180). The total cost for PAC meetings in subsequent years is calculated at $12,240 (17 members x 4 meetings x $180) each year.

Section 192.380.9 indicates that the DHSS is to promulgate rules and regulations by January 1, 2017 to establish the standards developed by the Council. DHSS will need a full time Registered Nurse Manager ($65,359 annually) and one Administrative Office Support Assistant (AOSA) ($28,104 annually) to support and staff the 17 member Perinatal Advisory Council appointed by the Governor. These two staff will be hired on September 1, 2015.

Section 192.380.10 requires DHSS, beginning January 1, 2016, to ensure that hospital application for license shall include the appropriate level of maternal care designation and neonatal care designation as determined by the standards outlined in subsection 5 of proposed legislation.

ASSUMPTION (continued)

DHSS will hire four Health Facilities Nursing Consultants (HFNC, $53,124 annually, each) to assist in stakeholder engagement and to enforce the rules and regulations as they are promulgated. The HFNC will also survey the facilities for compliance with the standards. This staff will be hired on September 1, 2015.

This program will be similar in operation to the existing Time Critical Diagnosis (TCD) program. The TCD program is voluntary and has two HFNCs and an AOSA dedicated to the program. The program proposed by this bill will impact any hospital with one or more obstetric beds, far more hospitals than the voluntary TCD program. As a result, DRL anticipates staffing requirements of four (4) HFNCs, one AOSA, and one program manager.

Section 192.380.3 states that "broad public and stakeholder input" will be utilized to assist the PAC in making recommendations for the division of the state into neonatal and maternal care regions. It is assumed that obtaining this input from the public will be the duty of the DHSS. Organizing a minimum of four town hall meetings across the state in urban and rural areas would be necessary to accomplish this task.

Total costs to the General Revenue Fund for this proposal are estimated to be $543,925 for FY 2016; $620,306 for FY 2017; and $627,871 for FY 2018.

Oversight extrapolated DHSS costs to FY 2021 using a 1% inflationary rate for salary related expenses and a 2.5% inflationary rate for all other costs (the same rates currently used in fiscal note calculations). Fully Implemented Costs present all agency costs to the first year of full implementation of all provisions of the proposal.

Also in response to similar legislation (HCS HB 735), officials from the **University of Missouri** stated it has been determined that the proposal, as written, should not create additional expenses in excess of $100,000 annually.

Oversight assume the University's response indicates that expenses would be absorbable within current funding levels.

§§208.670, 208.671 and 208.673 - Asynchronous Store-and-Forward Services and Telehealth Services Advisory Committee

In response to similar legislation (HCS HB 319), the following responses were provided:

DSS-MHD stated section 208.670.4 adds the use of asynchronous store-and-forward technology to the practice of telehealth.

ASSUMPTION (continued)

In 2014 there were 16,478 telehealth visits. MHD estimates that 20% of the telehealth visits will be the amount of new asynchronous store-and-forward visits resulting in 3,296 (16,478 * 20%) visits. MHD estimates that the costs to transmit the data from the patient site to the distant site will be $21.90 per transmission for a total cost of $72,183 (3,296 visits X $21.90). MHD estimates that 2,472 (3,296 X 75%) store-and-forward visits will require additional care. MHD estimates that it will costs $63 for each additional care visit for a total cost of $155,736 (2,472 X $63).

The total cost for asynchronous store-and-forward in Fiscal Year (FY) 2016 is $227,919 ($72,183 + $155,736). Since there will be only 10 months in FY 2016, the cost will be $189,933 ($227,919 X 10/12). A 1.9% inflation factor was used to calculated FY 2017 and beyond.

With patients utilizing store-and-forward, there would be a non-emergency medical transportation (NEMT) savings of $25 per visit for a total savings of $82,400 ($25 X 3,296 visits). MHD doesn't expect to see these savings until FY 2018 due to rate development methodologies in NEMT capitation payments (there is a two year lag to incorporate the lower NEMT utilization into the rates). The $82,400 was trended using a 1.9% inflation factor to get to the savings for FY 18. MHD assumes it will see 75% of the FY 2018 savings due to FY 2016 costs only being for 10 months.

A State Plan Amendment (SPA) would be required for the asynchronous store-and-forward services.

For Section 208.671 there would be a Medicaid Management Information System (MMIS) cost to update the system. MHD estimates that it will cost $200,000 in system work and $75,000 in staff time to do the work for a total of $275,000.

MHD estimates it will need 1.25 additional FTEs at the Management Analysis Specialist II position for system work, integration, evaluation, and to establish guidelines.

Oversight assumes the MHD would not hire 0.25 FTE Management Analysis Specialist II and would assign the duties to existing staff.

Section 208.673 establishes the "Telehealth Services Advisory Committee." MHD estimates it will need 1 additional FTE at the Program Development Specialist level to coordinate the new advisory committee, coordinate between state departments, oversee the program, plan agendas, attend meetings, take minutes, oversee filling vacancies, etc.

ASSUMPTION (continued)

The total costs for this proposal, as amended, are:
FY 2016 (10 months): Total $699,206 (GR $298,923; Other $45,880; Federal $354,403);
FY 2017: Total $488,336 (GR $185,234; Other $50,026; Federal $253,076); and
FY 2019: Total $395,977 (GR $151,411; Other $50,839; Federal $193,727) fully implemented.

Oversight will calculate FY 2018 costs and present them in the fiscal note table.

Oversight will extrapolate costs to FY 2021 when other provisions of this proposal become fully implemented.

§§208.675 and 208.677 - Telehealth Services

In response to the previous version of this proposal, the following agency responses were provided:

Officials from the **Department of Social Services** (**DSS), MO HealthNet Division (MHD)** state Section 208.675 and 208.677 lists eligible health care providers and originating sites for telehealth services. 13 CSR 70-3.190 describes MO HealthNet's (MHD) telehealth services and does not include School, MHD participant's home, and clinical designated area pharmacy as an originating site. After further research, MHD assumes School based telehealth services would likely increase the utilization of Behavioral Health counseling services. Behavioral health counseling is currently considered the only allowable service through telehealth that can be billed by schools. MHD reimburses schools for the federal share of costs incurred. The current FY2014 spend for Behavioral Health counseling is $477,000 for 12,639 annual visits. Assuming a 5% increase in number of visits to the school based originating site, this would add $5,846 in originating fees in FY 2016 (632 visits x $9.25 federal portion of originating site fees per visit as schools pay the state share). There is also a savings to NEMT costs for providing this service in schools. Due to NEMT capitation rate methodologies, there is a two year lag to incorporate the lower NEMT utilization in to the rates. Initially, MHD would see increased costs in FY 2016 and FY 2017 and NEMT savings would begin to occur in FY 2018 and be fully implemented into the rates by FY 2019.

MHD assumes that the requirements for adding a clinical designated area in a pharmacy for telehealth services would be cost prohibitive to the pharmacy and will not have a fiscal impact on MHD.

13 CSR 70-3.190 Telehealth Services requires the telehealth service to be performed on a "private, dedicated telecommunications line approved through the Missouri Telehealth Network (MTN). The telecommunications line must be secure and utilize a method of encryption

ASSUMPTION (continued)

adequate to protect the confidentiality and integrity of the Telehealth service information. The Missouri Telehealth Network must also approve the equipment that will be used in Telehealth service." It further states that both a distant and originating site shall use authentication and identification to ensure confidentiality. In addition, the Code of State Regulations (CSR) specifies that the originating site (patient location) must ensure immediate availability of clinical staff during a Telehealth encounter in the event a participant requires assistance.

Based on these requirements, MHD assumes in-home telehealth would be cost prohibitive to MHD participants and there would be no fiscal impact.

Officials from the **DSS, Division of Legal Services (DLS)** state this proposal defines who is an eligible health care provider for providing telehealth services and what an originating site is. These terms are already defined in 13 CSR 70-3.190. Because this proposal expands the definitions beyond those found in regulations, the regulation will have to be revised. It is expected that these revisions can be done with no additional changes in staff.

Oversight assumes, for purposes of this fiscal note, that the MHD's fully implemented NEMT savings resulting from the implementation of telehealth services in school based settings, would remain constant after becoming fully implemented in FY 2019. Some provisions of this proposal will not be fully implemented until FY 2021. Therefore, Oversight assumes no additional increase in the annual NEMT savings between FY 2019 and FY 2021.

§208.686 - Statewide Home Telemonitoring Services

In response to similar legislation from the current session (HCS HB 319), the following agency responses were provided:

DSS-MHD stated section 208.686 provides, subjection to appropriations, the department shall establish a statewide program that permits reimbursement under the MHD program for home telemonitoring services if it would be cost effective and feasible.

MHD is currently running reports to see if telemonitoring is cost effective. Assuming that it is cost effective, there will be no impact to MHD. This bill would make telemonitoring a state plan service which would require a State Plan Amendment (SPA).

MHD estimates it will need 1 FTE at the Social Services Manager B2 position for evaluation of the cost effectiveness of the service.

ASSUMPTION (continued)

Proposal as a whole:

Officials from the **Office of the Governor (GOV)** state section 197.020 establishes the Perinatal Advisory Council which is comprised of seventeen gubernatorial appointees. Section 208.673 establishes the Telehealth Services Advisory Committee which includes seven gubernatorial appointees. There should be no added cost to the GOV as a result of this measure. However, if additional duties are placed on the office related to appointments in other Truly Agreed To and Finally Passed (TAFP) legislation, there may be the need for additional staff resources in future years.

Officials from the **Department of Higher Education** and the **Joint Committee on Administrative Rules** each assume the proposal would not fiscally impact their respective agencies.

In response to various similar legislation from the current session, officials from the **Office of the Secretary of State (SOS)** stated many bills considered by the General Assembly include provisions allowing or requiring agencies to submit rules and regulations to implement the act. The SOS 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 that this is a small amount and does not expect that additional funding would be required to meet these costs. However, the SOS also recognizes 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 with the 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.

Oversight assumes the SOS could absorb the costs of printing and distributing regulations related to this proposal. If multiple bills pass which require the printing and distribution of regulations at substantial costs, the SOS could request funding through the appropriation process.

FISCAL IMPACT - State Government	FY 2016 (6 months)	FY 2017	FY 2018	Fully Implemented (FY 2021)
GENERAL REVENUE FUND				
Savings - DSS-MHD (§§208.675 and 208.677)				
Reduced NEMT costs	$0	$0	$0	$38,717
Costs - DHSS (§192.380)				
Personal service	($287,406)	($348,336)	($351,819)	($362,480)
Fringe benefits	($149,465)	($181,152)	($182,963)	($188,508)
Equipment and expense	($77,234)	($73,844)	($75,690)	($81,510)
PAC meeting expense	($29,820)	($16,974)	($17,399)	($18,737)
Total Costs - DHSS	($543,925)	($620,306)	($627,871)	($651,235)
FTE Change - DHSS	9 FTE	9 FTE	9 FTE	9 FTE
Costs - DHSS (§192.667)				
Personal service	($67,300)	($81,568)	($82,383)	($84,880)
Fringe benefits	($34,999)	($42,419)	($42,843)	($44,142)
Equipment and expense	($35,902)	($27,896)	($28,593)	($33,159)
Total Costs - DHSS	($138,201)	($151,883)	($153,819)	($162,181)
FTE Change - DHSS	2 FTE	2 FTE	2 FTE	2 FTE
Costs - OA-ITSD (§192.667)				
Development, implementation and storage costs	($129,772)	($123,980)	$0	$0
On-going maintenance and storage costs	$0	$0	($27,449)	($29,560)
Total Costs - OA-ITSD	($129,772)	($123,980)	($27,449)	($29,560)
Costs - DSS-MHD (§192.667)				
Increase in hospital reimbursements	$0	$0	$0	($766,418)

FISCAL IMPACT - State Government	FY 2016 (6 months)	FY 2017	FY 2018	Fully Implemented (FY 2021)
GENERAL REVENUE FUND (cont.)				
Costs - DSS-MHD				
MMIS system costs (§208.671)	($137,500)	$0	$0	$0
Program distributions for asynchronous telehealth services (§208.670.4)	($69,660)	($85,181)	($86,800)	($91,842)
Total Costs - DSS-MHD	($207,160)	($85,181)	($86,800)	($91,842)
Costs - DSS-MHD (§§208.670 - 208.673 and 208.686)				
Personal service	($48,273)	($58,507)	($59,092)	($61,491)
Fringe benefits	($25,104)	($30,427)	($30,731)	($31,979)
Equipment and expense	($12,207)	($6,328)	($6,486)	($6,985)
Total Costs - DSS-MHD	($85,584)	($95,262)	($96,309)	($100,455)
FTE Change - DSS-MHD	1.2 FTE	1.2 FTE	1.2 FTE	1.2 FTE
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**($1,104,642)**	**($1,076,612)**	**($992,248)**	**($1,801,691)**
Estimated Net FTE Change on the General Revenue Fund	12.2 FTE	12.2 FTE	12.2 FTE	12.2 FTE

FISCAL IMPACT - State Government	FY 2016 (6 months)	FY 2017	FY 2018	Fully Implemented (FY 2021)
MoPHS FUND (§191.332)				
Income - DHSS				
Increase in infant screening revenues	$362,880	$725,760	$725,760	$725,760
Transfer-in from DSS Federal Fund				
Reimbursement for screening costs	At least $33,311	At least $67,888	At least $69,178	At least $69,178
Total Income and Transfers-in - DHSS	At least $396,191	At least $793,648	At least $794,938	At least $794,938
Costs - DHSS				
Personal service	($45,864)	($92,645)	($93,572)	($97,371)
Fringe benefits	($23,852)	($48,180)	($48,662)	($50,638)
Equipment and expense	($340,614)	($617,896)	($632,893)	($681,557)
Total Costs - DHSS	($410,330)	($758,721)	($775,127)	($829,566)
FTE Change	2 FTE	2 FTE	2 FTE	2 FTE
ESTIMATED NET EFFECT ON THE MoPHS FUND	**(Less than $14,139)**	**Could exceed $34,927**	**Could exceed $19,811**	**(Less than $34,628)**
Estimated Net FTE Change for the MoPHS Fund	2 FTE	2 FTE	2 FTE	2 FTE

FISCAL IMPACT - State Government	FY 2016 (6 months)	FY 2017	FY 2018	Fully Implemented (FY 2021)
OTHER STATE FUNDS (various)				
Costs - DSS-MHD (§§208.670 - 208.673 and 208.686)				
Personal service	($24,137)	($29,254)	($29,546)	($30,746)
Fringe benefits	($12,552)	($15,214)	($15,365)	($15,989)
Equipment and expense	($6,102)	($3,164)	($3,243)	($6,831)
Total Costs - DSS-MHD	($42,791)	($47,632)	($48,154)	($53,566)
FTE Change - DSS-MHD	0.6 FTE	0.6 FTE	0.6 FTE	0.6 FTE
ESTIMATED NET EFFECT ON OTHER STATE FUNDS (various)	**($42,791)**	**($47,632)**	**($48,154)**	**($53,566)**
Estimated Net FTE Change on Other State Funds (various)	0.6 FTE	0.6 FTE	0.6 FTE	0.6 FTE
FEDERAL FUNDS				
Income - DSS-MHD (§191.332)				
Reimbursement for SCID newborn screening expenses	At least $33,311	At least $67,888	At least $69,178	At least $69,178
Income - DSS-MHD (§192.667)				
Increase in program reimbursements	$0	$0	$0	$1,323,223
Income - DSS-MHD				
Increase in program reimbursements (§§208.670 - 208.673 and 208.686)	$345,294	$248,285	$252,423	$265,638
Savings - DSS-MHD (§§208.675 and 208.677)				
Reduced NEMT costs	$0	$0	$0	$66,844
Total Income & Savings	$345,294	$248,285	$252,423	$1,655,705

FISCAL IMPACT - State Government	FY 2016 (6 months)	FY 2017	FY 2018	Fully Implemented (FY 2021)
FEDERAL FUNDS (cont.)				
Costs - DSS-MHD (§192.667) Increase in hospital program costs	$0	$0	$0	($1,323,223)
Costs - DSS-MHD MMIS system costs (§208.671)	($137,500)	$0	$0	$0
Program distributions for asynchronous telehealth services (§208.670.4)	($122,210)	($153,023)	($156,114)	($165,183)
Total Costs - DSS-MHD	($259,710)	($153,023)	($156,114)	($165,183)
Costs - DSS-MHD (§§208.670 - 208.673 and 208.686)				
Personal service	($48,273)	($58,507)	($59,092)	($61,491)
Fringe benefits	($25,104)	($30,427)	($30,731)	($31,979)
Equipment and expense	($12,207)	($6,328)	($6,486)	($6,985)
Total Costs - DSS-MHD	($85,584)	($95,262)	($96,309)	($100,455)
FTE Change - DSS-MHD	1.2 FTE	1.2 FTE	1.2 FTE	1.2 FTE
Transfer-out - DSS-MHD (§191.332)				
Transfer-out to DHSS MoPHS Fund for SCID newborn screening expenses	(At least $33,311)	(At least $67,888)	(At least $69,178)	(At least $69,178)
Loss - DSS-MHD (§§208.675 and 208.677)				
Reduction in NEMT reimbursements	$0	$0	$0	($66,844)
Total Costs, Loss, & Transfer-out	($345,294)	($248,285)	($252,423)	($1,655,705)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**	**$0**
Estimated Net FTE Change on Federal Funds	1.2 FTE	1.2 FTE	1.2 FTE	1.2 FTE

FISCAL IMPACT - Local Government	FY 2016 (6 months)	FY 2017	FY 2018	Fully Implemented (FY 2021)
	$0	**$0**	**$0**	**$0**

FISCAL IMPACT - Small Business

Small business birthing centers, midwives and any other entities that purchase newborn screening collection forms would have to pay an additional fee. However, this cost may be recovered by the fees charged. There would also be additional administrative costs. (Section 191.332)

Small business perinatal centers who provide perinatal care may incur a fiscal impact to adequately address the requirements of the proposed legislation. (Section 192.380)

This proposal could impact small business ambulatory surgical centers (ASCs) administrative costs as ASCs are required to develop an antimicrobial stewardship program. In addition, ASCs will have to meet new reporting requirements. (Section 192.667)

This proposal may positively impact small business healthcare providers by allowing them to provide telehealth services to participants in their homes or schools. (Sections 208.670 - 208.673)

This proposal may positively impact small business healthcare providers by allowing them to provide telehealth services to participants in their homes or schools. (Sections 208.675 and 208.677)

FISCAL DESCRIPTION

This proposal requires the Department of Health and Senior Services, subject to appropriations, to add severe combined immunodeficiency (SCID), also known as the bubble boy disease to the list of newborn screening requirements. (Section 191.332)

This proposal establishes the Perinatal Advisory Council, which shall be comprised of representatives from specified community and health organizations and professions. After receiving public input, the council shall make recommendations for the division of the state into neonatal and maternal care regions. The council shall also establish standards for all neonatal and maternal levels of birthing hospital care, focusing on facilities, coordination, management, risk identification and referrals, consultation services, reporting requirements, and monitoring

FISCAL DESCRIPTION (continued)

and evaluation of performance. The council shall base its standards upon evidence and best practices as identified by the American Academy of Pediatrics and the American Congress of Obstetricians and Gynecologists. By January 1, 2017, hospital license applications shall include the appropriate level of maternal care and neonatal care designations under the standards established in this proposal. Beginning January 1, 2017, any hospital operated by a state university shall report, upon request by the department, the appropriate level of maternal care designation and neonatal care designation as determined by the standards. The department may partner with appropriate nonprofit organizations meeting specified requirements to administer the provisions of the section. (Section 192.380)

This proposal changes the laws regarding infection reporting. In its main provisions, the proposal: (1) Adds carbapenem-resistant enterobacteriaceae (CRE) to the list of communicable or infections diseases that must be reported to the Department of Health and Human Services; (2) Requires the infection control advisory panel to make recommendations to the department regarding implementation of the Centers for Medicare and Medicaid Services' health care-associated infection data collection, analysis, and public reporting requirements and specifies certain reporting requirements that must be considered by the panel; (3) Requires as a condition of licensure that specified hospitals participate in the National Healthcare Safety Network (NHSN) and permit the NHSN to disclose facility-specific infection data to the department; (4) By January 1, 2016, requires the advisory panel to recommend requirements for specified types of infections and by January 1, 2017, the department to adopt the recommendations in regulations; (5) Requires the department to develop and disseminate publications based on data compiled for a period of 24 months; (6) Requires the department to make specified reports available to the public for a minimum of two years; (7) Requires, no later than August 28, 2016, each hospital, excluding mental health facilities, and each ambulatory surgical center, to establish an antimicrobial stewardship program for evaluating the judicious use of antimicrobials, especially antibiotics that are the last line of defense against resistant infections and specifies certain requirements of the stewardship program; (8) Requires specified hospitals to meet the National Health Safety Network requirements for reporting antimicrobial usage or resistance by using the Center for Disease Control's Antimicrobial Use and Resistance (AUR) Module when regulations concerning stage three of Medicare and Medical Electronic Health Record incentive programs established by the Center for Medicare and Medicaid Services that enable the electronic interface for the reporting are effective and specifies the process for when the reporting takes effect; and (9) Requires the department to make a report to the General Assembly beginning January 1, 2017, and on every January 1 thereafter on the incidence, type, and distribution of antimicrobial-resistant infections identified in the state and within regions of the state. (Sections 192.020 and 192.667)

The proposal changes the laws regarding the use of store-and-forward technology in the practice of telehealth services for MO HealthNet recipients. The proposal defines "asynchronous store-and-forward" as the transfer of a patient's clinically important digital samples, such as still images, videos, audio, and text files, and relevant data from an originating site through the use of

FISCAL DESCRIPTION (continued)

a camera or similar recording device that stores digital samples that are forwarded via telecommunication to a distant site for consultation by a consulting provider without requiring the simultaneous presence of the patient and the patient's treating provider. The proposal requires the Department of Social Services, in consultation with the departments of Mental Health and Health and Senior Services, to promulgate rules governing the use of asynchronous store-and-forward technology in the practice of telehealth in MO HealthNet. The rules must address asynchronous store-and-forward usage issues as specified in the bill. Telehealth providers using asynchronous store-and-forward technology must be required to obtain patient consent before asynchronous store-and-forward services are initiated and to ensure confidentiality of medical information. Asynchronous store-and-forward technology in the practice of telehealth may be utilized to service individuals who are qualified as MO HealthNet participants under Missouri law. Reimbursement for the asynchronous store-and-forward services must be made so that the total payment for the consultation must be divided between the treating provider and the consulting provider. The total payment for both the treating provider and the consulting provider must not exceed the payment for a face-to-face consultation of the same level. The standard of care for the use of asynchronous store-and-forward technology in the practice of telehealth must be the same as the standard of care for face-to-face care.

The proposal establishes the Telehealth Services Advisory Committee to advise the Department of Social Services and propose rules regarding the coverage of telehealth services utilizing asynchronous store-and-forward technology. The committee must be comprised of the following members with non-Department of Social Services members appointed by the Governor: (1) The Director of the MO HealthNet Division within the Department of Social Services, or the director's designee; (2) The medical director of the MO HealthNet Division; (3) A representative from a Missouri institution of higher education with expertise in telemedicine; (4) A representative from the Missouri Office of Primary Care and Rural Health within the Department of Health and Senior Services; (5) Two board-certified specialists licensed to practice in Missouri; (6) A representative from a hospital located in Missouri that utilizes telehealth medicine; (7) A primary care provider from a federally qualified health center (FQHC) or rural health clinic; and (8) A primary care provider from a rural setting other than from an FQHC or rural health clinic. Members of the committee must not receive any compensation for their services but must be reimbursed for any actual and necessary expenses incurred in the performance of their duties. (Sections 208.670 - 208.673)

Subject to appropriations, the department must establish a statewide program that permits reimbursement under the MO HealthNet Program for home telemonitoring services. The proposal defines "home telemonitoring service" as a health care service that requires scheduled remote monitoring of data related to a patient's health and transmission of the data to a Utilization Review Accreditation Commission accredited health call center. The program must: (1) Provide that home telemonitoring services are available only to individuals who are diagnosed with conditions specified in the bill and who exhibit two or more of specified risk factors; (2) Ensure that clinical information gathered by a home health agency or hospital while

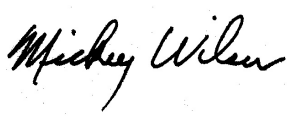
FISCAL DESCRIPTION (continued)

providing home telemonitoring services is shared with the patient's physician; and (3) Ensure that the program does not duplicate any disease management program services provided by MO HealthNet. If, after implementation, the department determines that the program established under these provisions is not cost effective, the department may discontinue the program and stop providing reimbursement under the MO HealthNet Program for home telemonitoring services. The department must determine whether the provision of home telemonitoring services to individuals who are eligible to receive benefits under both the MO HealthNet and Medicare programs achieves cost savings for the Medicare Program. If, before implementing any of these provisions, the department determines that a waiver or authorization from a federal agency is necessary for implementation, it must request the waiver or authorization and may delay implementation until the waiver or authorization is granted. (Section 208.686)

This legislation is not federally mandated, would not duplicate any other program but may require additional capital improvements or rental space.

SOURCES OF INFORMATION

Department of Higher Education
Department of Health and Senior Services
Department of Public Safety -
    Missouri State Highway Patrol
Department of Social Services -
    MO HealthNet Division
    Division of Legal Services
Office of the Governor
Joint Committee on Administrative Rules
Missouri Consolidated Health Care Plan
Missouri Department of Conservation
Missouri Department of Transportation
Office of Administration -
    Information Technology Services Division
Office of Secretary of State
University of Missouri



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