COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 6694-01
Bill No.: SB 1111
Subject: Auditor, State; Contracts and Contractors; Health Care; Health Care Professionals; Hospitals; Insurance - Health; Medicaid; Physicians; Social Services Department
Type: Original
Date: March 16, 2016

Bill Summary: This proposal modifies provisions of law relating to MO HealthNet managed care.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2017	FY 2018	FY 2019
General Revenue	($1,076,832)	($440,990)	($444,386)
Total Estimated Net Effect on General Revenue	**($1,076,832)**	**($440,990)**	**($444,386)**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2017	FY 2018	FY 2019
Total Estimated Net Effect on Other State Funds	**$0**	**$0**	**$0**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 12 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2017	FY 2018	FY 2019
Federal*	$0	$0	$0
Total Estimated Net Effect on All Federal Funds	**$0**	**$0**	**$0**

* Income and expenses exceed $700,000 annually and net to $0.

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2017	FY 2018	FY 2019
General Revenue	3	3	3
Federal	3	3	3
Total Estimated Net Effect on FTE	**6**	**6**	**6**

☒ 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 2017	FY 2018	FY 2019
Local Government	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Department of Social Services (DSS)** provide the following assumptions for this proposal:

Division of Legal Services (DLS)Response:

DLS provides legal advice to the Department of Social Services (DSS) and the MO HealthNet Division (MHD). DLS assumes MHD would be charged with implementation of the suggested changes to the Managed Care contracts. As such, DLS will need to provide legal analysis of the managed care contracts. No additional FTE will be needed as DLS can complete the necessary analysis with current staff.

DLS defers to MHD for impact on Total Revenue.

MO HealthNet Division (MHD) Response:

This legislation adds a new section to Chapter 208 relative to MO HealthNet Managed Care. Section 208.1100(1) Utilization review protocols: This section requires the Department of Social Services (DSS) to establish utilization review protocols and standards, including hospital emergency department coverage and behavioral health services. The DSS is required to ensure active engagement of network health care providers in developing the protocols and standards. It is assumed that the requirements in the current Managed Care contract integrate guidelines prescribed by the Centers for Medicare and Medicaid Services (CMS). Given the health plans already must meet program standards for monitoring and evaluating systems to meet Federal and State regulations and implement components to improve utilization management, MHD assumes there will be no fiscal impact to the rates for this provision.

It is assumed the DSS will undergo a Request for Information (RFI) process or other process to meet the requirement for engagement with network health care providers. It is assumed existing staff can perform this requirement.

Section 208.1100(2) Timely utilization appeal: This section requires that decisions regarding appeals of utilization review or payment authorization decisions to be timely.

The health plans already have member grievance systems in place which address the appeals process. Specifically, the current contract requires as part of the administrative services, a Complaint, Grievance, and Appeal Coordinator to manage and adjudicate member and provider complaints, grievances, and appeals in a timely manner. MHD assumes that there would be no impact to the Managed Care rates for this provision.

ASSUMPTION (continued)

Section 208.1100(3) Network adequacy standards: This section requires that network adequacy standards be established and enforced to ensure vendors provide comparable access to adult and pediatric primary care and specialty medical care and behavioral health services as is provided to enrollees of private insurance plans.

The current managed care contract requires the health plans' Primary Care, Specialty Care, Dental Service, and Behavioral Health networks comply with travel distance standards as set forth by the Department of Insurance, Financial Institutions & Professional Registration in 20 CSR 400-7.095 regarding Provider Network Adequacy Standards. MHD assumes that there would be no impact to the Managed Care rates for this provision.

Section 208.1100(4) Administrative requirements: This section requires that administrative requirements imposed on health plans including collection of data to be standardized and uniformly applied.

Health plans currently must have in place sufficient administrative personnel and an organizational structure to comply with all requirements of the contract, including data collection. MHD assumes that there would be no impact to the Managed Care rates for this provision.

Section 208.1100(5) Supplemental payments: This section requires that to the extent upper payment limits are prevented from being paid, that supplemental hospital payments will be made in lieu thereof.

The intent of this provision is unclear. Further discussion with the sponsor would be needed to understand how to implement.

Section 208.1100(6) Provider assessment pass-through: This section requires that a portion of the capitation payments made to Managed Care plans funded by provider assessment proceeds shall be used to pay providers subject to the applicable tax. Contracts described in this section shall ensure the collection and distribution of payment and encounter data necessary to verify continuous compliance.

MHD interprets this provision to require a pass-through payment from the health plans to providers in the amount of any applicable provider tax. Additional discussion related to this requirement is needed to completely understand the intent and application within the Managed Care program. However, the CMS may not allow this type of requirement in the health plan contract pursuant to the 2016 Managed Care Rate Development Guide.

ASSUMPTION (continued)

If this requirement is allowed by CMS, the requirement that contracts ensure compliance with this section will result in the need for an audit process. MHD will require additional staff in the Managed Care Rate Setting Unit, which could be the same staff as required in 208.1105.

Section 208.1100(7) Financial penalties: This provision requires financial penalties to health plans for not meeting non-emergent hospital emergency department visit metrics. Additionally, a group will be convened to reduce the incidence of non-emergency use of hospital emergency departments.

The current managed care rates already incorporate the LANE adjustment, which reduces the regional experience for low acuity, non-emergent visits. MHD assumes that there would be no impact to the Managed Care rates for this provision.

This section will require a new withhold metric to be added to the current Performance Withhold Program. It is assumed that existing staff would be able to absorb the work necessary to develop this new metric.

Section 208.1100(8) Medical Loss Ratios (MLR): This section requires the health plan to maintain a MLR (medical loss ratio) of at least ninety (90%) percent.

No definitions are included of which services are eligible to be included in the calculation of the MLR. The MLR in the SFY 2016 capitation rates is 88-88.5%, so this provision may suggest that the administrative component of the rates be reduced by about 2% depending on the definition of services to be included in the MLR; however, this provision may not support actuarially sound rates.

Section 208.1100(9) Provide monthly data for monitoring: This section requires the health plan to provide at least monthly all data necessary to monitor payments and determine compliance with contractual agreements between the vendor and providers of healthcare services. The DSS is allowed to monitor payments.

Under the current Managed Care contract, the state does not interfere with the health plans' contractual agreements with providers. Data may be necessary to ensure required reimbursement, e.g. FQHCs, (Federally Qualified Health Centers) is provided. MHD assumes that there would be no impact to the Managed Care rates for this provision. Since the auditing is permissive, it is assumed that any additional auditing would be handled by existing staff; therefore, no fiscal impact to MO HealthNet.

ASSUMPTION (continued)

Section 208.1100(10) Shared savings: This section requires that the Managed Care contract permit shared savings and risk and gain-sharing arrangements between vendors and health care providers.

MHD believes the health plans are already competitively negotiating contracts with providers and this provision would allow them to take part in value-based purchasing arrangements with providers. MHD assumes that there would be no impact to the Managed Care rates for this provision.

Section 208.1100(11) Coercion: This section requires that no contract shall compel or coerce health care providers to participate in a health care system.

MHD assumes that there would be no impact to the Managed Care rates for this provision.

Section 208.1100(12) Timely payment: This section requires contracts to include standards for timely payment of providers.

Managed Care contracts already require the health plans to follow state law for timely payment and allows the health plans to contractually require more stringent requirements. MHD assumes that there would be no impact to the Managed Care rates for this provision.

Section 208.1105 Regional Plan Proposals from Coordinated Care Organizations: This legislation requires the DSS to accept regional plan proposals from provider-sponsored care management organizations as an option for coverage of beneficiaries. Coordinated Care Organizations (CCO) are defined as an organization of health care providers, including a health care home, which agrees to be accountable for the quality, cost, coordination, and overall care of a defined group of MO HealthNet participants. The CCOs must comply with standards established by the DSS to ensure comparable levels of benefits, quality and protection to enrollees. The CCOs are required to use a shared savings and risk model. Regional or statewide CCOs shall be reimbursed through global payment methodologies. The DSS may develop performance incentive payments to reward increased quality and decreased cost of care and these payments would be available by the second full year of operation.

MHD assumes this section requires the DSS to award contracts to provider-sponsored care management organizations to provide health care services as an option for MO HealthNet beneficiaries to choose instead of choosing a health plan that is available under the MO HealthNet Managed Care Program. It is assumed that the intent is to cover only Managed Care-like populations and not the aged, blind and disabled population. It is not clear if the intent

ASSUMPTION (continued)

is for the CCO to provide services to all Managed Care-like members in a region or to targeted populations, e.g., children only. As written, it is unclear if CCO enrollment would be limited to MO HealthNet participants or if it could include the commercial market.

Currently, the health plans that are contracted in the MO HealthNet Managed Care program operate as health maintenance organizations (HMO). These HMOs must be appropriately licensed and able to meet adequate access requirements as regulated by the Department of Insurance, Financial Institutions and Professional Registration (DIFP). Coordinated Care Organizations (CCO) are regional, comprised of health care providers and provide services to a defined group of people. Since they are regional, CCOs would not be able to reach the network adequacy standards set by the DIFP. Therefore, a new procurement would be needed to solicit proposals for this program.

Currently, health plans are required to bid on contracts statewide to provide services in all regions. This statewide requirement combines the financially attractive urban areas with the more difficult and less lucrative rural areas. Limiting the number of health plans supports the business viability of the health plans. If additional entities were awarded contracts, the distribution of the members would be spread over more entities and it is possible that some may not have sufficient business to be successful.

This new program will create additional administrative, operational, monitoring and reporting duties for the Managed Care Unit. A new contract will need to be written; a procurement process will need to be managed; policies and procedures will need to be developed to establish standards to ensure comparable levels of benefits, quality and protection to enrollees for this program. Contracts and waivers would need to be revised and approved by the CMS. Additional staff will be needed to participate in the new required audits with the state auditor and to develop and maintain data for reporting requirements. Additional staff will be needed to operationalize, implement and monitor the new CCOs. New staff will have new daily duties to coordinate program requirements and ensure compliance. Ongoing marketing and member education from the CCO to their members would need to be reviewed and approved by the state for the CCO. If performance incentive payments were used, the performance incentive program would need to be developed, implemented and monitored. Eligibility and payment systems will also need to be revised.

Since it is not known what number or combination of health plans and CCOs would be awarded contracts, the cost of this provision is unknown. However, it is anticipated that at least one (1 FTE) Social Service Manager II ($63,996 annually), one (1 FTE) Program Development Specialist ($40,380 annually), and two (2 FTE) Management Analysis Specialists II ($41,940 annually each) will be needed in the Managed Care Unit.

ASSUMPTION (continued)

With the addition of CCOs, a separate global payment methodology would need to be determined apart from the current HMO rates. MHD estimates two new fiscal staff would be needed in the Managed Care Rate Setting Unit at the level of a Management Analysis Specialist II ($41,940 annually) and a Fiscal and Administrative Manager I ($48,144 annually). These fiscal staff would also be responsible for the payments related to performance incentives.

It is assumed that the MHD will incur costs for the needed system changes to accommodate the new CCO model. It is difficult to determine exactly what this new CCO program would look like with the information available in this bill; however, MHD assumes this would require setting up an entirely new "managed-care-like" system. The effort needed would be very high, and is estimated to be $3,000,000 for system changes in the first year (i.e. updated managed care logic, new rate cells, etc.), with an additional $500,000 per year to add operational staff to the fiscal agent contract to support this new program.

MO HealthNet assumes that the Managed Care capitation rates would increase by at least $100,000 as a result of these changes. The actuarial cost to evaluate this program change to the HMO Managed Care capitation rates would be a one-time cost of $50,000. Furthermore, MHD estimates an ongoing increase to the actuarial contract to determine actuarial sound rates for each CCO. While the actual contract increase would depend on the number of CCOs, MHD estimates an increase of $100,000 for this purpose.

Section 208.1110 Annual Audits: This section requires the state auditor to conduct annual evaluations of the savings and costs pursuant to the expanded implementation of prepaid capitated health services.

MHD assumes these requirements could be met with the new staff requested in response to Section 208.1105. MHD also assumes that there would be no impact to the Managed Care rates for this provision.

Total estimated costs to the General Revenue Fund for this proposal are $1,076,832 for FY 2017; $440,990 for FY 2018; and $444,386 for FY 2019. Cost to Federal funds are estimated to be $2,578,058 for FY 2017; $687,964 for FY 2018; and $692,178 for FY 2019.

Officials from the **Office of Administration, Division of Budget and Planning (B&P)** state the proposal will have no fiscal impact on the B&P; however, B&P defers to the Department of Social Services for response regarding the potential fiscal impact the proposal will have on the MO HealthNet Division.

ASSUMPTION (continued)

Officials from the **Department of Health and Senior Services**, the **Department of Insurance, Financial Institutions and Professional Registration**, the **Department of Mental Health**, the **OA, Division of Purchasing and Materials Management** and the **State Auditor's Office** each assume the proposal would not fiscally impact their respective agencies.

FISCAL IMPACT - State Government	FY 2017 (10 Mo.)	FY 2018	FY 2019
GENERAL REVENUE FUND			
Costs - DSS (§§208.1100, 208.1105 and 208.1110)			
Personal service	($115,975)	($140,562)	($141,967)
Fringe benefits	($56,914)	($68,678)	($69,061)
Equipment and expenses (including computer changes and actuarial costs)	($903,943)	($231,750)	($233,358)
Total Costs - DSS	($1,076,832)	($440,990)	($444,386)
FTE Change - DSS	3 FTE	3 FTE	3 FTE
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**($1,076,832)**	**($440,990)**	**($444,386)**
Estimated Net FTE Change on the General Revenue Fund	3 FTE	3 FTE	3 FTE

FISCAL IMPACT - State Government	FY 2017 (10 Mo.)	FY 2018	FY 2019
FEDERAL FUNDS			
Income - DSS (§§208.1100, 208.1105 and 208.1110)			
Increase in program reimbursements	$2,603,288	$718,240	$722,454
Costs - DSS (§§208.1100, 208.1105 and 208.1110)			
Personal service	($115,975)	($140,562)	($141,967)
Fringe benefits	($56,914)	($68,678)	($69,061)
Equipment and expense (including computer changes and actuarial costs)	($2,430,399)	($509,000)	($511,426)
Total Costs - DSS	($2,603,288)	($718,240)	($722,454)
FTE Change - DSS	3 FTE	3 FTE	3 FTE
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**
Estimated Net FTE Change on Federal Funds	3 FTE	3 FTE	3 FTE

FISCAL IMPACT - Local Government	FY 2017 (10 Mo.)	FY 2018	FY 2019
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

No direct fiscal impact to small businesses would be expected as a result of this proposal.

FISCAL DESCRIPTION

Under this act, any contract between the state and a vendor of prepaid capitated health services issued, reauthorized, or renewed after August 28, 2016, shall incorporate the standards specified in this act, including: (1) utilization review protocols, standards for determining medical necessity for services, and payment authorizations; (2) timely appeals of utilization reviews and

FISCAL DESCRIPTION (continued)

payment authorizations; (3) network adequacy standards; (4) standardized administrative requirements; (5) alternative or supplemental payments made to hospitals if Medicaid upper payment limit payments are prevented by federal statutory or regulatory requirements; (6) actuarially-sound capitation rates; (7) penalties for failure to reduce non-emergency use of hospital emergency departments; (8) medical loss ratios; (9) the provision of monitoring data; (10) shared savings and risk-and-gain-sharing arrangements between vendors and health care providers; (11) prohibitions on compelling or coercing health care providers to participate in a health care system; and (12) timely payment of providers.

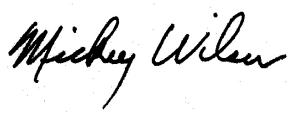
The Department of Social Services shall accept regional plan proposals from provider-sponsored care management organizations as an option for coverage of beneficiaries. Such regional proposals may be submitted by coordinated care organizations (CCOs), which are organizations that are accountable for the quality, cost, coordination, and overall care of a defined group of MO HealthNet participants. The regional or statewide CCOs shall use a shared savings-shared risk model, and the Department shall reimburse the CCOs through a global payment methodology, which may utilize a population-based mechanism based on a per-member, per-month calculation with risk-adjustment, risk sharing, and aligned payment incentives. The Department may develop performance incentive payments designed to reward increased quality and decreased cost of care.

The State Auditor shall conduct an annual evaluation of the savings and costs attributable to state government, political subdivisions, health care providers, and MO HealthNet participants following the expansion of MO HealthNet managed care on or after May 1, 2017. The annual evaluations shall include an assessment of the financial implications attributable to the use of subcontractors by prepaid capitated health services to administer the delivery of health services, including behavioral health services, to MO HealthNet participants.

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 Health and Senior Services
Department of Insurance, Financial Institutions and Professional Registration
Department of Mental Health
Department of Social Services -
MO HealthNet
Division of Legal Services
Office of Administration -
Division of Budget and Planning
Division of Purchasing and Materials Management
State Auditor's Office



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