COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 0719-01
Bill No.: SB 82
Subject: Boards, Commissions, Committees, and Councils; Certificate of Need; Disabilities; Elderly; Health Care; Health and Senior Services Department; Hospitals; Nursing Homes and Long-term Care Facilities
Type: Original
Date: February 5, 2019

Bill Summary: This proposal modifies provisions of law relating to health care facilities and certificates of need.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
General Revenue	($1,455,501 to $3,822,067)	($1,888,491 to $5,061,306)	($2,033,841 to $5,564,034)
Total Estimated Net Effect on General Revenue	**($1,455,501 to $3,822,067)**	**($1,888,491 to $5,061,306)**	**($2,033,841 to $5,564,034)**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
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 2020	FY 2021	FY 2022
Federal*	$0	$0	$0
Total Estimated Net Effect on All Federal Funds	**$0**	**$0**	**$0**

* Income and expenses exceed $8.7 million annually and net to $0.

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
General Revenue	0 to 2 FTE	0 to 2 FTE	0 to 2 FTE
Total Estimated Net Effect on FTE	**0 to 2 FTE**	**0 to 2 FTE**	**0 to 2 FTE**

☒ 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 2020	FY 2021	FY 2022
Local Government	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

§§197.300 - 197.367 - Certificate of Need law

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

§197.305 - No Certificate of Need for major medical equipment

This section of the proposal removes major medical equipment from the definition of a new institutional health service; therefore, a Certificate of Need (CON) would not be required for major medical equipment.

The DHSS generates an average of $83,494 of General Revenue (GR) from major medical equipment applications. Using a 2.5 percent annual growth rate, the total fiscal impact projected to GR will be a reduction of equipment applications fees of $73,101 ($83,494 (average fees) x 1.025 x 1.025 = $87,721 x 10/12) for FY 2020; $89,914 for FY 2021; and $92,162 for FY 2022.

The funding to administer the Certificate of Need Program (CON) program was cut from the DHSS budget and duties were absorbed by Division of Regulation and Licensing's (DRL) Director's Office using existing staff. DHSS currently processes an average of 137 applications annually related to CON for major medical equipment and applications for new/additional beds.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the loss in application fees as provided by DHSS for fiscal note purposes.

§§197.310 - Health Facilities Review Committee

The Missouri Health Facilities Review Committee (MHFRC) is eliminated. The DHSS anticipates being able to absorb these costs. However, until the FY20 budget is final, the department cannot identify specific funding sources.

Oversight notes from the DHSS FY 2020 budget that costs for the MHFRC for FY 2016 were $106,744; FY 2017 were $97,227; and FY 2018 were $95,689 (Governor Recommended $118,681). The DHSS 2019 budget request was for $118,681, but the Governor's Recommendation was $0. Even though the MHFRC was eliminated, the DHSS still administers the CON program with resources pulled in from various other programs. As the CON program is still on-going (though changed in this bill), Oversight will range DHSS need to administer from 0 up to the 2 FTE in previous budgets for the MHFRC since the CON program goes on.

ASSUMPTION (continued)

§197.323.3 - Additional beds and demonstration of need

DHSS provides that this section of the proposal states that no consideration shall be given to any application for new or additional licensed beds unless the applicant can demonstrate that the average occupancy of all facilities within the service area of the project site has been equal to or greater that eighty percent during the four most recent quarters.

Based on 2018 submitted applications, only 11.5 percent of the applications submitted met the 80 percent occupancy requirement. Therefore, DHSS assumes that 88.5 percent of the applications would not be submitted upon implementation of this proposal. DHSS generates an average of $266,063 of GR from new long-term care bed applications. If 88 percent of these were not received, the fiscal impact to GR would be a reduction of $235,466 in application fees. Using a 2.5 percent annual growth rate, the total fiscal impact projected to GR will be a reduction of application fees of $206,155 ($235,466 (average fees) x 1.025 x 1.025 = $247,386 x 10/12) for FY 2020; $253,571 for FY 2021; and $259,910 for FY 2022.

This section also states that no consideration shall be given to any other licensed beds located more than 15 miles from the applying facilities in all non-urban areas and 10 miles in all urban areas.

DHSS assumes that while the unmet need for beds may increase in the stated service areas, the relevant facilities are currently applying for new or additional long-term care beds. Therefore there will be no increase in long-term care bed applications or fiscal impact to GR.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the loss in application fees as provided by DHSS for fiscal note purposes.

Officials from the **Department of Social Services (DSS), MO HealthNet Division (MHD)** and **Division of Legal Services (DLS)** state this legislation implements stricter requirements for the MO Health Facilities Review Committee to apply when considering certificate of need (CON) applications.

The MHD hospital program currently reimburses ten Long Term Acute Care (LTAC) hospitals for bed days of MHD patients. The last one opened on 10/1/2009. Because of the limited number of LTACs, the infrequency of opening a new one, and stricter requirements for opening new LTAC facilities and adding new beds, MHD assumes little or no impact to the MO HealthNet hospital program.

ASSUMPTION (continued)

Stricter requirements also apply to skilled and intermediate care facilities reimbursed under the MO HealthNet nursing facility program. Because there are limited new nursing facilities entering the MO HealthNet program and due to the stricter requirements for opening new nursing facility beds, MHD assumes little or no impact to the MO HealthNet nursing facility program due to these requirements.

MHD estimates a vendor would be needed to audit/adjust rates for nursing homes. MHD estimates this will cost:

FY 2020 total: $136,383 (GR $68,191, FF $68,191)
FY 2021 total: $141,565 (GR $70,783, FF $70,783)
FY 2022 total: $146,945 (GR $73,472, FF $ 73,472)

Oversight does not have any information to the contrary. However, Oversight notes FY 2020 costs are for a full year. Oversight will reflect the vendor costs for FY 2020 for 10 months rather than 12 months for fiscal note purposes.

§208.225 - Capital expenditures by long-term care facilities - rebase

DHSS officials state the proposed changes to section 208.225 would modify the way the Nursing Facility per diem rate is calculated for MO HealthNet. DHSS assumes there will be a corresponding fiscal impact to Home- and Community-Based Services expenditures because reimbursement for these services is based on the Nursing Facility rates.

DHSS defers to the Department of Social Services (MoHealthNet) (DSS) to calculate the fiscal impact of altering long-term care facility (nursing home) provider rates.

In estimating the impact on DHSS home- and community-based programs, DHSS used the DSS (MoHealthNet) nursing home provider rate estimates. Any increase or decrease in the average monthly cost will equate to a corresponding increase or decrease to the monthly maximum allowable cost of home- and community-based services (HCBS) that eligible participants could potentially use. Currently, recipients of State Plan Basic Personal Care and Consumer-Directed Services HCBS are limited to a maximum monthly cost not to exceed 60 percent of the average monthly cost of nursing facilities for a participant, as calculated by DSS. Additionally, recipients of State Plan Advanced Personal Care, as well as Adult Day Care services, within both the Adult Day Care Waiver and the Aged and Disabled Waiver are limited to a maximum monthly cost not to exceed 100 percent of the average monthly cost of nursing facilities for a participant, as calculated by DSS.

ASSUMPTION (continued)

DHSS used HCBS participant data for the last three fiscal years where the nursing facility rate increased, but the provider rate did not simultaneously increase (FY 14, FY 16, and FY 18). For the purposes of this fiscal note, only those participants that were authorized for services within the range of the previous fiscal years' 60 percent cap and the new fiscal years' 60 percent cap were considered to be those affected by the HCBS 60 percent cost cap increase in those specific years. By taking an average of the participants with increased authorization within this range from those years, DHSS estimates that the number of participants that will benefit from a new 60 percent cost cap increase would be 1,572 participants per year. DHSS used this participant count and the DSS (MHD) estimated rate calculations and ranges to estimate the HCBS cost cap ranging from $1,932 to $1,947 for FY 2020, $1,940 to $1,972 for FY 2021, and $1,948 to $1,998 for FY 2022. Subtracting the FY 2019 cost cap of $1,924 from these projections results in the increased cost cap range of $7.67 to $23.18, $15.69 to $47.63, and $23.91 to $73.55 per participant for FY 2020, FY 2021, and FY 2022, respectively. DHSS estimates additional total costs ranging from:

FY 2020 - $144,656 ($7.67*1,572*12) to $437,175 ($23.18*1,572*12);
FY 2021 - $295,913 ($15.69*1,572*12) to $898,302 ($47.63*1,572*12); and
FY 2022 - $450,943 ($23.91*1,572*12) to $1,387,153 ($73.55*1,572*12).

Additionally, those participants that were authorized for services within the range of the previous fiscal years' 100 percent cap and the new fiscal years' 100 percent cap were considered to be those affected by the 100 percent nursing facility cost cap increase in those specific years. By taking an average of the participants with increased authorization within this range from those years, DHSS assumed that the number of participants that will benefit from a new 100 percent cost cap increase would be 603 participants per year. DHSS used this participant count and the DSS (MHD) estimated rate calculations and ranges to estimate the average monthly nursing facility cost cap ranging from $3,220 to $3,246 for fiscal year 2020, $3,233 to $3,287 for fiscal year 2021, and $3,247 to $3,330 for fiscal year. Subtracting the FY 2019 cost cap of $3,207 from these projections results in the increased cost cap range of $12.78 to $38.63, $26.16 to $79.39, and $39.85 to $122.58 per participant for FY 2020, FY 2021, and FY 2022, respectively. DHSS estimates additional total costs ranging from:

FY 2020 - $92,527 ($12.78*603*12) to $279,681 ($38.63*603*12);
FY 2021 - $189,398 ($26.16*603*12) to $574,784 ($79.39*603*12); and
FY 2022 - $288,514 ($39.85*603*12) to $887,479 ($122.58*603*12).

ASSUMPTION (continued)

Accordingly, DHSS estimates total costs ranging from:
FY 2020 - $237,183 ($144,656 + $92,527) to $716,856 ($437,175 + $279,681);
FY 2021 - $485,312 ($295,913 + $189,398) to $1,473,086 ($898,302 + $574,784); and
FY 2022 - $739,457 ($450,943 + $288,514) to $2,274,632 ($1,387,153 + $887,479).

The current FMAP split for FY 2020 is 34.412 % GR and 65.588% Fed.

FY 2020: $81,620 - $246,684 (GR) and $155,564 - $470,172 (Fed)
FY 2021: $167,006 - $506,918 (GR) and $318,306 - $966,167 (Fed)
FY 2022: $254,462 - $782,746 (GR) and $484,995 - $1,491,886 (Fed).

Oversight determined from DHSS officials that the FY 2020 costs in the fiscal note are for a full year. Oversight will present FY 2020 costs for 10 months. Therefore, after applying the FMAP split, FY 2020 costs will be ranged from $68,017 - $205,570 (GR) and $129,637 - $391,810 (Fed).

DSS officials state MHD used the average rate increase for rate adjustments granted in 2002 for the impact of the "Adjust Capital Rate Only" scenario (adjusted for increase in nursing facility rates between 2002-2019 + 2.1% inflation for SFYs 20-22). MHD only used allowable nursing facility related capital expenditures to determine qualifying facilities (excludes capital expenditures for non-allowable items like construction in progress, vehicles, land, etc) or non-nursing facility related items (residential care facilities, apartments, etc). MHD assumes a range due to different rates recalculated for the capital costs vs all costs.

Costs associated with adjustment to Capital Rate-only are listed first; the second number in the range is for all costs incurred during the facility fiscal year during which such capital expenditures were made.

FY 2020 total: $3,666,401 (GR $1,261,682; FF $2,404,719) to $11,094,434 (GR $3,817,817; FF $7,276,617);
FY 2021 total: $7,465,126 (GR $2,568,899; FF $4,896,227) to $22,780,587 (GR $7,839,256; FF $14,941,331);
FY 2022 total: $11,399,319 (GR $3,922,734; FF $7,476,585) to $35,093,336 (GR $12,076,319; FF $23,017,018)

Oversight notes the DSS has provided “cumulative” costs for Capital Rate-only and costs incurred during the facility fiscal year for FY 2021 and FY 2022. For fiscal note purposes, Oversight will present estimated costs for each year. In addition, Oversight will present FY 2020 costs for 10 months rather than 12 months.

ASSUMPTION (continued)

Grand estimated total with Vendor Costs:
FY 2020 total: $3,802,784 (GR $1,329,873; FF $2,472,910) to $11,230,817 (GR $3,886,008; FF $7,344,809);
FY 2021 total: $7,606,691 (GR $2,639,682; FF $4,967,009) to $22,922,152 (GR $7,910,038; FF $15,012,114);
FY 2022 total: $11,546,264 (GR $3,996,206; FF $7,550,058) to $35,240,281 (GR $12,149,791; FF $23,090,490).

Bill as a whole

Officials from the **Office of Attorney General (AGO)** assume any additional litigation costs arising from this proposal can be absorbed with existing personnel and resources. However, the AGO may seek additional appropriations if there is a significant increase in litigation.

Oversight does not have any information to the contrary. Therefore, Oversight assumes the AGO has sufficient staff and current resources to handle any potential increase in litigation costs and will reflect no impact to the AGO for fiscal note purposes.

Oversight notes officials from the **Department of Mental Health**, the **Office of the Governor**, the **Missouri Ethics Commission** and the **Office of State Courts Administrator** assume this proposal will not fiscally impact their organizations. Oversight does not have any information to the contrary. Therefore, Oversight will no impact to these organizations for fiscal note purposes.

Oversight only reflects the responses that we have received from state agencies and political subdivisions; however, **St. Louis City**, **St. Louis County**, **Jackson County**, hospitals and nursing homes were requested to respond to this proposed legislation but did not. For a general listing of political subdivisions included in our database, please refer to www.legislativeoversight.mo.gov.

FISCAL IMPACT - State Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
GENERAL REVENUE FUND			
Costs - DHSS (§§197.310)			
DHSS administers CON program instead of MHFRC	$0 to ($98,901)	$0 to ($118,681)	$0 to ($118,681)
FTE Change - DHSS	0 to 2 FTE	0 to 2 FTE	0 to 2 FTE
Costs - DSS (§§197.300 - 197.367)			
Contractor costs	($56,826)	($70,783)	($73,472)
Costs - DHSS (§208.225) - Increase in HCBS cap rates	($68,017 to $205,570)	($167,006 to $506,918)	($254,462 to $782,746)
Costs - DSS (§208.225)			
Increase in capital expenditures	($1,051,402 to $3,181,514)	($1,307,217 to $4,021,439)	($1,353,835 to $4,237,063)
Total All Costs	($1,176,245 to $3,443,910)	($1,545,006 to $4,599,140)	($1,681,769 to $5,093,281)
Loss - DHSS			
Reduction in CON fees (§197.305)	($73,101)	($89,914)	($92,162)
Reduction in application fees (§197.323.3)	($206,155)	($253,571)	($259,910)
Total Loss - DHSS	($279,256)	($343,485)	($352,072)
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**($1,455,501 to $3,822,067)**	**($1,888,491 to $5,061,306)**	**($2,033,841 to $5,564,034)**
Estimated Net FTE Change on the General Revenue Fund	0 to 2 FTE	0 to 2 FTE	0 to 2 FTE
FEDERAL FUNDS			
Income - DSS			
Reimbursement for contractor costs (§§197.300 - 197.367)	$56,826	$70,783	$73,472
Reimbursement for increase in capital expenditures (§208.225)	$2,003,933 to $6,063,848	$2,491,508 to $7,664,714	$2,580,359 to $8,075,686
Income - DHSS (§208.225)			
Reimbursement for increase in HCBS cap rates	$129,637 to $391,810	$318,306 to $966,167	$484,995 to $1,491,886
Total All Income	$2,190,396 to $6,512,484	$2,880,597 to $8,701,664	$3,138,826 to $9,641,044

FISCAL IMPACT - State Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
FEDERAL FUNDS (continued)			
Costs - DSS			
Contractor costs (§§197.300 - 197.367)	($56,826)	($70,783)	($73,472)
Increase in capital expenditures (§208.225)	($2,003,933 to $6,063,848)	($2,491,508 to $7,664,714)	($2,580,359 to $8,075,686)
Costs - DHSS (§208.225)			
Increase in HCBS cap rates	($129,637 to $391,810)	($318,306 to $966,167)	($484,995 to $1,491,886)
Total All Costs	($2,190,396 to $6,512,484)	($2,880,597 to $8,701,664)	($3,138,826 to $9,641,044)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**

FISCAL IMPACT - Local Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

This proposal may have a positive fiscal impact on small businesses that provide Home- and Community-Based services if they realize an increase in reimbursement.

FISCAL DESCRIPTION

This act modifies several provisions relating to health care facilities, including: (1) Missouri Health Facilities Review Committee; (2) certificates of need (CON) for major medical equipment; (3) CON applications; (4) long-term care CON need formula; (5) CON appeals; and (6) long-term care facility Medicaid per diem reimbursement rates.

MISSOURI HEALTH FACILITIES REVIEW COMMITTEE

Currently, the Missouri Health Facilities Review Committee administers the CON process in Missouri. This act repeals the Committee and places the responsibility over CON with the Department of Health and Senior Services.

FISCAL DESCRIPTION (continued)

CON FOR MAJOR MEDICAL EQUIPMENT (Sections 197.305 and 197.315)

This act removes the requirement to obtain a certificate of need for major medical equipment.

CON APPLICATIONS (Sections 197.315 and 197.330)

Under current law, a CON can be forfeited if no capital expenditure on an approved project is incurred within 6 months of approval. The applicant may seek an extension from the Missouri Health Facilities Review Committee. This act prohibits the granting of an extension for approved long-term care projects for which no substantial capital expenditure has been incurred within 3 years of the original approval date. Any applicant whose request for an extension is not granted under this act shall be permitted to apply for a new certificate of need.

Under current law, the Missouri Health Facilities Review Committee issues a written decision on a CON application within 100 days of filing. Failure to do so shall constitute approval of and final administrative action on the application. This act removes that provision so that the Department's failure to act within the statutory time frame to issue a decision on an application shall not constitute approval of the application.

LONG-TERM CARE CON NEED FORMULA (Sections 197.315, 197.318, and 197.323)

This act removes the word "available" when referencing licensed long-term care beds.

Under this act, the Department shall apply the following when determining whether or not to grant a CON for any new or additional licensed long-term care beds:

- No consideration shall be given to any other licensed beds located more than 15 miles from the applying facilities in all non-urban areas and 10 miles in all urban areas;
- Within the 10 or 15-mile service area, the following need formula shall apply: (1) for intermediate care and skilled nursing facilities (ICF/SNF), 53 beds per 1,000 population aged 65 and older minus the current number of ICF/SNF beds; (2) for residential care and assisted living facilities (RCF/ALF), 25 beds per 1,000 population aged 65 and older minus the current number RCF/ALF beds; and (3) for long-term care hospital beds (LTCH), one-tenth of a bed per 1,000 population minus the current number of LTCH beds; and
- No CON shall be granted unless the applicant can demonstrate that the average occupancy of all facilities in the same category within the service area of the project site has been equal to or greater than 80% during the four most recent quarters.

FISCAL DESCRIPTION (continued)

LONG-TERM CARE FACILITY MEDICAID PER DIEM REIMBURSEMENT RATES (Section 208.225)

Under this act, any intermediate care facility or skilled nursing facility participating in MO HealthNet that incurs total capital expenditures in excess of $2,000 per bed shall be entitled to obtain a recalculation of its Medicaid per diem reimbursement rate based on its additional capital costs or all costs incurred during the facility fiscal year during which such capital expenditures were made.

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 Attorney General
Department of Health and Senior Services -
    Division of Regulation and Licensure
    Missouri Health Facilities Review Commission
Department of Mental Health
Department of Social Services -
    MO HealthNet Division
    Division of Legal Services
Office of the Governor
Missouri Ethics Commission
Office of State Courts Administrator

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