COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 1130-10
Bill No.: Truly Agreed To and Finally Passed CCS for SS for SCS for HCS for HB 399
Subject: Children and Minors; Disabilities; Drugs and Controlled Substances; Health Care; Health Care Professionals; Health and Senior Services Department; Insurance - Health; Insurance, Financial Institutions, and Professional Registration Department; Medicaid/MO HealthNet; Medical Procedures and Personnel; Mental Health; Physicians; Prisons and Jails; Psychologists
Type: Original
Date: June 26, 2019

Bill Summary: This proposal enacts provisions relating to health care.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
General Revenue	($1,604,285 or Could exceed $1,822,444)	($1,074,217 or Could exceed $1,180,019)	($1,079,638 or Could exceed $1,186,246)
Total Estimated Net Effect on General Revenue	**($1,604,285 or Could exceed $1,822,444)**	**($1,074,217 or Could exceed $1,180,019)**	**($1,079,638 or Could exceed $1,186,246)**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
Insurance Dedicated (0566)	Up to $22,500	$0	$0
Total Estimated Net Effect on Other State Funds	**Up to $22,500**	**$0**	**$0**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 24 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 $150,000 or $175,000 annually and net to $0.

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2020	FY 2021	FY 2022
General Revenue	7.5 to 8.13 FTE	7.5 or 8.5 FTE	7.5 or 8.5 FTE
Federal	7.5 to 7.97 FTE	7.5 FTE	7.5 FTE
Total Estimated Net Effect on FTE	**15 to 16.1**	**15 or 16**	**15 or 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 2020	FY 2021	FY 2022
Local Government	**$0 to (Unknown)**	**$0 to (Unknown)**	**$0 to (Unknown)**

FISCAL ANALYSIS

ASSUMPTION

§§191.1164 - 191.1168 - "Ensuring Access to High Quality Care for the Treatment of Substance Use Disorder Act"

Officials from the **Department of Corrections (DOC)** stated the proposed legislation removes any reference to the DOC and adds drug courts and diversion programs. It is assumed that the language is intended to remove the DOC from the impact of this legislation. However, §191.1165.5 might still be interpreted to include the DOC.

For purposes of this fiscal note the DOC assumes no fiscal impact.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the no fiscal impact DOC provided for fiscal note purposes.

Officials from the **Office of State Courts Administrator (OSCA)** state the proposed legislation may result in some fiscal impact but there is no way to quantify the amount at the current time. Any significant changes will be reflected in future budget requests.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the costs for the OSCA as $0 to (Unknown) for fiscal note purposes.

Officials from the **City of Kansas City (Kansas City)** state this legislation would have a negative fiscal impact on Kansas City because subsection 7 of 191.1165 requires "Drug courts or other diversion programs that provide for alternatives to jail or prison for persons with a substance use disorder shall be required to ensure all persons under their care are assessed for substance use disorders using standard diagnostic criteria by a licensed physician who actively treats patients with substance use disorders."

The above persons in Kansas City's drug courts are treated by licensed clinicians or substance use counselors, but generally not physicians. If someone is on MAT (Medication Assisted Treatment), then they are treated by physicians. However, many in drug court are not on MAT.

In response to similar legislation (HCS SS SCS SB Nos. 70 & 128), officials from the **City of Columbia** assumed this proposal will have little, if any, fiscal impact on the City of Columbia.

Oversight does not have any information to the contrary. Oversight will reflect costs to Local Governments as $0 to (Unknown) for fiscal note purposes.

ASSUMPTION (continued)

Officials from the **Department of Insurance, Financial Institutions and Professional Registration (DIFP)** state §§191.1164 - 376.1042 are anticipated to have no fiscal impact on the DIFP. However, should the extent of the work be more than anticipated, the DIFP would request additional appropriations and/or FTE through the budget process.

§§208.909, 208.918, and 208.924 - Consumer directed services

Officials from the **Department of Health and Senior Services (DHSS)** would promulgate by rule a consumer-directed services division provider certification manger course; however, it is assumed that Missouri Medicaid Audit and Compliance (MMAC), Department of Social Services (DSS) would enforce the rule. Therefore, any fiscal note costs outside of rule-making would impact MMAC rather than DHSS.

DHSS states §208.918.2(3)(a) is interpreted to mean the DHSS would promulgate a rule to define the elements and frequency of the consumer-directed division provider certification manager course, and MMAC, within the DSS, would maintain responsibility for provisions of the course and administering the exam. This would be similar to the current certified manager course required of agency model in-home services providers and would follow the delineation of authorities granted through executive order to MMAC, specifically related to the responsibilities of provider education and oversight.

The proposed legislation (§§ 208.918 and 208.935) requires the promulgation of rules and regulations, which include the following duties (but not all inclusive): establish guidelines, implement strategies, make evidence-based system changes, and create policy recommendations. The DHSS, Office of General Counsel will need an additional 0.10 FTE for an attorney (salary of $64,500 per year) to perform the research necessary to ensure the new guidelines and information for this proposed legislation has been properly vetted and implementation is completed quickly and with fiscal responsibility. Due to current workload being at maximum limits, these costs cannot be absorbed.

Oversight assumes 0.1 FTE would not be provided fringe benefits and the state would only pay Social Security and Medicare benefits of 7.65 percent. In addition, Oversight assumes the DHSS would not need additional rental space for 0.1 FTE. However, if multiple proposals pass during the legislative session requiring additional FTE, cumulatively the effect of all proposals passed may result in the DHSS needing additional rental space.

Oversight assumes since DHSS states their responsibility to perform the research necessary to ensure the new guidelines and information for this proposed legislation has been properly vetted and implementation is completed quickly and with fiscal responsibility, Oversight will range the cost of the partial FTE from $0 to DHSS' estimate less fringe benefits over 7.65% and rental space costs.

ASSUMPTION (continued)

Officials from the **Department of Social Services (DSS)** state this bill will have a fiscal impact on Missouri Medicaid Audit and Compliance Unit (MMAC).

§208.918.2 (3) (a), RSMo, will create a fiscal impact. The section requires the creation of a consumer-directed services provider certification manager course. Currently, MMAC enrolls in-home care providers. Because of this role with providers, MMAC will need to create the consumer-directed services provider certification manager course.

The Department of Health and Senior Services (DHSS) interprets the statute to mean that DHSS will promulgate the rule and MMAC will provide the course. To accomplish this task, MMAC will need one Medicaid Specialist FTE ($38,304 annually).

§208.918.2(5) is added to require vendors to maintain a proper business location that complies with all applicable city, county, state, and federal regulations and is verified by MMAC. MMAC currently verifies that vendors meet state and federal regulations; however, ensuring that vendors meet applicable city and county regulations will take an additional 10 FTE Medicaid Specialists ($38,304 per FTE annually). The new FTE will need to become versed in city and county regulations throughout the state.

§208.918.3 states that no state or federal funds shall be authorized or expended for an owner or manager of a consumer-directed services vendor for attendant services. MMAC will need an additional 4 FTE Medicaid Specialists ($38,304 per FTE annually) to monitor vendors to ensure funds are not being expended for this purpose.

The Grand Total for the Department is:
FY 2020 (10 mo.) - Total: $1,015,436 (GR: $507,718; FF: $507,718);
FY 2021 - Total: $1,107,314 (GR: $553,657; FF: $553,657);
FY 2022 - Total: $1,118,912 (GR: $559,455; FF: $559,455).

These costs are split 50%/50% between State and Federal funds.

Oversight notes the DSS did not indicate additional rental space is needed for the addition of 15 FTE as they will be located around the state. However, DSS did include leasing costs in their fiscal note response. Oversight determined from DSS officials that the Office of Administration re-allocates costs between agencies that share building space based on the amount of space occupied by each agency. As a result, if DSS adds personnel, its allocated portion of lease costs will increase. However, the costs allocated to other state agencies occupying the same building decreases by the same amount so the net effect is $0. Therefore, for fiscal note purposes, Oversight will exclude the estimated leasing costs provided by DSS from the fiscal impact.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the costs provided by DSS less rental space related costs for fiscal note purposes.

ASSUMPTION (continued)

§208.930 - Consumer-directed personal care assistance services

Officials from the **DHSS, Division of Senior and Disability Services (DSDS)** assumes this legislation extends the sunset date for the Non-Medicaid Eligible (NME) program to June 30, 2025.

While the sunset was extended, the funding for the NME program was cut during the budget process. DSDS does not have sufficient authority to pay all anticipated NME claims for FY 2020. DSDS anticipates that the existing funding will likely only be sufficient to pay claims for the first several months of FY 2020. When those appropriations have been exhausted, DSDS will begin holding claims invoices and will submit a supplemental funding request to pay those claims. In addition, DSDS will submit a FY 2021 new decision item to restore funding for the program as a result of the extension of the sunset date.

Oversight obtained addition information from the DHSS regarding the cost to continue personal care assistance services under this proposal. For FY 2018 and 2019, the DHSS stated funding for consumer-directed personal care assistance services totaled $505,140 annually. For FY 2017, funding was $740,140. Based on this information, Oversight will present on-going costs to fund consumer-directed personal care assistance services of $505,140 annually to the General Revenue Fund through FY 2025 as a result of extending the expiration date from these provisions.

§208.935 - Interactive assessment tool/mobile assessments

Officials from the **DHSS** state Home and Community-Based (HCBS) assessor staff conduct initial assessments to determine nursing home level of care (LOC) eligibility for services. In addition, assessors conduct annual reassessments on current participants to ensure continued eligibility for HCBS and aid in care plan changes. Currently, the assessments and reassessments are completed in the participant's home using a 13-page paper copy form which is manually filled out by DSDS staff and then manually entered into the Cyber Access Web Tool, resulting in a duplication of efforts. It is estimated DSDS assessor staff spend one hour of time for the manual data entry of initial assessments, as well as one hour of time for the manual data entry of annual reassessments in the Web Tool. Based on FY 2018 data, the manual data entry results in 38,002 hours of staff time per year (18,170 initial assessments + 19,832 annual reassessment = 38,002 x 1 hour of time = 38,002 hours).

This section would allow for the development of a mobile application to conduct both initial HCBS assessments as well as annual reassessments. This would equip assessor staff with tablets that could be preloaded each morning with assessments to be completed using a touch screen

ASSUMPTION (continued)

application rather than a hard paper copy. Staff could then upload or sync those assessments to the Cyber Access Web Tool using a secure Wi-Fi connection or "docked" at the office at the end of the day, thereby eliminating the need to manually enter the information at a desktop. Staff time will be reinvested in a variety of ways to improve integrity of the program, including: implementation of a certified assessor process which requires more stringent training guidelines and quality assurance for assessors to ensure quality and accuracy in HCBS assessments; and completion of additional annual reassessments in person. (Currently, reassessments may be completed via telephone when workload exceeds staff capacity.)

Eliminating the hard paper copy would also lead to cost savings in the amount of paper and toner used annually. The current hard paper copy assessment tool is 13 pages - seven pages front and back, resulting in 266,014 pieces of paper annually, or 532 reams (7 pages x 38,002 assessments = 266,014; 266,014 pieces of paper / 500 pieces of paper per ream = 532 reams). At a cost of $2.77 per ream, the total savings for paper per year would be $1,474 (532 x $2.77 = $1,474). It is estimated one toner cartridge can print 35,000 pieces of paper. The reduction in hard paper copies would also lead to $1,314 in toner savings per year (266,014 pieces of paper / 35,000 pieces of paper per toner cartridge = 7.6 less cartridges used; 7.6 x $172.90 cost per cartridge = $1,314 savings - GR 50% / Fed 50%). Total cost savings per year are estimated to be $2,788 ($1,474 + $1,314; GR 50% / Fed 50%).

One-time development costs by the current Cyber Access contractor, Conduent, for the mobile assessment application are estimated to be $500,000 (GR 50%/Fed 50% or could potentially be GR 10%/Fed 90% if approved by application to the Centers for Medicare and Medicaid Services (CMS)), which would occur in State Fiscal Year (SFY) 2020, and annual maintenance fees of $100,000 per year thereafter (GR 50% / Fed 50% or could potentially be GR 25%/Fed 75%). Due to the unknown of GR/Fed split at this time, the costs have been represented as a range. In addition, an initial investment of approximately $50,750 will be required for the purchase of 125 tablets/iPads with related accessories (as quoted to by Office of Administration, Information Technology Services Department (ITSD) vendor as of 1/18/19) with an anticipated replacement cycle of every three years (GR 50% / Fed 50%).

Oversight notes, based on discussions with DHSS officials, it is possible the development of the mobile technology/interactive assessment tool (estimated at $500,000) may qualify for a 90%/10% Federal/state match ($450,000 Federal; $50,000 GR) in FY 2020. However, the Center for Medicare and Medicaid Services (CMS) indicated DHSS would have to apply for the enhanced match. For fiscal note purposes, Oversight will range costs from the current 50/50 split to the 90/10 split.

ASSUMPTION (continued)

In addition, DHSS officials are in the process of verifying a potential enhanced split for maintenance costs ($100,000 annually beginning in FY 2021). It is possible these costs could be reimbursed at a 75%/25% Federal/state rate rather than the estimated 50%/50% split previously used. Therefore, for fiscal note purposes, Oversight will range the FY 2021 and FY 2022 maintenance costs between the 50/50 split and the 75/25 split.

§§217.930 and 221.125 - Suspension of MO HealthNet benefits when incarcerated

Officials from the **DSS, MO HealthNet Division (MHD)** state under current practice, when the Family Support Division (FSD) is notified that an individual has become incarcerated, MHD eligibility is closed and a new application is required upon release. The FSD has a Memorandum of Understanding (MOU) in place with the Missouri Department of Corrections (DOC) to accept applications facilitated by the DOC when an individual is temporarily released to receive inpatient treatment for twenty-four hours or longer and when an inmate is expected to be permanently released. The DOC facilitates the application process on behalf of FSD for certain inmates within its custody who would appear to meet all factors for eligibility and coverage for MHD and assists in completing the necessary forms for application forms. FSD notifies the inmate in writing the outcome when eligibility determination is complete.

In State Fiscal Year (SFY) 2018, the FSD closed MHD eligibility for 1,124 individuals due to incarceration and determined 461 individuals eligible for MHD benefits upon release. Of the 461 individuals determined eligible upon release, 155 were due to a temporary release of at least twenty-four hours for inpatient treatment and 306 were due to permanent release.

The proposed changes do not change MHD eligibility criteria established by CMS and participants will still need to meet all program eligibility requirements in order to keep active and/or suspended MHD benefits. To ensure the proper eligibility is determined, the FSD completes a review anytime there is a change in circumstances. An individual becoming incarcerated is a change in circumstance, and when a participant with active or suspended coverage no longer meets the criteria for his or her current program benefits, FSD will explore an ex parte review to determine if the participant qualifies for coverage under another MHD program. If the individual does not qualify for coverage under another MHD program, their coverage will be closed. If the individual qualifies for coverage under another MHD program, they will be moved to the proper program. Therefore, "restored" coverage refers to the activation of coverage. However, this may not be at the same level as when the individual became incarcerated due to a change in circumstances. The FSD will continue to work with the DOC and will also work with county, city, and private jails to facilitate applications and eligibility reviews of incarcerated individuals.

ASSUMPTION (continued)

The eligibility determination systems FSD uses to determine and maintain coverage for MHD programs do not currently have the capability to suspend rather than terminate coverage. FTE deters to the Office of Administration (OA), Information Technology Services Division (ITSD) for any programmatic changes necessary to implement this legislation.

Therefore, there is no fiscal impact to FSD.

Because FSD only determines eligibility for covered services, FSD defers to MHD regarding any services or medical expenses the participant may incur during periods of suspended coverage.

FSD assumes the Office of Administration, Information Technology Services Division will include the system programming costs for the system changes necessary to implement provisions of this bill.

Currently, MHD has a process for persons that are incarcerated, but it involves terminating eligibility and requiring a new application for coverage when an individual is released. In order to add a process to suspend eligibility, system work would need to be completed. This system work would include creating lock in segments for all incarcerated members. MHD does not pay for services while individuals are incarcerated, only when they are admitted into the hospital for 24 hours, or when they are released from prison. The lock in would have to be ended and a new lock in created for the date when/if they return to prison. Also, MHD would have to update the eligibility verification responses sent to providers to reflect the lock in to prison. This would require Medicaid Management Information System (MMIS) system modifications costing up to $500,000. MMIS system work would be paid 25% GR/75% Federal ($125,000 GR/$375,000 Federal).

Additional staff time would be needed to manually add and close the lock-ins described above. This is estimated to be approximately 4 extra hours a month. These duties could be handled by a Management Analysis Specialist II (MAS II). At approximately $22/hr for a MAS II, the total administrative costs associated with this legislation would be $1,056 ($22/hr*4 hrs*12 months) per year. It is assumed that MHD could absorb these costs with a MAS II already on staff.

Oversight contacted DSS staff regarding the $500,000 in system modifications that would be needed. DSS assumes it would have to issue a request for proposal and get bids for the modifications that would be needed. Oversight contacted officials with the Office of Administration, Division of Purchasing and Materials Management (DPMM). DPMM officials indicated that a request for proposal would have to be submitted and bids received for these system modifications.

ASSUMPTION (continued)

In addition, Oversight contacted DSS officials regarding any potential savings as a result of not having to process Medicaid applications for offenders being released from prison because benefits were suspended rather than terminated. Officials indicated the DSS would still need to go through a re-verification process to determine whether an individual would be eligible for benefits upon release. Any savings would be very small and there is no way to track the potential savings. Re-verification would still have to be performed manually for each offender being released from prison/jail to determine eligibility.

Oversight does not have any information to the contrary. Oversight assumes the MHD has sufficient staff and resources to absorb the additional duties required by this proposal to manually add and close the lock-ins described in their response. However, Oversight will reflect the costs for MMIS modifications provided by DSS for fiscal note purposes.

Oversight notes this legislation appears to require the DOC to notify DSS within 20 days of an offender on Medicaid coming to prison and to notify them within 45 days of the offender leaving prison. This will be less burdensome than the current process. This bill should provide qualifying offenders access to the medical and mental health care they need immediately upon release which may increase their probability of success in the community. This bill could immensely aid re-entry purposes and continuation of care.

The bill does not specify how the DOC determines if a person is receiving benefits under MO HealthNet. Therefore, it is unclear how this practice will be implemented.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect no fiscal impact as provided by the DOC for fiscal note purposes.

Officials from the **Office of Administration, Information Technology Services Division (OA, ITSD)/DSS** state system modifications will be required for the Missouri Eligibility Determination and Enrollment System (MEDES) to reconfigure and customize Curam and other applications to transfer inmate information from the Department of Corrections. System modifications will be executed via a Project Assessment Quotation under the existing Redmane contract (CT 170849002) for MEDES Maintenance and Operations as an enhancement. It is assumed the system modifications will require 6,535.08 IT consultant contract hours at $160 per hour for a cost of $1,045,613 plus an additional upgrade effort of $320,000 for a total cost of $1,365,613 ($341,403 GR; $1,024,210 Federal funds) in FY 2020.

In addition, it is assumed the Family Assistance Management and Information System (FAMIS) will require modifications. IT consultants are estimated to require 669.60 hours at $75/hours to do the necessary modifications for a total of $50,220 ($26,617 General Revenue (GR); $23,603 Federal Funds) in FY 2020.

ASSUMPTION (continued)

It is assumed that every new IT project/system will be bid out because all ITSD resources are at full capacity. Contracted IT consultant hours are estimated at a rate of $75 per hour.

Oversight notes, based on information from OA, ITSD officials, changes to FAMIS are generally contracted out to IRG (maintenance and operations contractor for FAMIS). ITSD staff can assist with changes but it depends on the scope of work that needs to be performed whether IRG or ITSD staff will perform the work.

Oversight also notes ITSD assumes that every new IT project/system will be bid out because all their resources are at full capacity. For this proposal, ITSD assumes system changes will need to be made to the MEDES and FAMIS systems. The state has a contract with Redmane to perform system changes/enhancements to MEDES. However, since changes to FAMIS are made using either a contractor or ITSD staff, Oversight assumes ITSD staff could make the required changes to FAMIS.

ITSD estimates the FAMIS project would take 669.60 hours at a contract rate of $75 per hour for a total cost to the state of $50,220 ($26,617 GR; $23,603 Federal funds). Oversight notes that an average salary for a current IT Specialist within ITSD is $51,618, which totals roughly $80,000 per year when fringe benefits are added. Assuming all ITSD resources are at full capacity, Oversight assumes ITSD may (instead of contracting out the programming) hire additional IT Specialists to perform the work required by this proposal. Therefore, Oversight will range the fiscal impact from the cost of contracting out the work for FAMIS updates ($50,220 in FY 2020) to hiring 1 ($50,220 / $75 / 2,080 hours = 0.32 FTE rounded up) additional FTE IT Specialist (roughly $80,000 per year) to complete the FAMIS system changes in approximately the same time as contract IT consultants. For FY 2021 and 2022, Oversight cannot assume FTE costs would be split between GR and Federal funds and will present costs as 100% GR.

Oversight notes ITSD assumes that every new IT project/system will be bid out because all their resources are at full capacity. For this proposal, ITSD assumes system changes will need to be made to the MEDES systems. The state has a contract with Redmane to perform system changes/enhancements to MEDES.

Oversight notes in response to similar legislation (SB 393), the **Joplin Police Department**, the **Springfield Police Department**, the **St. Louis County Police Department**, and the **St. Louis County Department of Justice Services** stated the proposal would not have a direct fiscal impact on their organizations. Oversight does not have any information to the contrary. Therefore, Oversight will reflect a zero impact in the fiscal note for these organizations.

ASSUMPTION (continued)

Oversight notes this proposal could have positive benefits to the state (including savings related to not having to process MoHealthnet applications once prisoners are released from prison and the potential reduced recidivism rates if newly-released inmates have access to health insurance immediately upon release) and to certain persons recently released from confinement in a prison or jail. Oversight assumes these benefits are indirect impacts and will not reflect them in the fiscal note.

§376.690 - Unanticipated out-of-network health care services

Officials from the **DSS** state health plans that contract with the state to provide health services in the MO HealthNet Managed Care Program are licensed as HMOs; therefore without a specific exemption, this legislation could pertain to these health plans.

This legislation revises legislation passed in FY 2018 that outlines reimbursement requirements and an arbitration system for reimbursement disputes for out-of-network providers providing "unanticipated out-of-network care" defined as services received in an in-network facility from an out-of-network provider when the patient presents with an emergency medical condition.

The legislation passed in FY 2018 was permissive and allowed for this reimbursement and arbitration system, and required an effective date of January 1, 2019. The current bill requires this reimbursement, the arbitration process and removes the January 1, 2019 effective date.

Currently, the MO HealthNet Managed Care contract requires that non-participating providers be reimbursed at 90% of the Fee-for-Service fee schedule. There are exceptions to this requirement including emergency services and "other non-participating reimbursement rates required by law or in the contract". Currently, emergency services provided by an out-of-network provider must be paid at no lower than the current MO HealthNet program rates in effect at the time of service.

If the proposed legislation passes and the MO HealthNet Managed Care contract would need to be amended to align non-participating reimbursement with the legislation, it would be assumed that unanticipated out-of-network care would be reimbursed at a rate higher than the current Fee For Service (FFS) fee schedule reimbursement. Given the negotiation process outlined and the connection of "reasonable" reimbursement to commercial levels, the "reasonable" level of reimbursement in Medicaid is not aligned with the negotiation benchmarks. This is true whether the Managed Care Organization (MCO) Medicaid contract required reimbursement at 90% of Medicaid FFS for non-participating providers or if the Medicaid FFS was required. It is assumed that the Managed Care capitation rates would increase **at least $100,000** for this change.

ASSUMPTION (continued)

DSS estimates the actuarial cost to evaluate this program change to the Managed Care capitation rates to be no more than $50,000. The below splits are based on the FMAP rate with a 2.10% medical inflation rate for FY 2021 and FY 2022.

FY 2020: ($150,000) - (GR $59,412; FF $90,588)
FY 2021: ($102,100) - (GR $35,135; FF $66,9655)
FY 2022: ($104,244) - (GR $35,872; FF $68,372)

Oversight notes that costs for capitation rate increases would be split 35.412% state funds and 65.588% federal funds. Costs for actuarial studies are split equally between state and federal funds.

§376.1224 and §376.1345 - Health care for persons with disabilities and prohibits health carriers from requiring providers use reimbursement methods that require payment of a fee

Officials from the **Department of Insurance, Financial Institutions and Professional Registration (DIFP)** state this legislation impacts group major medical policies only. Companies may choose to file a rider under the "other" code to impact multiple lines in one filing. Therefore, it is unknown how many filings the DIFP will receive.

The DIFP estimates up to 150 companies will file one policy amendment each for a total of 150 filings submitted to the department for review along with a $150 filing fee. Additional revenues to the Insurance Dedicated Fund are estimated to be up to $22,500 (150 X $150 = $22,500).

Additional staff and expenses are not being requested with this single proposal, but if multiple proposals pass during the legislative session which require policy form reviews the department may need to request additional staff to handle increase in workload.

Oversight does not have any information contrary to the information provided by DIFP and will reflect one-time revenues up to $22,500 to the Insurance Dedicated Fund for FY 2020.

In response to similar legislation (HCS for SCS for SB 45), officials from the **City of Keytesville** stated the proposal will have a “low” fiscal impact on their organization.

In response to similar legislation (HCS for SCS for SB 45), officials from the **City of Columbia (Columbia)** stated, based on conversations with their benefits consultant, that the additional claims cost estimate for its medical health plan could be $40,000 per year. The added coverage was calculated at 0.5% (one-half of one percent) on only medical (excluding Rx) claims cost.

ASSUMPTION (continued)

The cost of prescriptions is unknown, but it is expected Columbia would see some sort of increase. Depending on the number of eligible participants in the plan, this estimate could be higher or lower. If significantly higher, city contributions and participant premiums could increase in future years, but there is no way to estimate the impact at this point. In addition, there is no way to determine who might use the benefit.

Oversight does not have any information contrary to the information provided by the City of Columbia. Oversight will assume there could be other political subdivisions that may incur higher insurance costs if their current plan does not have coverage for "treatment of symptoms and behaviors for individuals with physical or developmental disabilities" but are required to with the passage of this bill. Therefore, Oversight will reflect potential unknown cumulative costs to political subdivisions as $0 to (Unknown).

Bill as a whole

Officials from the **Office of the Secretary of State (SOS)** assume 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 $5,000. 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 require additional resources.

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

Oversight assumes JCAR will be able to administer any rules resulting from this proposal with existing resources.

ASSUMPTION (continued)

Officials from the **Missouri Department of Transportation (MoDOT)** state the provisions of this proposal will have no fiscal impact on the MoDOT as all the provisions addressing the treatment for an individual diagnosed with developmental or physical disability are already covered by the department's healthcare plan.

Oversight does not have any information to the contrary. Therefore, Oversight will reflect the no fiscal impact provided by the MoDOT for fiscal note purposes.

Officials from the **Department of Public Safety (DPS), Missouri State Highway Patrol (MHP)** anticipate the proposal will have no fiscal impact on their organization. However, the MHP defers to the Missouri Department of Transportation, Employee Benefits Section (MoDOT/MHP Medical Plan) for response to the proposed legislation. Please see MoDOT's fiscal note response for the potential fiscal impact of this proposal.

Officials from the **Department of Mental Health**, the **Missouri Consolidated Health Care Plan**, and the **Missouri Department of Conservation** each assume the proposal will have no fiscal impact on their respective organizations.

Oversight notes that the above mentioned agencies have stated the proposal would not have a direct fiscal impact on their organization. Oversight does not have any information to the contrary. Therefore, Oversight will reflect a zero impact on the fiscal note.

Officials from the **Office of Administration** defer to the Missouri Consolidated Health Care Plan to estimate the fiscal impact of the proposed legislation on their respective organization.

Oversight only reflects the responses that we have received from state agencies and political subdivisions; however, other Cities and Counties 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			
Savings - DHSS (§208.935)			
Reduction in paper and toner p. 7	$1,161	$1,394	$1,429
Costs - OSCA (§191.1165) p. 3			
Increase in court costs	$0 to (Unknown)	$0 to (Unknown)	$0 to (Unknown)
Costs - DHSS (§208.918) p. 4			
Personal service	$0 or ($5,375)	$0	$0
Fringe benefits	$0 or ($411)	$0	$0
Equipment and expense	$0 or ($3,657)	$0	$0
Total Costs - DHSS	$0 to ($9,443)	$0	$0
FTE Change - DHSS	0 or 0.1 FTE	0 FTE	0 FTE
Costs - DSS (§208.918) p. 5			
Personal service	($239,400)	($290,153)	($293,054)
Fringe benefits	($151,770)	($183,000)	($183,884)
Equipment and expense	($81,329)	($37,185)	($38,116)
Total Costs - DSS	($472,499)	($510,338)	($515,054)
FTE Change - DSS	7.5 FTE	7.5 FTE	7.5 FTE
Costs - DHSS (§208.930) p.6			
Personal care assistance service costs/ extension of Non-Medicaid Eligible program to FY 2025	($505,140)	($505,140)	($505,140)
Costs - DHSS (§208.935) p. 7			
Mobile access system changes	($50,000 or $250,000)	($25,000 or $50,000)	($25,000 or $50,000)
Mobile assess tablets & accessories p. 7	($25,375)	$0	$0
Total Costs - DHSS	($75,375 or $275,375)	($25,000 or $50,000)	($25,000 or $50,000)
Costs - DSS (§§217.930 and 221.125)			
MMIS system modifications p. 9	($125,000)	$0	$0

FISCAL IMPACT - State Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
GENERAL REVENUE FUND (continued)			
Costs - OA, ITSD (§§217.930 and 221.125) p. 10-11			
MEDES system update	($341,403)	$0	$0
FAMIS system update	($26,617 or $35,333)	$0 or ($80,800)	$0 or ($81,608)
Total Costs - OA, ITSD	($368,020 or $376,736)	$0 or ($80,800)	$0 or ($81,608)
FTE Change - OA, ITSD	0 or 0.53 FTE	0 or 1 FTE	0 or 1 FTE
Cost - DSS (§376.690) p. 13			
Increase in Managed Care capitation rates	($34,412)	($35,135)	($35,873)
Actuarial Study	($25,000)	$0	$0
Total Costs - DSS	($59,412)	($35,135)	($35,873)
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**($1,604,285 or Could exceed $1,822,444)**	**($1,074,217 or Could exceed $1,180,019)**	**($1,079,638 or Could exceed $1,186,246)**
Estimated Net FTE Change on the General Revenue Fund	7.5 to 8.13 FTE	7.5 or 8.5 FTE	7.5 or 8.5 FTE
INSURANCE DEDICATED FUND (0566)			
Income - DIFP (§376.1224) p. 13			
Form filing fees	Up to $22,500	$0	$0
ESTIMATED NET EFFECT ON THE INSURANCE DEDICATED FUND	**Up to $22,500**	**$0**	**$0**

FISCAL IMPACT - State Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
FEDERAL FUNDS			
Income - DSS (§208.918) p. 5			
Program reimbursements	$472,499	$510,338	$515,054
Income - DHSS (§208.935) p. 7			
Mobile access system changes	$250,000 or $450,000	$50,000 or $75,000	$50,000 or $75,000
Mobile assess tablets & accessories	$25,375	$0	$0
Income - DSS (§§217.930 and 221.125)			
Program reimbursements for MMIS modifications p. 9	$375,000	$0	$0
Income - OA, ITSD (§§217.930 and 221.125) p. 10-11			
MEDES system update reimbursement	$1,024,210	$0	$0
FAMIS system update reimbursement	$23,603 or $31,333	$0	$0
Income - DSS (§376.690) p. 13			
Increase in Managed Care capitation rates	$65,588	$66,965	$68,371
Actuarial Study	$25,000	$0	$0
Total All Income	$2,261,275 or $2,469,005	$627,303 or $652,303	$633,425 or $658,425
Costs - DSS (§208.918) p. 5			
Personal service	($239,400)	($290,153)	($293,054)
Fringe benefits	($151,770)	($183,000)	($183,884)
Equipment and expense	($81,329)	($37,185)	($38,116)
Total Costs - DSS	($472,499)	($510,338)	($515,054)
FTE Change - DSS	7.5 FTE	7.5 FTE	7.5 FTE
Costs - DHSS (§208.935) p. 7			
Mobile access system changes	($250,000 or $450,000)	($50,000 or $75,000)	($50,000 or $75,000)
Mobile assess tablets & accessories	($25,375)	$0	$0

FISCAL IMPACT - State Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
FEDERAL FUNDS (continued)			
Costs - DSS (§§217.930 and 221.125)			
MMIS system modifications p. 9	($375,000)	$0	$0
Costs - OA, ITSD (§§217.930 and 221.125) p. 10-11			
MEDES system update reimbursement	($1,024,210)	$0	$0
FAMIS system update reimbursement	($23,603 or $31,333)	$0	$0
Total Costs - OA, ITSD	($1,047,813 or $1,055,543)	$0	$0
FTE Change - OA, ITSD	0 or .47 FTE	0 FTE	0 FTE
Costs - DSS (§376.690) p. 13			
Increase in Managed Care capitation rates	($65,588)	($66,965)	($68,371)
Actuarial Study	($25,000)	$0	$0
Total All Costs	($2,261,275 or $2,469,005)	($627,303 or $652,303)	($633,425 or $658,425)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**
Estimated Net FTE Effect on Federal Funds	7.5 or 7.97 FTE	7.5 FTE	7.5 FTE

FISCAL IMPACT - Local Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
LOCAL GOVERNMENTS - ALL			
Costs - All local governments (§191.1165) p. 3			
Increase in drug court costs	$0 to (Unknown)	$0 to (Unknown)	$0 to (Unknown)

FISCAL IMPACT - Local Government	FY 2020 (10 Mo.)	FY 2021	FY 2022
LOCAL GOVERNMENTS - ALL (continued)			
Costs - Local county governments (§376.1224) p. 13-14 Increase in health care plan expenditures to cover treatment of symptoms and behaviors for individuals with physical or developmental disabilities	$0 to (Unknown)	$0 to (Unknown)	$0 to (Unknown)
ESTIMATED NET EFFECT ON LOCAL GOVERNMENTS - ALL	**$0 to (Unknown)**	**$0 to (Unknown)**	**$0 to (Unknown)**

FISCAL IMPACT - Small Business

This will directly impact small businesses that provide insurance to their employees if the cost of the insurance increases. (§191.1165)

Not extending the expiration date for the provision of personals care assistance services could directly impact small businesses that provide these services. (§208.930)

This proposal could impact small businesses that provide insurance coverage to their employees if the cost of the insurance increases upon passage of this proposal. (§376.1224)

FISCAL DESCRIPTION

This bill establishes the "Ensuring Access to High Quality Care for the Treatment of Substance Use Disorders Act."

This bill requires that medication-assisted treatment (MAT) services shall include pharmacologic therapies. A formulary used by a health insurer or pharmacy benefits manager, or a benefit coverage in the case of medications dispensed through an opioid treatment program shall include medications specified in the proposal.

All MAT medications required for compliance must be placed on the lowest cost-sharing tier of the formulary managed by the health insurer or the pharmacy benefits manager.

FISCAL DESCRIPTION (continued)

MAT services shall not be subject to: (1) Annual or lifetime dollar limitations; (2) Financial requirements and quantitative treatment limitations that do not comply with the Mental Health Parity and Addition Equity Act of 2008; (3) Step therapy that conflicts with a prescribed course of treatment; and (4) Prior authorization for MAT services.

The health care benefits and MAT services required by the bill applies to all health insurance plans in the state.

Drug courts and other diversion programs that provide for alternatives to jail or prison for persons with a substance use disorder shall be required to ensure all persons under their care assessed for substance use disorders using standard diagnostic criteria by a licensed physician who actively treats patients with substance use disorders.

All health insurance companies and other payers must disclose which providers in its network provide MAT services and the level of care provided.

The Department of Insurance, within the Department of Insurance, Financial Institutions and Professional Registration (DIFP), must require that provider networks meet time and distance standards and minimum wait time standards for providers of MAT services. When a health insurance plan is deemed inadequate under the requirements of the bill, the health insurer must treat the health care services an enrollee receives from an out-of-network provider as if the services were provided by an in-network provider. A health insurer must provide a determination to an enrollee for covered benefits for MAT services and for urgent care services for MAT from an out-of-network provider within 24 hours. All health coverage payers must submit an annual report to the DIFP.

This proposal contains a severability clause. (§§191.1164 - 191.1168)

This bill requires a consumer of consumer-directed services to allow a vendor to comply with its quality assurance and supervision process, including bi-annual face-to-face home visits and monthly case management activities. During the home visits, the vendor must monitor the performance of the personal care assistance services plan and document whether the attendant was present and providing services required under the plan of care.

The bill repeals language requiring the Department of Health and Senior Services to establish regional telephone tracking system pilot programs.

The bill requires vendors to notify consumers during orientation that falsification of attendant verification records is fraud and will be reported to the department.

FISCAL DESCRIPTION (continued)

The bill removes a requirement that vendors must submit an annual audit report to the department.

The bill requires that the department create rules for a consumer directed services division provider certification manager course.

Additionally, a vendor must perform face-to-face home visits with a consumer at least bi-annually. The vendor still has a responsibility to provide ongoing diligence of case management activity oversight. A vendor must maintain a business location.

The bill prohibits state or federal funds from being given if the owner, primary operator, certified manager, or any direct employer of the vendor is also the personal care attendant. Currently, a consumer's personal care attendant services can be discontinued if the consumer has falsified records; this bill allows the services to be discontinued if the consumer provides false information about his or her condition, functional capacity, or level of care needs. (§§208.909, 208.918, and 208.924)

This bill extends the expiration date for financial assistance for consumer-directed personal care assistance services. (§208.930)

The Department shall develop an interactive assessment tool for utilization by the Division when implementing the assessment and authorization process. (§208.935)

Under this act, MO HealthNet benefits shall be suspended, rather than cancelled or terminated, for offenders entering into a correctional facility or jail if the Department of Social Services is notified of the person's entry into the correctional center or jail, the person was currently enrolled in MO HealthNet, and the person is otherwise eligible for MO HealthNet benefits but for his or her incarcerated status. Upon release from incarceration, the suspension shall end and the person shall continue to be eligible for MO HealthNet benefits until such time as he or she is otherwise ineligible.

The Department of Corrections shall notify the Department of Social Services within 20 days of receiving information that a person receiving MO HealthNet benefits is or will become an offender in a correctional center or jail and within 45 days prior to the release of such person whose benefits have been suspended under this act. City, county, and private jails shall notify the Department of Social Services within 10 days of receiving information that person receiving MO HealthNet benefits is or will become an offender in the jail. (§§217.930 and 221.1251)

This act specifies that health care professionals shall, rather than may, utilize the process outlined in statute for claims for unanticipated out-of-network care. (§376.690)

FISCAL DESCRIPTION (continued)

This act adds therapeutic care for developmental and physical disabilities, as such terms are defined in the act, to the insurance coverage mandate for autism spectrum disorders, and makes the mandate applicable to policies issued or renewed on or after January 1, 2020, rather than to group policies only. Medical necessity of coverage provided under the act shall be determined by the health benefit plan.

The act specifies that autism spectrum disorder shall not be subject to any limits on the number of visits an individual may make to an autism service provider. Coverage for therapeutic care provided under the act for developmental and physical disabilities may be limited to a number of visits per calendar year, provided that additional coverage shall be provided if approved and deemed medically necessary by the health benefit plan. Provisions requiring coverage for autism spectrum disorders and developmental or physical disabilities shall not apply to certain grandfathered plans as described in the act. This act applies to policies issued, delivered, or renewed on or after January 1, 2020. (§376.1224)

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

Department of Health and Senior Services
Department of Insurance, Financial Institutions and Professional Registration
Department of Corrections
Department of Public Safety
- Missouri State Highway Patrol
Department of Social Services
Joint Committee on Administrative Rules
Missouri Consolidated Health Care Plan
Missouri Department of Conservation
Missouri Department of Transportation
Office of Administration
Office of State Courts Administrator
City of Columbia
City of Kansas City
City of Keytesville
Joplin Police Department
Springfield Police Department
St. Louis County Police Department
St. Louis County Department of Justice Services

Kyle Rieman
Director
June 26, 2019

Ross Strope
Assistant Director
June 26, 2019

HWC:LR:OD