

COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 4653-07
Bill No.: Truly Agreed To and Finally Passed CCS for HCS for SCS for SB's 842, 799 and 809
Subject: Medicaid
Type: Original
Date: June 3, 2010

Bill Summary: This legislation modifies provisions relating to public assistance programs administered by the state.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2011	FY 2012	FY 2013
General Revenue	Unknown but Greater than \$8,227,205	Unknown but Greater than \$8,894,141	Unknown but Greater than \$9,199,800
Total Estimated Net Effect on General Revenue Fund	Unknown but Greater than \$8,227,205	Unknown but Greater than \$8,894,141	Unknown but Greater than \$9,199,800

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2011	FY 2012	FY 2013
Third Party Liability Fund	Unknown but Greater than \$367,100	Unknown but Greater than \$367,100	Unknown but Greater than \$367,100
Total Estimated Net Effect on <u>Other</u> State Funds	Unknown but Greater than \$367,100	Unknown but Greater than \$367,100	Unknown but Greater than \$367,100

Numbers within parentheses: () indicate costs or losses.

This fiscal note contains 12 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2011	FY 2012	FY 2013
Federal Fund	\$6,500,000	\$6,500,000	\$6,500,000
Total Estimated Net Effect on <u>All</u> Federal Funds	\$6,500,000	\$6,500,000	\$6,500,000

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2011	FY 2012	FY 2013
Total Estimated Net Effect on FTE	0	0	0

Estimated Total Net Effect on All funds expected to exceed \$100,000 savings or (cost).

Estimated Net Effect on General Revenue Fund expected to exceed \$100,000 (cost).

ESTIMATED NET EFFECT ON LOCAL FUNDS			
FUND AFFECTED	FY 2011	FY 2012	FY 2013
Local Government	\$0	\$0	\$0

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Office of the State Courts Administrator, Office of the Missouri State Treasurer, Department of Insurance, Financial Institutions and Professional Registration** and the **Department of Labor and Industrial Relations** each assume the proposal would have no fiscal impact on their respective agencies.

Section 208.010.10:

Officials from the **Department of Mental Health** assume this proposal allows MO HealthNet Division to re-price outpatient hospital claims when the individual is dually Medicare and Medicaid eligible. Normally Medicaid pays the provider 20% of the payment amount under Medicare as coinsurance and Medicare pays the rest. On these claims Medicaid will pay 20% of the amount currently paid under Medicaid which is less than the amount paid by Medicare resulting in savings to MO HealthNet. Most of the Part B claims paid on behalf of DMH clients are paid on behalf of individuals who are inpatients. General Revenue impact unknown cost less than \$100,000 dollars.

Officials from the **Department of Social Services-MO HealthNet Division (MHD)** states that currently MHD is required to reimburse full payment of Medicare Part B coinsurance and deductibles for dual eligibles. 1902(n)(2) of the SSA provides that a state is not required to provide payment to the extent that the payment under Medicare would exceed the payment amount under Medicaid. The proposed legislation will allow the MHD to re-price Part B outpatient crossover claims to no more than the MHD fee schedule amount.

A sample of the Part B outpatient crossover claims was taken and 26% of the sample could be re-priced to the MHD fee schedule. Based on this sample, it is estimated MHD could save annually FY 11 \$21.9 million. (Outpatient crossover payments were multiplied by 26% to arrive at the cost savings.)

Cost Savings for re-price of Part B Hospital Outpatient claims: FY11 \$21,900,000, FY12 \$22,710,300 and FY13 \$23,550,581. A 3.7% trend was added for FY12 & FY13. FY 11 savings were not reduced for 10 months in order to match the budget request.

Section 208.198:

Officials from the **Department of Social Services-MO HealthNet Division (MHD)** states optometrists are not always reimbursed the same as physicians for similar services. Therefore, equalizing reimbursement between these groups of providers would yield a range between a cost

ASSUMPTION (continued)

of \$306,680 and a savings of \$289,205. If optometrist rates would be raised to ophthalmology (physician) rates MHD would incur a cost. If ophthalmology rates would be reduced to optometrist rates MHD would incur a savings.

The range of costs to savings for the first year (FY11) are (\$306,680) to \$289,205. An inflation factor of 3.7% is applied to FY12 and FY13. FY11: (\$306,680) to \$289,205 ((\$112,582) to \$106,167 GR); FY12: (\$318,027) to \$299,906 ((\$116,748) to \$110,095 GR); and FY13: (\$329,794) to \$311,003 ((\$121,067) to \$114,169 GR).

Section 208.215:

Officials from the **Office of the Attorney General** assume the proposal would require health plans and other specified third parties to pay MO Health Net liens without requiring the agency to submit the claim in a particular format or a particular time frame and without requiring action on the part of the MO HealthNet participant when they secure medical services. AGO assumes that an increase in cases could result when a plan or other specified third party disagrees with the agency on whether a claim was a "properly submitted medical assistance subrogation claim" as set forth in the proposal, as AGO defends MO HealthNet on third party liability matters. AGO assumes that any potential costs could be absorbed with existing resources. If significant referrals result, the AGO may seek additional appropriations to adequately represent the agency.

Officials from the **Department of Social Services - MO HealthNet Division** state Section 208.215 requires health benefit plans to process MO HealthNet subrogation claims for a period of three years from the date of service, regardless of their timely filing requirements. This would significantly increase third party liability recoveries. The estimated increase in recoveries is unknown but greater than \$1,000,000.

Section 208.453:

Officials from the **Department of Mental Health** states the legislation deletes from RSMo section 208.453 the language exempting DMH psychiatric hospitals from the hospital provider tax. This change will allow DMH hospitals to generate additional Federal Medicaid revenues of approximately \$6.5 million.

Officials from the **Department of Social Services - MO HealthNet Division** state the proposed change in the legislation will allow MHD to assess public hospitals, which are operated primarily for the care and treatment of mental disorders, under the current hospital FRA structure. These hospitals are operated by the Department of Mental Health and the proposed changes will impact them. The tax will increase the amount collected and deposited into the federal reimbursement

ASSUMPTION (continued)

allowance fund. Moneys in the FRA fund are used as a GR equivalent enabling the state to earn additional federal earnings (DMH estimated earnings of \$6.5 million).

The proposed legislation has other changes to section 208. However the funding for these services is not included in the MHD budget. It is assumed the DHSS will include the fiscal impact to these changes in their response.

Section 208.895:

Officials from the **Department of Health and Senior Services** state the following:

Third Party Assessment: Assessments conducted by an independent third party was another recommendation made by the Lewin Group (ibid., page 9). This legislation addresses the Home and Community Based Services (HCBS) assessment component. When implemented in other states, increases in denial rates increased up to 0.75 percent were seen, due to more accurate and consistent assessments. Using the Lewin Group's estimates:

Cost avoidance for 10,000 nurse assessments at \$40.85/assessment as currently conducted (pursuant to section 208.895, RSMo): \$408,500 (standard FMAP). This is reduced to \$340,417 in FY 2011 (10 months).

DSDS projects that there will be an increased cost for IT modifications of the web-based assessment tool, currently under construction. Projected costs are unknown, <\$500,000 (50 percent GR/FED) for FY 2011.

Annual cost of conducting up to 20,000 to 25,000 nurse assessments (as projected by Lewin) at a cost of \$172/assessment, at a 50 percent FMAP = (\$3,440,000 to \$4,300,000) (50 percent GR/FED). This is reduced to (\$2,866,667 to \$3,583,333) in FY 2011 (10 months).

Projected cost avoidance: Lewin assumes up to two percent increase in denial rates for HCBS services. Again assuming 20,000 to 25,000 assessments, this would be a denial at intake of an additional 400 to 500 participants. Based upon an average cost per participant of \$7,766 (FY 2009 average), there would be a cost avoidance of \$3,106,400 to \$3,883,000. This is reduced to \$2,588,667 to \$3,235,833 in FY 2011 (10 months).

Additionally, Lewin projects a cost avoidance of one percent of annual cost per participant. Based upon FY 2009 total clients touched of 56,717 and an average cost avoidance of \$77.66, cost avoidance due to decreased cost per client: \$4,404,642. This is reduced to \$3,670,535 in FY 2011 (10 months).

ASSUMPTION (continued)

DSDS assumes that the language added to Section 208.895 will not a significant adverse impact on these cost avoidance estimates.

Total Net Effect:

FY 2011:	GR:	\$360,925 - \$1,204,589
	FED:	\$2,155,361 - \$3,175,259
	TOTAL:	\$2,516,286 - \$4,380,118
FY 2012:	GR:	\$733,109 - \$1,445,830
	FED:	\$2,886,433 - \$3,810,312
	TOTAL:	\$3,619,542 - \$5,256,142
FY 2013:	GR:	\$733,109 - \$1,445,830
	FED:	\$2,886,433 - \$3,810,312
	TOTAL:	\$3,619,542 - \$5,256,142

Section 208.909:

Officials from the **Department of Health and Senior Services** state telephony is a form of an electronic verification system, and was recommended by the Lewin Group to the Department of Social Services (<http://www.dss.mo.gov/mhd/oversight/pdf/longterm-care2010jan07.pdf>, page 20). When used in other states, telephony has resulted in more accurate billing and cost savings of up to five percent. Under this language, all providers of in-home services and all vendors of consumer directed services must utilize telephony services on or before July 1, 2015. While some savings may be realized prior to FY 2016, no cost savings are described in this fiscal note, as the use prior to this date is optional. According to the Lewin Group report, savings as the result of telephony could exceed five percent, or over \$25,000,000 if currently used. (FY 2011: \$0; FY 2012: \$0; FY 2013: \$0)

FISCAL IMPACT - State Government

FY 2011
(10 Mo.)

FY 2012

FY 2013

GENERAL REVENUE FUND

Savings - Department of Social Services

Program Savings

Unknown but
Greater than
\$7,966,280

Unknown but
Greater than
\$8,261,032

Unknown but
Greater than
\$8,566,691

Savings - Department of Health and
Senior Services Section 208.895

Program Savings

\$360,925 to
\$1,204,589

\$733,109 to
\$1,445,830

\$733,109 to
\$1,445,830

Costs - Department of Mental Health-
Reprice Part B Section 208.010.10

(Unknown but
Less than
\$100,000)

(Unknown but
Less than
\$100,000)

(Unknown but
Less than
\$100,000)

**ESTIMATED NET EFFECT ON
GENERAL REVENUE FUND**

Unknown but
Greater than
\$8,227,205

Unknown but
Greater than
\$8,894,141

Unknown but
Greater than
\$9,199,800

THIRD PARTY LIABILITY FUND

Savings - Department of Social Services

Program Savings

Unknown but
Greater than
\$367,100

Unknown but
Greater than
\$367,100

Unknown but
Greater than
\$367,100

**ESTIMATED NET EFFECT ON
THIRD PARTY LIABILITY FUND**

Unknown but
Greater than
\$367,100

Unknown but
Greater than
\$367,100

Unknown but
Greater than
\$367,100

<u>FISCAL IMPACT - State Government</u> (continued)	FY 2011 (10 Mo.)	FY 2012	FY 2013
FEDERAL FUNDS			
<u>Savings - Department of Social Services</u>			
Program Savings	Unknown but Greater than \$14,549,145	Unknown but Greater than \$15,064,047	Unknown but Greater than \$15,597,999
<u>Savings - Department of Health and Senior Services Section 208.895</u>			
Program Savings	\$2,155,361 to \$3,175,259	\$2,886,433 to \$3,810,312	\$2,886,433 to \$3,810,312
<u>Income - Department of Mental Health-Section 208.453</u>			
Federal Revenues	\$6,500,000	\$6,500,000	\$6,500,000
<u>Costs - Department of Social Services</u>			
Return Federal Assistance	(Unknown but Greater than \$14,549,145)	(Unknown but Greater than \$15,064,047)	(Unknown but Greater than \$15,597,999)
<u>Costs - Department of Health and Senior Services Section 208.895</u>			
Return Federal Assistance	<u>(\$2,155,361 to \$3,175,259)</u>	<u>(\$2,886,433 to \$3,810,312)</u>	<u>(\$2,886,433 to \$3,810,312)</u>
ESTIMATED NET EFFECT ON FEDERAL FUNDS	<u>\$6,500,000</u>	<u>\$6,500,000</u>	<u>\$6,500,000</u>
 <u>FISCAL IMPACT - Local Government</u>			
	FY 2011 (10 Mo.)	FY 2012	FY 2013
	<u>\$0</u>	<u>\$0</u>	<u>\$0</u>

FISCAL IMPACT - Small Business

This legislation will mandate that in-home services providers and consumer directed services vendors must have a telephonic based billing system, and interact through an independent third party assessor for the purpose of providing home and community based services.

FISCAL DESCRIPTION

Exemption for Mo HealthNet from paying Medicare Part B deductible amounts for hospital services: Current law requires reimbursement for services provided to an individual who is eligible for MO HealthNet, Medicare Part B, and Supplementary Medical Insurance to include payment in full of deductible and coinsurance amounts as determined by federal Medicare Part B provisions. This legislation exempts MO HealthNet from paying for the Medicare Part B deductible and coinsurance amounts for hospital outpatient services. SECTION 208.010

Reimbursement: Subject to appropriations, the Department of Social Services shall establish an equal reimbursement rate for the same or similar services rendered by physicians and optometrists to MO HealthNet patients. SECTION 208.198

Third party payers/subrogation: Under this legislation any third party payer, such as third party administrators, administrative service organizations, health benefit plans and pharmacy benefits managers, shall process and pay all properly submitted MO HealthNet subrogation claims using standard electronic transactions or paper claims forms for a period of three years from the date services were provided or rendered. However, such third party payers shall not:

- (1) Be required to reimburse for items or services which are not covered under MO HealthNet;
- (2) Deny a claim submitted by the state solely on the basis of the date of submission of the claim, the type or format of the claim form, failure to present proper documentation of coverage at the point of sale, or failure to obtain prior authorization;
- (3) Be required to reimburse for items or services for which a claim was previously submitted to the third party payer by the health care provider or the participant and the claim was properly denied by the third party payer for procedural reasons, except for timely filing, type or format failure to present proper documentation of coverage at the point of sale, or failure to obtain prior authorization;
- (4) Be required to reimburse for items or services which are not covered under or were not covered under the plan offered by the entity against which a claim form for subrogation has been filed.

FISCAL DESCRIPTION (continued)

Such third party payers shall reimburse for items or services to the extent that the entity would have been liable as if it had been properly billed at the point of sale, and the amount due is limited to what the entity would have paid as if it has been properly billed at the point of sale. The MO HealthNet Division shall also enforce its rights within six years of a timely submission of a claim.

Certified computerized MO HealthNet records shall be prima facie evidence of proof of moneys expended and the amount due the state. SECTION 208.215

Repeal of public hospital exemption from the hospital reimbursement allowance: This legislation no longer allows public hospitals which are operated primarily for the care and treatment of mental disorders to be exempted from participating in the Hospital Reimbursement Allowance. SECTION 208.453

Independent third party in-home and community based assessments: This legislation allows, rather than requires, the Department of Health and Senior Services to reimburse in-home providers for nurse assessments of participants in the in-home and home and community based programs. New language is added allowing the Department to contract for home and community based assessments through an independent third-party assessor.

The contracts shall include a requirement that within 15 days of receipt of a referral for service, the contractor shall have made a face to face assessment of care need and developed a plan of care and the contractor shall notify the referring entity within 5 days of receipt of referral if additional information is needed to process the referral.

The contract shall also include the same requirements for such assessments as of January 1, 2010, related to timeliness of assessments and the beginning of service.

The two nurse visits that are currently allowed under section 660.300, shall continue to be performed by home and community-based providers for, including but not limited to, reassessments and level of care recommendations. These reassessments and care plan changes shall be reviewed and approved by the independent third party assessor. In the event of dispute over the level of care required, the third party assessor shall conduct a face-to-face review with the client in question. This provision has a three-year expiration date. SECTION 208.895

Telephone tracking system: This legislation requires both personal care assistance vendors and in-home services providers to use a telephone tracking system to review and certify the accuracy of reports of delivered services and to ensure more accurate billing by July 1, 2015. The requirements of the telephone tracking system are specified in the legislation. In order for

FISCAL DESCRIPTION (continued)

vendors or provider agencies to obtain an agreement with the Department of Social Services, the vendor or agency must demonstrate the ability to implement the telephone tracking system.

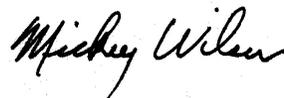
Personal care assistance consumers shall be responsible for approving requests through the telephone tracking system and shall provide the vendor with necessary information to complete the required paperwork for establishing the employer identification number.

DHSS in collaboration with centers for independent living must establish a telephony pilot project in an urban and a rural area. This legislation requires the telephony report provided to the Governor to include a minority report detailing elements not agreed upon by centers for independent living and the executive branch. Entities interested in participating in the telephony pilot project will not be required to pay the full cost of the project and can contract with a vendor of their choice. SECTIONS 208.909, 208.918, 660.023

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 the Attorney General
Office of the State Courts Administrator
Department of Insurance, Financial Institutions and Professional Registration
Department of Mental Health
Department of Health and Senior Services
Department of Social Services
Office of the Missouri State Treasurer
Department of Labor and Industrial Relations



Mickey Wilson, CPA

L.R. No. 4653-07

Bill No. Truly Agreed To and Finally Passed CCS for HCS for SCS for SB's 842, 799 and 809

Page 12 of 12

June 3, 2010

Director
June 3, 2010