COMMITTEE ON LEGISLATIVE RESEARCH
OVERSIGHT DIVISION

FISCAL NOTE

L.R. No.: 2189-01
Bill No.: HB 926
Subject: Medicaid; Elderly; Disabilities; Social Services Department
Type: Original
Date: April 16, 2013

Bill Summary: This proposal establishes a MO HealthNet pilot project program and demonstration project to provide medical assistance to certain aged, blind, and disabled populations.

FISCAL SUMMARY

ESTIMATED NET EFFECT ON GENERAL REVENUE FUND			
FUND AFFECTED	FY 2014	FY 2015	FY 2016
General Revenue	$0	(Unknown, greater than $28,911,590)	(Unknown, greater than $30,049,380)
Total Estimated Net Effect on General Revenue Fund	**$0**	**(Unknown, greater than $28,911,590)**	**(Unknown, greater than $30,049,380)**

ESTIMATED NET EFFECT ON OTHER STATE FUNDS			
FUND AFFECTED	FY 2014	FY 2015	FY 2016
Total Estimated Net Effect on Other State Funds	**$0**	**$0**	**$0**

Numbers within parentheses: ( ) indicate costs or losses.
This fiscal note contains 14 pages.

ESTIMATED NET EFFECT ON FEDERAL FUNDS			
FUND AFFECTED	FY 2014	FY 2015	FY 2016
Federal*	$0	$0	$0
Total Estimated Net Effect on <u>All</u> Federal Funds	**$0**	**$0**	**$0**

*** Income and expenditures net to $0.**

ESTIMATED NET EFFECT ON FULL TIME EQUIVALENT (FTE)			
FUND AFFECTED	FY 2014	FY 2015	FY 2016
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 2014	FY 2015	FY 2016
Local Government	**$0**	**$0**	**$0**

FISCAL ANALYSIS

ASSUMPTION

Officials from the **Department of Social Services (DSS) - Division of Finance and Administrative Services (DFAS)** provide the following:

208.166.2 (1): Based on an analysis from the MO HealthNet (MHN) actuary dated February 24, 2012, if the current Managed Care population were to receive their pharmacy benefits through the managed care plans, the net cost to MO HealthNet would be $14,671,877 to $69,796,579 (the first full year begins FY15). This is based on the loss of the pharmacy provider assessment as a funding source. It is unclear whether the pharmacy tax could continue with a managed care carve-in based on Section 338.550, RSMo.

Oversight notes in HB 925 from the current session that DSS stated, based on an analysis from the MO HealthNet actuary (Mercer) dated February 24, 2012, if the current Managed Care population were to receive their pharmacy benefits through the managed care plans, the net cost to MO HealthNet would be an additional $37,029,374 per year. A 3.9% growth rate was applied for fiscal years 2015 and 2016. FY 15 costs totaled $38,473,520 ($14,671,877 GR: $23,801,643 Federal) and FY 16 costs totaled $39,973,987 ($15,244,080 GR; $24,729,907 Federal).

DSS continued by stating that at the present time, retail pharmacies statewide are charged a provider assessment tax that is used as a funding source to draw down federal Medicaid matching funds. Pursuant to the conditions in Section 338.550, the entire pharmacy provider assessment tax could no longer be a viable source of revenue. It may be the pharmacy providers that currently purchase drugs for Medicaid recipients would no longer be purchasing those drugs for Medicaid recipients. As managed care organizations would be paid a capitated rate by the state that would include drug costs, the managed care company could become the "buyer" of the drugs, not the pharmacies. If this is determined to be the case, the state would no longer be allowed to charge the pharmacy provider assessment tax. FY 12 total revenue from this assessment tax was $95,230,655. Losing the pharmacy provider assessment tax would result in a significantly increased need for General Revenue funds.

Oversight also notes that according to DSS staff, the $69,796,579 referred to above is the state share of the $95,230,655 provider assessment tax. Oversight assumes the potential loss of the pharmacy provider assessment tax to be speculative and is not including this potential loss in the impact statement of the fiscal note.

Per discussions with DSS personnel, DSS is making the same assumption for this proposal, i.e. that pharmacy would be "carved" back in to the managed care option and that it (the pharmacy portion) would be done for the entire managed care population, not simply the population included in this proposal.

ASSUMPTION (continued)

In response to this proposal, DSS - DFAS officials further provide:

208.166.2 (2): Requires the DSS to apply for a waiver from Centers for Medicare and Medicaid Services to implement a pilot program demonstration project in Phelps County (current Managed Care Eastern Region) and Jackson County (current Managed Care Western Region) to deliver health care services to certain elderly and disabled Medicaid participants through managed care.

Elderly and disabled Medicaid participants to be covered by the managed care pilot program demonstration project are defined in the following sections:

208.166.2 (2)(a): Medicaid participants participating in the nursing home vendor program.

In February 2013, there were 296 Phelps County Medicaid participants and 4,123 Jackson County Medicaid participants receiving services through the nursing home vendor program.

It is estimated that providing health care benefits through a managed care model to currently eligible Medicaid participants will have a marginal fiscal impact. Any savings realized from better care management would be offset by higher costs of care since managed care models are risk-based and there are a small number of lives over which a plan can spread the risk. Additionally, individuals described under 208.166.2 are typically high cost users. Managed care rates paid to plans in the Medicaid program must be actuarially sound.

208.166.2 (2)(b) through 208.166.2 (2)(d) Medicare beneficiaries receiving limited assistance through the MO HealthNet program as described below.

QMBs (Qualified Medicare Beneficiary):
- Benefit: MO HealthNet pays Part B premiums and some Part A premiums; co-pays and deductibles and crossover claims for Medicare approved services
- Income: > 85% Federal Poverty Level (FPL) to 100% FPL

SLMB (Specified Low Income Medicare Beneficiary):
- Benefit: MO HealthNet pays Part B premium only
- Income: >100% FPL and < 120% FPL

QI - 1 (Qualifying Individual)
- Benefit: MO HealthNet pays Part B premium only
- Income: >120% FPL and < 135% FPL
- Note, coverage for this group is limited to Federal allotments

HWC:LR:OD

ASSUMPTION (continued)

QWDI (Qualified Working Disabled Individual):
- Benefit: MO HealthNet pays Part A premium only
- Income: <200% Federal poverty level (FPL)
- Note, often there are no QWDIs in the Missouri caseload, typically this caseload will not be over 5 to 10 individuals for the entire state.

Covering these groups in the pilot would result in an unknown cost to the State. Today Medicare pays for the majority of costs related to QMBs, SLMBs, QIs and QWDIs. Implementing a program that would provide a full managed care benefit to these individuals would cost the State with most savings related to better care management realized in the Medicare program, not the Medicaid program.

208.166.2 (2)(e)a.: Medicaid participants receiving benefits through the Ticket to Work Program authorized under RSMo 208.146. In February 2013, 13 individuals in Phelps County and 110 individuals in Jackson County were participating in Medicaid through the Ticket to Work Program.

It is estimated that providing health care benefits through a managed care model to currently eligible Medicaid participants will have a marginal fiscal impact. Any savings realized from better care management would be offset by higher costs of care since managed care models are risk-based and there are a small number of lives over which a plan can spread the risk. Additionally, individuals described under 208.166.2 are typically high cost users. Managed care rates paid to plans in the Medicaid program must be actuarially sound.

208.166.2 (2)(e)b.: Requires the State to establish a demonstration project, allowable under Section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999. Section 204 allows states to request approval of a demonstration project to provide health care benefits to a certain number of individuals who are between the ages of 16 and 65; employed; and have a specific physical or mental impairment that, as defined by the State under the demonstration project, is reasonably expected, but for the receipt of health care benefits provided under Medicaid, would result in the individual being considered blind or disabled by the Social Security Administration and eligible for benefits.

Missouri Medicaid does not cover this population today. There would be a cost to provide health care benefits to the individuals identified to participate in the demonstration. The current Ticket to Work population in the pilot counties is 123 participants. If the demonstration project provided for in this section included a population equal to 50% of the current Ticket to Work population in the pilot counties, costs are estimated to be unknown > $1.0 million.

ASSUMPTION (continued)

123 Current Ticket to Work Participants x 50% = 62 new individuals participating in demonstration project. 62 participants x $1,866.81 FY14 estimated disabled per member per month (PMPM) rate x 80% (assume cost less than avg. disabled population) x 12 months = $1.1 million annualized cost. However, it is estimated that the pilot would begin no earlier than July 1, 2014 since CMS must approve the pilot demonstration project and managed care rates must be set; therefore, there would be no fiscal impact until FY15.

208.166.2 (2)(f): Individuals who are older than 65 years of age or who are disabled with incomes less than 135% FPL and who are not receiving Medicare.

Today elderly and disabled with incomes up to 85% FPL are eligible for full Medicaid benefits if they meet the resource test. Individuals who meet the resource test but have incomes above 85% FPL may participate in Spenddown to qualify for Medicaid services. DSS understands this language to increase the income limit for which non-Medicare elderly and disabled individuals would qualify for Medicaid benefits in the pilot area.

In February 2013, 1,802 aged, blind and disabled individuals in Phelps County and 19,678 aged, blind and disabled individuals in Jackson County were participating in Medicaid. Assuming 95% of elderly and 48% of disabled are duals (Medicare eligible), it is estimated that 8,343 currently eligible elderly and disabled Medicaid, non-Medicare participants would be eligible to participate in the pilot demonstration project.

It is estimated that providing health care benefits through a managed care model to currently eligible Medicaid participants will have a marginal fiscal impact. Any savings realized from better care management would be offset by higher costs of care since managed care models are risk-based and there are a small number of lives over which a plan can spread the risk. Additionally, individuals described under 208.166.2 are typically high cost users. Managed care rates paid to plans in the Medicaid program must be actuarially sound.

Additional costs to provide health care benefits through the managed care pilot demonstration project to non-Medicare aged, blind and disabled individuals with incomes above 85% to 135% FPL is unknown >$17.9 million.

In September 2012, there were 6,050 individuals statewide with incomes between 85% and 138% FPL who did not meet spenddown and were not on Medicare.

6,050 statewide x 11.5% (percent current aged, blind and disabled Medicaid participants in Phelps and Jackson County) = 696 newly eligible Medicaid participants.

HWC:LR:OD

ASSUMPTION (continued)

696 newly eligible x $1,866.81 FY14 PMPM cost x 12 months = $15,591,597 annualized cost. However, it is estimated that the pilot would begin no earlier than July 1, 2014 and that begin date is aggressive since CMS must approve the project and managed care rates must be set. Therefore, there would be no fiscal impact until FY15.

There may be additional non-Medicare aged, blind and disabled individuals with incomes between 85% and 135% FPL who are not known to DSS because they have not applied to receive benefits through the spenddown process.

Raising the income limit decreases the amount of spenddown for individuals above the full Medicaid benefit eligibility limit which increases the Medicaid costs (so individuals in the pilot areas with incomes higher than 135% FPL would spend less of their own income to qualify for Medicaid, increasing Medicaid costs) It is unknown how this would be handled in a demonstration application.

In September 2012, there were 3,547 individuals statewide who met spenddown and were not on Medicare.

3,547 statewide x 11.5% (percent current aged, blind and disabled Medicaid participants in Phelps and Jackson County) = 408 meeting spenddown with a lesser spenddown amount.

408 x $465.38 lesser spenddown amount x 12 months = $2,278,500 annualized cost.

208.166.2 (2)(g): Individuals who are older than 65 years of age or who are disabled with incomes less than 135% FPL and who are end-stage renal disease on dialysis, cancer patients on chemotherapy or organ transplant recipients on anti-rejection drugs.

Many of these individuals with incomes less than 85% FPL will be participating in Medicaid. Some of these individuals would also be eligible and their costs considered in new costs under 208.166.2 (2)(f). However, this provision is not limited to non-Medicare recipients and there are most likely Missourians who would qualify for this program that are not known to DSS.

Medicare recipients known to DSS from the spenddown program who do not meet spenddown are five times greater than individuals who do not meet spenddown and are not Medicare recipients (6,050 individuals). Based on this information it is not unlikely to estimate that adding individuals under this section would have a cost equal to or greater than the cost estimate for 208.166.2 (2)(f), so costs are estimated at unknown > $17.9 million.

HWC:LR:OD

ASSUMPTION (continued)

208.166.2 (2)(h): This section provides for payment of Part D subsidy for individuals with incomes less than 150% FPL. It is assumed this provision is meant to pay for individual recipient cost sharing in the Part D program for individuals with incomes less than 150% FPL.

Today the MO Rx program pays 50% of members' out of pocket costs remaining after their Medicare Prescription Drug Plan pays, 50% of the copays before the coverage gap, 50% of the coverage gap and 50% of the copays in the catastrophic coverage.

If Missouri were to earn a federal match of 61.87% match on 100% of the costs describe above, there would be some savings to the state. DSS is unsure why the Federal government would approve a demonstration of this component.

Comments:

The proposal is silent on whether individuals described under 208.166.2 (2) would be required to participate in the pilot demonstration project or if participation would be at their option.

A portion of current Medicaid participants in Phelps County and Jackson County are participating in a health home. There would be a concern with discontinuing the health home model to place these individuals in the pilot demonstration project.

208.166.2 (2)(e)b , 208.166.2(2)(f) and 208.166.2 (2)(g): Expands Medicaid coverage to certain individuals in the pilot demonstration area and does not provide the same coverage for other areas of the state. DSS is not sure CMS will approve a program that expands eligibility to only certain geographic areas. Additionally, 208.166.2 (2)(g) expands coverage to certain individuals with specific diagnoses and treatment plans in the pilot demonstration area. Again, DSS is not sure CMS would approve such an expansion.

Oversight notes DSS did not include any savings that may result from individuals that are currently receiving help for out of pocket costs from the MO Rx Program but would be covered under the pilot and demonstration projects and receive benefits through a managed care corporation. Per DSS staff, savings were not included because the MO Rx Program covers people throughout the state. This proposal only includes two counties and there was no way to determine what the potential savings to the MO Rx Program would be. Therefore, for fiscal note purposes, Oversight will present Unknown savings to the General Revenue Fund for FY 15 and FY 16 for the MO Rx Program.

ASSUMPTION (continued)

Officials from the **Department of Mental Health (DMH)** state the existing managed care contracts provide the following DMH services on a fee-for-service (FFS) basis when provided by a DMH certified provider: 1) community psychiatric rehabilitation, 2) comprehensive substance abuse treatment and rehabilitation, 3) targeted case management, and 4) developmental disabilities waiver services. Per the MO HealthNet Division (MHD) within Department of Social Services, these services would continue to be carved-out of the health plan benefit package; therefore, the result would be no fiscal impact to DMH.

The proposed language also requires pharmacy to be included in the health plan benefit package under the statewide managed care expansion for all populations. The Centers for Medicare & Medicaid Services (CMS) requires Medicaid Managed Care pharmacy benefits to be comparable to FFS, and historically, managed care participants had the opportunity to appeal Managed Care Pharmacy denials to MHD for review under the FFS Pharmacy criteria. Without the ability to appeal, participants may be denied access to medications resulting in increased hospitalizations and DMH being responsible for these additional medical costs. Also, Managed Care plans are not required to submit encounter data daily, while FFS providers submit encounter data through CyberAccess in real time. The delay in pharmacy encounter claims processing creates a barrier to appropriate medical care because DMH providers will not have immediate access to pharmacy utilization for DMH clients. The anticipated impact of the increased medical costs is unknown, but greater than $100,000

The overall fiscal impact of this legislation is an unknown cost, but greater than $100,000.

Oversight assumes since DSS states the pilot and demonstration projects will not begin until FY 15 that DMH will not incur any potential losses until the projects become effective.

Officials from the **Department of Health and Senior Services** assume the proposal would not fiscally impact their agency.

FISCAL IMPACT - State Government	FY 2014 (10 Mo.)	FY 2015	FY 2016
GENERAL REVENUE FUND			
Savings - DSS			
Reduction in MO Rx Program expenditures (§208.166.2(2)(h)	$0	Unknown	Unknown
Costs - DSS			
Increased program pharmacy costs (§ 208.166.2(1))	$0	($14,671,877)	($15,244,080)
QMBs, SLMBs. QIs, & QWDIs (§ 208.166.2(2)(b) - (d))	$0	(Unknown)	(Unknown)
Demonstration Project under Ticket to Work (§208.166.2(2)(e)b)		(Unknown, greater than $440,677)	(Unknown, greater than $458,304)
Non-Medicare elderly & disabled above 85% FPL to less than 135% FPL (§ 208.166.2(2)(f)	$0	(Unknown, greater than $6,849,518)	(Unknown, greater than $7,123,498)
Medicare & non-Medicare elderly & disabled above 85% FPL to less than 135% FPL with specified conditions (§208.166.2(2)(g))	$0	(Unknown, greater than $6,849,518)	(Unknown, greater than $7,123,498)
Costs - DMH			
Increase in program costs for statewide managed care plan (§ 208.166)	$0	(Unknown, greater than $100,000)	(Unknown, greater than $100,000)
ESTIMATED NET EFFECT ON THE GENERAL REVENUE FUND	**$0**	**(Unknown, greater than $28,911,590)**	**(Unknown, greater than $30,049,380)**

HWC:LR:OD

FISCAL IMPACT - State Government	FY 2014 (10 Mo.)	FY 2015	FY 2016
FEDERAL FUNDS			
Income - DSS			
Increased reimbursements for pharmacy expenditures (§ 208.166.2(1))	$0	$23,801,643	$24,729,907
Increased reimbursement for QMBs, SLMBs, QIs, and QWDIs	$0	Unknown	Unknown
Reimbursement for Demonstration Project under Ticket to Work (§208.166.2(2)(e)b)	$0	Unknown, greater than $714,893	Unknown, greater than $743,489
Reimbursement for Non-Medicare elderly & disabled above 85% FPL to less than 135% FPL (§ 208.166.2(2)(f)	$0	Unknown, greater than $11,111,719	Unknown, greater than $11,556,188
Reimbursement for Medicare & non-Medicare elderly & disabled above 85% FPL to less than 135% FPL with specified conditions (§208.166.2(2)(g))	$0	Unknown, greater than $11,111,719	Unknown, greater than $11,556,188
Income - DMH			
Increased program reimbursements for statewide managed care plan (§ 208.166)	$0	Unknown, greater than $100,000	Unknown, greater than $100,000
Total Income - DSS & DMH	$0	Unknown, greater than $46,839,974	Unknown, greater than $48,685,772

FISCAL IMPACT - State Government	FY 2014 (10 Mo.)	FY 2015	FY 2016
FEDERAL FUNDS (cont.)			
Costs - DSS			
Increased reimbursements for pharmacy expenditures (§ 208.166.2(1))	$0	($23,801,643)	($24,729,907)
Increased reimbursement for QMBs, SLMBs, QIs, and QWDIs	$0	Unknown	Unknown
Reimbursement for Demonstration Project under Ticket to Work (§208.166.2(2)(e)b)	$0	(Unknown, greater than $714,893)	(Unknown, greater than $743,489)
Reimbursement for Non-Medicare elderly & disabled above 85% FPL to less than 135% FPL (§ 208.166.2(2)(f)	$0	(Unknown, greater than $11,111,719)	(Unknown, greater than $11,556,188)
Reimbursement for Medicare & non-Medicare elderly & disabled above 85% FPL to less than 135% FPL with specified conditions (§208.166.2(2)(g))	$0	(Unknown, greater than $11,111,719)	(Unknown, greater than $11,556,188)
Costs - DMH			
Increased program expenditures for statewide managed care plan (§ 208.166)	$0	(Unknown, greater than $100,000)	(Unknown, greater than $100,000)
ESTIMATED NET EFFECT ON FEDERAL FUNDS	**$0**	**$0**	**$0**

FISCAL IMPACT - Local Government	FY 2014 (10 Mo.)	FY 2015	FY 2016
	$0	**$0**	**$0**

FISCAL IMPACT - Small Business

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

HWC:LR:OD

FISCAL DESCRIPTION

This proposal changes the laws regarding medical assistance. The Department of Social Services must maximize the use of existing contracted prepaid health plans and other alternative service delivery and reimbursement methodologies to facilitate the cost-effective purchase of comprehensive health care, including pharmacy benefits and services. The department must permit each prepaid health plan to have full control over its formulary and preferred drug list (PDL). The department must apply for a waiver from the Centers for Medicare and Medicaid Services (CMS) for a pilot program and a demonstration project in selected service areas, including Phelps County in the Eastern Region and Jackson County in the Western Region. The pilot program must provide services to: (1) Persons certified by the MO HealthNet Division within the department who are patients in a medical facility, including nursing homes, hospitals, tuberculosis sanatoriums, or institutions for the treatment of mental disease and, except for the fact they're patients in the medical facility, would qualify for grants under Title IV, Supplemental Social Security Income (SSI) benefits under Title XVI or state supplements and aged, blind and disabled persons who would not be eligible for SSI benefits or state supplements if they were not institutionalized in a medical facility but whose income is below the maximum standard set by the division; (2) Individuals who are qualified Medicare beneficiaries (QMB) entitled to Medicare Part A as defined in Section 301 of the Medicare Catastrophic Coverage Act of 1988 and whose income does not exceed 100% of the nonfarm official poverty level as defined by the federal Office of Management and Budget (OMB). The eligibility of these individuals must be determined by the department and the individuals determined to be eligible must receive Medicare cost-sharing expenses only as more fully defined by the Medicare Catastrophic Coverage Act of 1988 and the Balanced Budget Act of 1997; (3) Individuals entitled to Medicare Part A as defined in Section 4501 of the Omnibus Budget Reconciliation Act of 1990 and whose income does not exceed 120% of the nonfarm official poverty level as defined by the federal OMB. Eligibility for MO HealthNet benefits is limited to the full payment of Medicare Part B premiums; (4) Individuals entitled to Medicare Part A with an income more than 120% but less than 135% of the federal poverty level and not otherwise eligible for MO HealthNet benefits. Eligibility for MO HealthNet benefits is limited to the full payment of Medicare Part B premiums. The number of eligible individuals is limited by the availability of the federal capped allocation at 100% of federal matching funds as defined in the Balanced Budget Act of 1997; (5) Disabled workers who are eligible to enroll in Medicare Part A as required by the Omnibus Budget Reconciliation Act of 1989 and whose income does not exceed 200% of the federal poverty level as determined in accordance with the SSI program. Eligibility must be determined by the department and the individuals must be entitled to buy-in coverage of Medicare Part A premiums only; and (6) Workers with a potentially severe disability as determined by the department. The individuals must be allowed to purchase MO HealthNet coverage.

HWC:LR:OD

FISCAL DESCRIPTION (continued)

The demonstration project must be conducted in a manner that is consistent with Section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999. The number of individuals and the eligibility of the individuals must be determined by the department including: (1) Individuals 65 years of age or older who are deemed disabled under Section 1614(a)(3) of the federal Social Security Act, as amended, and whose income does not exceed 135% of the nonfarm official poverty level as defined by the federal OMB and the MO HealthNet program and are not otherwise covered by Medicare. These individuals are not entitled to benefits and his or her eligibility must be determined by the department; (2) Individuals 65 years of age or older who are disabled as determined by the Section 1614(a)(3) of the federal Social Security Act, as amended and are end-stage renal disease patients on dialysis, cancer patients on chemotherapy, or organ transplant recipients on anti-rejection drugs. The individuals income must not exceed 135% of the nonfarm official poverty level as defined by the federal OMB, and his or her resources must not exceed those established by the department. The individuals are not entitled to benefits and eligibility of these individuals must be determined by the department; and (3) Individuals who are entitled to Medicare Part D and whose income does not exceed 150% of the nonfarm official poverty level as defined by the federal OMB. Eligibility for payment of the Medicare Part D subsidy must be determined by the department.

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 Mental Health
Department of Health and Senior Services
Department of Social Services

Ross Strope
Acting Director
April 16, 2013

HWC:LR:OD