Department of Legislative Services

Maryland General Assembly
2012 Session

FISCAL AND POLICY NOTE

Senate Bill 539 (Senators Kelley and Montgomery)
Finance

Maryland Medical Assistance Program - Long-Term Care Services - Eligibility

This bill requires the Department of Health and Mental Hygiene (DHMH) to provide an applicant for long-term care or home- and community-based waiver services with written notice of eligibility within 60 days of receiving a complete application. Otherwise, DHMH must provide the individual with presumptive Medicaid eligibility. DHMH and the Department of Human Resources (DHR) must submit budget estimates to the Governor that enable the departments to achieve timely and accurate Medicaid eligibility determinations. These budget estimates must be considered prescribed by law under the Maryland Constitution. DHMH and DHR must report monthly to the General Assembly on specific measures and outcomes of the Medicaid eligibility determination process.

The bill takes effect July 1, 2012.

Fiscal Summary

State Effect: DHMH expenditures increase by as much as $48.8 million, and DHR expenditures increase by $0.9 million in FY 2013 to provide and administer presumptive eligibility as required under the bill. DHMH and DHR administrative costs will be eligible for federal matching funds of an estimated $0.7 million in FY 2013, but general funds will support the majority of the new costs. Future years reflect inflation. While the bill intends to establish mandated funding sufficient to achieve timely and accurate Medicaid eligibility determinations, according to the Office of the Attorney General, the language does not qualify as a mandate under the Maryland Constitution.

($ in millions)	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
FF Revenue	$.7	$.4	$.4	$.4	$.4
GF Expenditure	$49.0	$50.5	$52.3	$54.2	$56.1
FF Expenditure	$.7	$.4	$.4	$.4	$.4
Net Effect	($49.0)	($50.5)	($52.3)	($54.2)	($56.1)

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: None.

Small Business Effect: None.

Analysis

Bill Summary: An application is complete if DHMH has not made a written request for additional documentation within 10 days of receiving the application or if any additional documentation requested has been received. DHMH is not required to authorize presumptive eligibility if it has not received the information necessary to assess the individual's medical eligibility for Medicaid and a complete application.

Individuals granted presumptive eligibility must receive full Medicaid benefits, including preexisting medical expense eligibility, effective on the first day of the month in which the individual's application was filed. If requested by the eligible individual, presumptive eligibility must be granted retroactively for up to three months, effective on the first day of the month of the earliest retroactive month requested.

DHMH must make a final decision regarding Medicaid eligibility within six months of a determination of presumptive eligibility. If the final decision is that an individual is not eligible, DHMH must provide timely and adequate written notice before terminating benefits. A presumptively eligible individual may appeal a decision to terminate benefits within 90 days of receiving a termination notice. If an individual appeals a decision within 10 days after receiving the notice, DHMH must continue to provide Medicaid coverage pending the hearing on the appeal.

If an applicant for long-term care services or home- and community-based waiver services has been denied eligibility in a prior application based on medical factors, a determination of presumptive eligibility in any subsequent application for long-term care services or home- and community-based waiver services must be made only if there is sufficient evidence of a worsening of the individual's physical or mental condition, or the existence of a new impairment, that demonstrates a need for allowing a subsequent decision regarding presumptive eligibility.

DHMH and DHR must report monthly on:

- the number of pending Medicaid applications and the length of time each application has been pending;
- the number of applications that were approved in the previous month;

- the number of applications that were denied in the previous month and the reason for denial;
- the number of Medicaid recipients who previously applied for a redetermination and whose benefits were terminated in the previous month and the reason for the termination;
- the number of applications that were denied for failure to provide information where no written request for information had been made by DHMH;
- the number of applicants who were determined to be presumptively eligible for Medicaid in the previous month; and
- the measures taken by the departments to streamline the application process and eliminate delays in processing applications for Medicaid long-term care services.

Current Law/Background: Medicaid provides health care coverage to children, pregnant women, elderly or disabled individuals, and indigent parents who pass certain income and asset tests. DHMH is responsible for administering and overseeing Medicaid and determines the eligibility rules. DHR is responsible for management of the Client Automated Resource and Eligibility System (CARES), the computer system for all eligibility information, and the initial determination and annual redetermination of eligibility for most Medicaid programs, including long-term care. DHMH staff determines eligibility for the Primary Adult Care program, home- and community-based services waiver programs, and the Maryland Children's Health Program.

Applications for the Medicaid program must be processed within 30 days or 60 days if a disability determination is necessary. Federal regulations require that Medicaid long-term care applications be processed within 45 days.

Chapters 613 and 614 of 2008 required DHMH and DHR to develop a plan to integrate the functions necessary for the determination of Medicaid eligibility for long-term care services. A plan was completed by DHMH and DHR, in consultation with LifeSpan Network and the Health Facilities Association of Maryland, and a report was submitted to the General Assembly in December 2008. The report presented the following recommendations: (1) adopt uniform forms; (2) eliminate the face-to-face interview; (3) centralize long-term care eligibility functions; (4) develop a new automated eligibility system; and (5) consider transferring direct control of all long-term care eligibility functions to DHMH once a new automated eligibility system is fully operational. New forms were implemented and the face-to-face interview requirement was eliminated effective December 1, 2008.

In 2009, the State opened a Bureau of Long-Term Care Eligibility, which combines the local departments of social services offices of Anne Arundel, Baltimore, and

Prince George's counties and Baltimore City. Though the bureau was intended to expedite eligibility cases, delays have continued and, to some extent, worsened.

In January 2011, DHMH and DHR submitted a long-term care business process analysis and reengineering work plan to address concerns repeatedly raised by the nursing facility industry and consumer advocates. The plan, much of which is based on the processes used in Virginia, includes the goal of streamlining the application and redetermination processes.

Federal law allows states to provide presumptive eligibility – upfront temporary coverage pending documentation of eligibility factors – to pregnant women, children, and women with breast and cervical cancer. Federal rules prohibit presumptive eligibility for the long-term care population. Medicaid does not currently provide presumptive eligibility to any populations.

State Fiscal Effect: Total expenditures increase by $49.7 million in fiscal 2013 to implement the bill. Most of the expense is related to providing presumptive eligibility; another $1.1 million is needed to administer the bill.

Medicaid general fund expenditures increase by as much as $48.6 million in fiscal 2013 to provide presumptive eligibility under the bill. This estimate is based on the following information and assumptions:

- annually, approximately 5,784 long-term care Medicaid applications are still pending after 60 days from the date of application;
- DHMH indicates that these applications are all for nursing home care as home- and community-based waiver applications are processed by DHMH within 60 days;
- on average, it takes DHR 90 days to process a long-term care application;
- all 5,784 individuals will be granted 90 days of presumptive eligibility until their application is finalized and they are determined eligible or ineligible for Medicaid;
- the estimated cost of care for each individual granted 90 days of presumptive eligibility will be $21,000;
- 40% of the individuals granted presumptive eligibility under the bill (2,314) will ultimately be found *ineligible* for Medicaid;
- the cost to provide 90 days of presumptive eligibility to those individuals who are later found ineligible for Medicaid will be $48.6 million in fiscal 2013; and
- as federal law prohibits presumptive eligibility for the long-term care population, any presumptive eligibility expenditures must be paid exclusively with general funds.

This estimate *does not* include the cost of providing retroactive benefits (*i.e.,* benefits for up to three months prior to the date of the application) or any other coverage enhancements above current law. Therefore, Medicaid expenditures could be significantly higher under the bill.

Expenditures at DHMH further increases by $234,317 (29% general funds, 71% federal funds), to reprogram the Medicaid Management Information Systems (MMIS) computer system and hire one part-time (50%) budget specialist to ensure that federal matching funds are not claimed for individuals initially granted presumptive eligibility and later found ineligible for Medicaid. This estimate accounts for the bill's July 1, 2012 effective date and includes a salary, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Position	0.5
MMIS Computer System Changes	$200,000
Salary and Fringe Benefits	27,901
One-time Start-up Costs	4,485
Other Operating Expenses	1,931
Total FY 2013 DHMH Administrative Expenditures	**$234,317**

Future years reflect a full salary with annual increases, employee turnover, and annual increases in operating expenditures.

To the extent that additional resources are provided to the departments in future years sufficient to achieve timely and accurate eligibility determinations within the required timeframes, the need for presumptive eligibility will be reduced. In turn, estimated expenditures under the bill will correspondingly decline.

DHR expenditures increase by $889,261 (40% general funds, 60% federal funds) in fiscal 2013, which accounts for the bill's July 1, 2012 effective date. This estimate reflects the cost of reprogramming the CARES system to process and track presumptive eligibility and hiring nine full-time and one part-time (50%) staff to track individuals who would qualify for presumptive eligibility and transmit the results to DHMH. It includes salaries, fringe benefits, one-time start-up costs, and ongoing operating expenses.

Positions	9.5
Salaries and Fringe Benefits	$569,196
CARES Computer System Changes	250,000
One-time Start-up Costs	41,340
Other Operating Expenses	28,725
Total FY 2013 DHR Expenditures	**$889,261**

Future years reflect salaries with annual increases, employee turnover, and annual increases in operating expenditures.

Article III, § 52 of the Maryland Constitution governs the State budget process. In most cases, only the Governor may determine the amount of funding for a program or purpose. However, the Maryland Constitution prohibits the Governor from "reducing an estimate for a program below a level of funding prescribed by a law which will be in effect during the fiscal year covered by the Budget, and which was enacted before July 1 of the fiscal year prior thereto." According to the Attorney General's Office (see 64 Opinions of the Attorney General 108 (1980)), the mandated funding language included in this bill does not qualify as a funding mandate under the Maryland Constitution because it does not include a dollar amount or an objective basis from which a level of funding can be computed.

Additional Information

Prior Introductions: Similar legislation, SB 843 of 2011, was heard by the Senate Finance Committee, but no further action was taken on the bill.

Cross File: HB 1029 (Delegates Braveboy and Alston) - Health and Government Operations.

Information Source(s): Department of Health and Mental Hygiene, Department of Legislative Services

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mc/mwc

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