Legislative Analysis

House Fiscal Agency

FOOD ASSISTANCE AND MEDICAID PROGRAMS

House Bills 5462 and 5463 as introduced
Sponsor: Rep. Pat Outman
Committee: Families, Children and Seniors
Revised 2-8-21

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Analysis available at
http://www.legislature.mi.gov

SUMMARY:

Taken together, House Bills 5462 and 5463 would amend the Social Welfare Act to specify procedures for the Department of Health and Human Services (DHHS) to receive and review information to ascertain an individual's eligibility for food assistance and Medicaid programs. House Bill 5462 addresses eligibility issues related to the Medicaid program. House Bill 5463 addresses public disclosures related to intentional program violations or investigated fraud cases.

House Bill 5462 would require DHHS to enter into a data matching agreement with the Bureau of State Lottery, Michigan Gaming Control Board, and any other relevant board or agency to identify, on at least a monthly basis, households with lottery or gambling winnings of $3,000 or more. DHHS would have to review this information and adjust or terminate medical assistance eligibility as necessary.

The bill also would require DHHS to do the following at least monthly:

- Receive and review information from the state registrar, including death records, concerning individuals enrolled in medical assistance that could indicate a change in circumstances that could affect eligibility.
- Review information concerning individuals enrolled in medical assistance that could indicate a change in circumstances affecting eligibility, including potential changes in residency as identified by out-of-state electronic benefit transfer (EBT) transactions.

At least quarterly, DHHS would have to receive and review information from the Unemployment Insurance Agency concerning individuals enrolled in medical assistance that could indicate a change in circumstances affecting eligibility, such as changes in employment or wages. The Unemployment Insurance Agency would have to provide required information to DHHS each quarter in compliance with the Michigan Employment Security Act.

DHHS could not accept any eligibility determinations for medical assistance from an exchange established under 42 USC 18041(c).[1] It could accept assessments from such an exchange, but it would have to verify eligibility and make eligibility determinations.

DHHS would have to review the case of any individual enrolled in medical assistance about whom it received information that indicated a change in circumstances affecting eligibility.

Memorandum of understanding

Under the bill, DHHS could execute a memorandum of understanding with any other state department, agency, or division for information required to be shared between agencies

[1] https://www.law.cornell.edu/uscode/text/42/18041

outlined in the bill. The bill would not prohibit DHHS from contracting with one or more independent vendors to provide additional data or information that could indicate a change in circumstances or eligibility.

Department prohibitions

Unless required under federal law, DHHS could not do any of the following:

- Designate itself as a qualified health entity for the purpose of making a Medicaid presumptive eligibility determination or for any purpose not expressly authorized by state law.
- Accept self-attestation for income, residency, age, household composition, caretaker or relative status, or receipt of other coverage without verification before enrolling an individual in Medicaid.
- Request authority to waive checking or decline to periodically check any available income-related data source to verify Medicaid eligibility.
- Request authority to waive or decline to comply with public notice requirements applicable to proposed changes in the state plan according to federal law.

Hospital presumptive eligibility determination

In making a presumptive eligibility determination, the hospital would have to do the following:

- Notify DHHS of each presumptive eligibility determination within five working days after the date the determination was made.
- Assist individuals determined to be presumptively eligible with completing and submitting a full Medicaid application form.
- Notify the applicant in writing and on all relevant forms with plain language and large print that if the applicant does not file a full Medicaid application with DHHS before the last day of the following month, presumptive eligibility coverage will end on that last day.
- Notify the applicant that if he or she files a full Medicaid application with DHHS before the last day of the following month, presumptive eligibility coverage will continue until an eligibility determination is made on the application that was filed.

Department standards for accurate presumptive eligibility determinations

DHHS would have to use the following standards to ensure that accurate presumptive eligibility determinations are made by each qualified hospital:

- Was the Medicaid presumptive eligibility card received by DHHS within five working days after the determination date?
- Was a full Medicaid application received by DHHS before the presumptive eligibility period expired?
- If a full application was received, was the individual found to be eligible for full Medicaid coverage?

Consequences for not meeting presumptive determination standard

DHHS would have to notify a qualified hospital in writing within five days after it determines that the hospital failed to meet a standard established for a presumptive determination. The notice would have to include the following:

- A description of the standard that was not met and an explanation of why it was not met.

- Confirmation that a second finding will require all applicable hospital staff to participate in mandatory training on hospital presumptive eligibility rules and regulations to be conducted by DHHS.

If within a year of a violation a qualified hospital again fails to meet a standard established for a presumptive eligibility determination, DHHS would have to notify the hospital in writing within five days after determining that the standard was not met. The written notice would have to include the following:

- A description of the standard that was not met and an explanation of why it was not met.
- Confirmation that all applicable hospital staff are required to participate in a mandatory training on hospital presumptive eligibility rules and regulations to be conducted by DHHS, including the date, time, and location of the training as determined by DHHS.
- A description of available appellate procedures by which a qualified hospital could dispute the finding of failure and remove the finding by providing clear and convincing evidence that the standard was met.
- Confirmation that if the hospital again fails to meet one or more of the standards for presumptive eligibility for a determination, it would no longer be qualified to make presumptive eligibility determinations.

If within a year of a second violation as described above a qualified hospital again fails to meet a standard established for a presumptive eligibility determination, DHHS would have to notify the hospital in writing within five days after determining that the standard was not met. The written notice would have to include the following:

- A description of the standard that was not met and an explanation of why it was not met.
- A description of available appellate procedures by which a qualified hospital could dispute the finding of failure and remove the finding by providing clear and convincing evidence that the standard was met.
- Confirmation that, effective immediately, the hospital is no longer qualified to make Medicaid presumptive eligibility determinations.

<u>Department funding for Medicaid</u>
DHHS would have to do all of the following when it receives funding for Medicaid contingent on temporary maintenance of effort restrictions or is limited in its ability to disenroll individuals, such as by restrictions imposed by the federal Families First Coronavirus Response Act:

- Continue to conduct redeterminations as in the normal course of business and act on the redeterminations to the fullest extent permissible under the law.
- Within 60 days after the restrictions expire, complete a full audit by doing the following:
    - Completing and acting on eligibility redeterminations for all cases that have not had a redetermination within the last 12 months.
    - Requesting federal approval from the Centers for Medicare and Medicaid Services for the authority to conduct and act on eligibility redeterminations for each individual enrolled during the period of restrictions enrolled for three or more total months and, within 60 days after approval, conduct and act on the redeterminations.

- Carry out an additional check of all verification measures established to verify eligibility and act on the information checked.
- Submit a summary report of the audit to the speaker of the house of representatives and the senate majority leader.

MCL 400.105c

House Bill 5463 would require DHHS to enter into a data matching agreement with the Bureau of State Lottery, Michigan Gaming Control Board, and any other relevant board or agency to identify, on at least a monthly basis, households with lottery or gambling winnings of $3,000 or more. To the extent permissible under federal law, DHHS would have to treat this data as verified upon receipt. To the extent it may not be verified upon receipt, DHHS would have to make referrals for further investigation to identify households with winnings equal to or greater than the resource limit for elderly or disabled households as defined in federal rules. Households failing to disclose winnings and identified through the database match would be presumed to have committed an intentional program violation.

At least quarterly, DHHS would have to receive and review information from the Unemployment Insurance Agency concerning individuals enrolled in public assistance that could indicate a change in circumstances affecting eligibility, such as changes in employment or wages. The Unemployment Insurance Agency would have to provide required information to DHHS each quarter in compliance with the Michigan Employment Security Act.

The bill also would require DHHS to do the following at least monthly:

- Receive and review information from the state registrar, including death records, concerning individuals enrolled in public assistance that could indicate a change in circumstances that could affect eligibility.
- Review information concerning individuals enrolled in public assistance that could indicate a change in circumstances affecting eligibility, including potential changes in residency as identified by out-of-state electronic benefit transfer (EBT) transactions.

At least quarterly, DHHS would have to make available to the pubic on its website data from findings of noncompliance and fraud investigations in public assistance for the following aggregate and nonconfidential and information that does not personally identify a recipient:

- The number of public assistance cases investigated for intentional program violations or fraud.
- The number of public assistance cases referred to the attorney general's office for prosecution.
- Improper payments and expenditures.
- Money recovered.
- Aggregate data concerning improper payments and ineligible recipients.
- The aggregate amount of funds expended by EBT card transaction in each other state.

DHHS would have to review the case of any individual enrolled in public assistance about whom it received information that indicated a change in circumstances affecting eligibility.

MCL 400.105c and MCL 400.10f

FISCAL IMPACT:

House Bills 5462 and 5463 would have an indeterminate fiscal impact on the Department of Health and Human Services (DHHS) related to any administrative costs necessary to provide for the required inter-agency agreements, reviews of medical assistance and public assistance cases, and modifying current reporting requirements/frequency of reporting. Such costs would likely include additional personnel hours and modifying information technology software systems.

DHHS currently requires Food Assistance Program (FAP) recipients to report lottery/gambling winnings of $3,750 or more within 10 days of receiving the cash asset, in accordance with Bridges Eligibility Manual (BEM) 403,[2] as of February 8, 2022. This is similar to the proposed requirement within House Bill 5462 to review medical assistance cases on a monthly basis for winnings of $3,000 or more. However, DHHS may have to modify current methodology for verification of the self-reporting to make it specific to the medical assistance case review requirements proposed, specifically the required review of medical assistance cases monthly in lieu of self-reporting and standard eligibility reevaluation.

In accordance with section 10f(3) of 1939 PA 280, DHHS is already required to perform monthly reviews of the United States Social Security Death Index Database for individuals who have already been issued Michigan Bridge Cards, in order to verify whether or not a recipient is deceased. DHHS would have to apply this requirement to medical assistance as well to meet the requirements of House Bill 5462.

DHHS currently assesses for intentional program violations of public assistance programs—such as the trafficking of Michigan Bridge cards and identifying recipients living out of the state—through the department's Office of Inspector General, which reports annually to the legislature in accordance with section 672(1) of the annual appropriations bill(s).[3] However, DHHS would have to modify the reporting frequency to meet the requirements proposed within these bills.

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■ This analysis was prepared by nonpartisan House Fiscal Agency staff for use by House members in their deliberations and does not constitute an official statement of legislative intent.

[2] https://dhhs.michigan.gov/OLMWEB/EX/BP/Public/BEM/403.pdf
[3] https://www.michigan.gov/documents/mdhhs/Section_672-1_713825_7.pdf