Testimony on House Bill 2320

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Good morning, Chairwoman Madden, Chairman Mentzer, committee members, and staff. My name is Hoa Pham, and I am the Deputy Secretary for the Office of Income Maintenance in the Pennsylvania Department of Human Services (DHS). Thank you for the opportunity to testify today regarding House Bill 2320, the subject of which is Medicaid Pendency and Timely Reimbursement for Long-Term Nursing Home Care. I am here to explain why the Department opposes this bill in its current form.

HB 2320 proposes to allow nursing facilities to request a payment when a Long-Term Care (LTC) facility eligibility determination is not made within 60 days of the date the application is submitted to DHS. Upon the provider's request, a payment would be made by the Commonwealth to the provider as though the application were approved, beginning on the date of the request. Under the bill, DHS could recover, offset, or recoup the cost of the payment within 60 days from the date of the provider's request if the eligibility determination is ultimately denied. If the application is approved, the Department may offset payments due for the period between the date of the provider's request and the final determination by deducting amounts already paid.

The Department is concerned that the provisions of HB 2320 may ultimately delay timely eligibility determinations, impact program integrity, violate federal HIPAA regulations around sharing of client information, conflict with federal guidance from the Centers for Medicare and Medicaid Services on valid recoupment, and result in significant costs to taxpayers.

Federal regulations at 42 CFR § 435.912 (relating to timely determination and redetermination of eligibility) set a 90-day standard for processing Medicaid applications for the aged, blind, and disabled populations due to the complexity of determining eligibility for these vulnerable groups. These benefit categories have requirements above and beyond what is required for non-LTC benefits, such as evaluating available resources and verifying assets were transferred in accordance with fair

consideration rules prior to the application's submission. In recognition of this, the federal government established the 90-day timeliness standard to allow state agencies sufficient time to accurately determine eligibility. In Pennsylvania, our policy is to process these applications within 30 days and extend the period to 45 days if needed. *See also* 55 Pa. Code § 125.84(e) (eligibility determined promptly; preferably within 30 days). This review can be extended further in unusual circumstances beyond the County Assistance Office's (CAO) control.

A review of DHS data from August 2023 to August 2024 shows that LTC applications are consistently processed in a timely manner. On average, 81.9% of approved LTC applications are processed within 30 days, and 98.5% are processed within 45 days. Additionally, internal quality control reviews confirm that LTC rejections are both timely and accurate. For example, in March 2024, DHS randomly reviewed 50 LTC applications rejected for failure to provide verifications. We found that 49 of the 50 closures (98%) were accurate and timely. Additionally, no backlogs in case processing were identified in this sample, and most rejected applicants and the facilities providing care were made whole once the necessary verifications were provided to the Department, either through reconsideration or the appeals process.

Despite these positive outcomes, we recognize that some applicants require longer periods to determine eligibility. DHS acknowledges that the high value of the care provided by facilities makes it critical that, even in these limited cases, prompt eligibility determinations and payments ensure that providers can continue serving those in their care.

In many cases where an eligibility determination for LTC is pending, the delay is due to difficulties in identifying and verifying necessary information about income, resources, insurance, or other assets from the applicant, their designated representative, third parties, or electronically. To alleviate the administrative burden on clients, providers, and third parties holding client information,

DHS uses information systems such as data exchanges and the Asset Verification System (AVS) to obtain as much needed client information as possible. Data exchanges and AVS can provide DHS with some employment income, bank account, and property information. Unfortunately, these services cannot verify all sources of income, resources, or property. When verifications are not provided by the client or available electronically, DHS' CAOs can help to obtain documentation if assistance is requested. CAOs have two forms that can be useful: the *Request for Financial Information,* which can be sent to banks if the AVS does not verify the applicant's information, and the *Request for Insurance Data,* which is sent to insurance companies for information not available to DHS electronically.

Here are some common situations that may lead to eligibility determinations exceeding DHS's standard timeframe for approval or denial:

- Applications for Medicaid coverage are not submitted immediately before or after admission to a nursing facility – Medicaid coverage can be requested retroactively for up to 90 days, as long as the individual would have been eligible during that time. These retroactive applications have the same 30/45-day timelines for processing. It is common for some LTC facilities to submit multiple applications on the same day each month. Often, these applications are for residents who have been in the facility for some time, making the process seem longer. For example, an application submitted on September 30th could be requesting eligibility dating back to June.
- Incomplete applications are submitted to DHS – A Medicaid application is considered valid as long as it includes a name, address, and signature. A valid application must be logged and processed within the standard 30/45 day timeline. Unfortunately, this policy allows individuals, their family members, or facilities to submit incomplete applications, which can delay the process due to missing information or documentation. This can hinder DHS' ability to process efficiently, as incomplete submissions often require additional follow-up.

- Undisclosed income and/or resource information is discovered – During the verification process, it is common for DHS to identify previously undisclosed income or resources. Bank statements are an example of provided documentation that can reveal deposits from unreported income sources or asset transfers. This requires an additional request for information, extending the processing time by 15 days to allow the applicant to gather and submit the required verifications.
- Financial institutions fail to comply with requests for information – County Assistance Offices (CAOs) can help to obtain documentation through Requests for Financial Information sent to banks or other financial institutions and Requests for Insurance Data sent to insurance companies. Unfortunately, some financial institutions fail to comply with these requests, requiring additional follow-up with the applicant to obtain the necessary information, further delaying the application process.

To put this in perspective, consider the following common scenario. Please note: The names are fictional, but the circumstances are based on real cases.

Mary Matthews has been residing in Happy Meadows Nursing Community since June 1, 2024. On September 30, 2024, representatives from Happy Meadows submit a valid Medicaid application consisting only of Mary's name, address, and signature, along with a request for coverage starting in June. On October 4, 2024, the CAO caseworker reviews the application and available data sources and discovers that additional information is needed to determine eligibility. The caseworker sends a notice to Mary, listing the documentation needed to process the application, which is due in 15 days. Happy Meadows receives the request and works with Mary and her family to gather the requested documentation, which is submitted to the CAO on October 19, 2024, within the required 15-day timeframe. However, during the review of Mary's bank statements, the CAO caseworker notices a deposit from an income source not disclosed on the initial application. The CAO is now required to send

a second notice requesting verification of the undisclosed income, adding another 15-day period to provide the information. Additionally, the CAO caseworker sends a letter to Mary to let her know the timeframe for reviewing her application has been extended from 30 days (October 30, 2024) to 45 days (November 14, 2024). Happy Meadows works with Mary and determines the income is from a forgotten pension. The verification of this pension income is difficult for Mary to obtain and is not provided to the CAO by November 14th. The application is rejected timely on November 15, 2024, and DHS sends Mary a notice explaining the application was rejected due to missing pension verification and outlining Mary's right to appeal the Department's decision. Mary and Happy Meadows submit appeal paperwork to the CAO on December 2, 2024, and a caseworker calls Mary and Happy Meadows to discuss what is needed to finish the application. The hearing is scheduled on December 20, 2024, and at the hearing, Mary and the CAO enter into a stipulated agreement to provide the pension verification dating back to June. On January 5, 2025, Mary and Happy Meadows submit the verification, and after accounting for mail delivery and case processing time, on January 18, 2025, the CAO determines Mary eligible for Medicaid retroactive to June 1, 2024. This process—working piecemeal to gather the necessary documentation — took nearly seven months to complete.

As previously stated, DHS' believes HB 2320 may in fact further delay proper eligibility determinations by removing the incentive for facilities to assist clients in obtaining necessary documentation. Many facilities currently work diligently to help their clients with Medicaid LTC applications, often acting as the client's representative or supporting family members who are doing so. However, under HB 2320, facilities would receive payments regardless of whether a Medicaid eligibility determination is pending. While the bill includes recoupment provisions, this process may be adversarial, costly and time limited. If DHS cannot recoup funds, facilities may have little incentive to assist residents in Mary's position. Federal rules also expressly prohibit DHS from recouping LTC

benefits, except in cases fraud, estate recovery, or overpayments related to service reduction or termination.

Further, it is unclear why HB 2320 proposes a 60-day timeframe for the state to make a payment to the facility when 98.5% of approved LTC applications are processed within 45 days. Rejections due to failure to provide verifications account for an extremely small portion of applications – just 1.5% of the 24,000 LTC rejections issued last year. Most rejections, like those in the Mary Matthews example, are ultimately approved after reconsideration or appeal once the required documentation is provided.

Additionally, limiting the recoupment period to the first 60 days after the state payment request introduces a timeline that conflicts with existing federal (90 days) and state (45 days) eligibility determination standards. If CAOs were to expedite eligibility determinations without thorough review of the unique circumstances of each case, DHS risks making improper eligibility determinations, leading to potential citations for payment errors by the federal Centers for Medicare and Medicaid Services' (CMS). LTC errors involve significant financial sums, and improper payments could result in CMS penalties, including potential disallowance of federal reimbursement as well as loss of federal medical assistance percentage (FMAP). This would endanger over $31.8 billion in federal matching funds that support the Medicaid program.

HB 2320, as proposed, would require DHS to make payments but does not specify the funding source. DHS is unaware of any federal regulations allowing a federal match for such payments under Pennsylvania's Medicaid program. The payments would therefore need to be fully funded by the state, and DHS would not have the necessary funds unless the General Assembly appropriates them. Further, DHS cannot calculate payment amounts before first completing the financial eligibility determination. The bill states that this payment would be "as though the application were approved." The amount paid

to the facility is based on the difference between the rate set by the Managed Care Organization (MCO) and the patient pay amount. The eligibility determination process sets the stage for the both the individual's MCO selection, and the related patient pay amount. It is worth noting here that an individual's MCO is automatically selected for them if they do not actively choose their own MCO. The individual's MCO may also not have been selected depending on the individual's pre-institutionalization circumstance.

Even if DHS were able to determine the amount of the state payments, significant changes would be required to update DHS' provider information system, PROMISe, and client information system, eCIS, to issue payments and flag cases for potential recoupment. The cost to create necessary system changes to recover these costs for so few cases would be time consuming and exorbitant.

There are also significant concerns about information sharing in this legislation. HB 2320 would require DHS to share client information, including application status and authorized representatives, with facilities, even without client consent. A complete application for Medicaid is an application that includes the name, address, and signature of the client. This bill could be interpreted as granting facilities the right to access further details about pending applications, which could violate federal HIPAA regulations. Currently, a signed release of information from an applicant or applicant's representative is required before any information regarding an application for benefits can be provided. The information disclosure requirements of HB 2320 risk breaching client confidentiality by bypassing this consent process.

DHS appreciates LTC providers' interest in faster eligibility determinations, and we share that goal. As noted, 98.5% of LTC approved applications are processed within 45 days, and 98% of rejections are accurate and timely. And while we are proud of this systemwide success, we also understand that 98.5% timeliness is not 100% timeliness. To improve further in these areas, in the last 6 months alone

our team has consolidated and enhanced long-term care expertise by creating long-term care processing hubs. Further, we have targeted resources to address operational concerns raised in Allegheny County, specifically onboarding additional caseworkers and tightening our processes to ensure that application and verification documents are progressed to caseworker review within two business days. And finally, DHS has shared local points of contact for providers to escalate and address areas of concern.

However, HB 2320, as currently proposed, would negatively impact this progress and could pressure CAOs to determine LTC eligibility in a timeframe far less than federally required – compromising accuracy and program integrity, creating financial burdens on Pennsylvania taxpayers, requiring extensive system changes, reducing the incentive for providers to assist with the application process, and potentially violating the privacy of LTC clients.

I would like to again thank both Chairs and the committee members for the opportunity to testify today on this important matter.