

HB2659



101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB2659

by Rep. Norine K. Hammond

SYNOPSIS AS INTRODUCED:

305 ILCS 5/11-5.4

Amends the Illinois Public Aid Code. Makes technical changes to specify in provisions concerning provisional eligibility for long-term care services that the Department of Healthcare and Family Services shall adopt rules. Effective immediately.

LRB101 09331 KTG 54427 b

A BILL FOR

1 AN ACT concerning public aid.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 5. The Illinois Public Aid Code is amended by
5 changing Section 11-5.4 as follows:

6 (305 ILCS 5/11-5.4)

7 Sec. 11-5.4. Expedited long-term care eligibility
8 determination and enrollment.

9 (a) Establishment of the expedited long-term care
10 eligibility determination and enrollment system shall be a
11 joint venture of the Departments of Human Services and
12 Healthcare and Family Services and the Department on Aging.

13 (b) Streamlined application enrollment process; expedited
14 eligibility process. The streamlined application and
15 enrollment process must include, but need not be limited to,
16 the following:

17 (1) On or before July 1, 2019, a streamlined
18 application and enrollment process shall be put in place
19 which must include, but need not be limited to, the
20 following:

21 (A) Minimize the burden on applicants by
22 collecting only the data necessary to determine
23 eligibility for medical services, long-term care

1 services, and spousal impoverishment offset.

2 (B) Integrate online data sources to simplify the
3 application process by reducing the amount of
4 information needed to be entered and to expedite
5 eligibility verification.

6 (C) Provide online prompts to alert the applicant
7 that information is missing or not complete.

8 (D) Provide training and step-by-step written
9 instructions for caseworkers, applicants, and
10 providers.

11 (2) The State must expedite the eligibility process for
12 applicants meeting specified guidelines, regardless of the
13 age of the application. The guidelines, subject to federal
14 approval, must include, but need not be limited to, the
15 following individually or collectively:

16 (A) Full Medicaid benefits in the community for a
17 specified period of time.

18 (B) No transfer of assets or resources during the
19 federally prescribed look-back period, as specified in
20 federal law.

21 (C) Receives Supplemental Security Income payments
22 or was receiving such payments at the time of admission
23 to a nursing facility.

24 (D) For applicants or recipients with verified
25 income at or below 100% of the federal poverty level
26 when the declared value of their countable resources is

1 no greater than the allowable amounts pursuant to
2 Section 5-2 of this Code for classes of eligible
3 persons for whom a resource limit applies. Such
4 simplified verification policies shall apply to
5 community cases as well as long-term care cases.

6 (3) Subject to federal approval, the Department of
7 Healthcare and Family Services must implement an ex parte
8 renewal process for Medicaid-eligible individuals residing
9 in long-term care facilities. "Renewal" has the same
10 meaning as "redetermination" in State policies,
11 administrative rule, and federal Medicaid law. The ex parte
12 renewal process must be fully operational on or before
13 January 1, 2019.

14 (4) The Department of Human Services must use the
15 standards and distribution requirements described in this
16 subsection and in Section 11-6 for notification of missing
17 supporting documents and information during all phases of
18 the application process: initial, renewal, and appeal.

19 (c) The Department of Human Services must adopt policies
20 and procedures to improve communication between long-term care
21 benefits central office personnel, applicants and their
22 representatives, and facilities in which the applicants
23 reside. Such policies and procedures must at a minimum permit
24 applicants and their representatives and the facility in which
25 the applicants reside to speak directly to an individual
26 trained to take telephone inquiries and provide appropriate

1 responses.

2 (d) Effective 30 days after the completion of 3 regionally
3 based trainings, nursing facilities shall submit all
4 applications for medical assistance online via the Application
5 for Benefits Eligibility (ABE) website. This requirement shall
6 extend to scanning and uploading with the online application
7 any required additional forms such as the Long Term Care
8 Facility Notification and the Additional Financial Information
9 for Long Term Care Applicants as well as scanned copies of any
10 supporting documentation. Long-term care facility admission
11 documents must be submitted as required in Section 5-5 of this
12 Code. No local Department of Human Services office shall refuse
13 to accept an electronically filed application. No Department of
14 Human Services office shall request submission of any document
15 in hard copy.

16 (e) Notwithstanding any other provision of this Code, the
17 Department of Human Services and the Department of Healthcare
18 and Family Services' Office of the Inspector General shall,
19 upon request, allow an applicant additional time to submit
20 information and documents needed as part of a review of
21 available resources or resources transferred during the
22 look-back period. The initial extension shall not exceed 30
23 days. A second extension of 30 days may be granted upon
24 request. Any request for information issued by the State to an
25 applicant shall include the following: an explanation of the
26 information required and the date by which the information must

1 be submitted; a statement that failure to respond in a timely
2 manner can result in denial of the application; a statement
3 that the applicant or the facility in the name of the applicant
4 may seek an extension; and the name and contact information of
5 a caseworker in case of questions. Any such request for
6 information shall also be sent to the facility. In deciding
7 whether to grant an extension, the Department of Human Services
8 or the Department of Healthcare and Family Services' Office of
9 the Inspector General shall take into account what is in the
10 best interest of the applicant. The time limits for processing
11 an application shall be tolled during the period of any
12 extension granted under this subsection.

13 (f) The Department of Human Services and the Department of
14 Healthcare and Family Services must jointly compile data on
15 pending applications, denials, appeals, and redeterminations
16 into a monthly report, which shall be posted on each
17 Department's website for the purposes of monitoring long-term
18 care eligibility processing. The report must specify the number
19 of applications and redeterminations pending long-term care
20 eligibility determination and admission and the number of
21 appeals of denials in the following categories:

22 (A) Length of time applications, redeterminations, and
23 appeals are pending - 0 to 45 days, 46 days to 90 days, 91
24 days to 180 days, 181 days to 12 months, over 12 months to
25 18 months, over 18 months to 24 months, and over 24 months.

26 (B) Percentage of applications and redeterminations

1 pending in the Department of Human Services' Family
2 Community Resource Centers, in the Department of Human
3 Services' long-term care hubs, with the Department of
4 Healthcare and Family Services' Office of Inspector
5 General, and those applications which are being tolled due
6 to requests for extension of time for additional
7 information.

8 (C) Status of pending applications, denials, appeals,
9 and redeterminations.

10 (g) Beginning on July 1, 2017, the Auditor General shall
11 report every 3 years to the General Assembly on the performance
12 and compliance of the Department of Healthcare and Family
13 Services, the Department of Human Services, and the Department
14 on Aging in meeting the requirements of this Section and the
15 federal requirements concerning eligibility determinations for
16 Medicaid long-term care services and supports, and shall report
17 any issues or deficiencies and make recommendations. The
18 Auditor General shall, at a minimum, review, consider, and
19 evaluate the following:

20 (1) compliance with federal regulations on furnishing
21 services as related to Medicaid long-term care services and
22 supports as provided under 42 CFR 435.930;

23 (2) compliance with federal regulations on the timely
24 determination of eligibility as provided under 42 CFR
25 435.912;

26 (3) the accuracy and completeness of the report

1 required under paragraph (9) of subsection (e);

2 (4) the efficacy and efficiency of the task-based
3 process used for making eligibility determinations in the
4 centralized offices of the Department of Human Services for
5 long-term care services, including the role of the State's
6 integrated eligibility system, as opposed to the
7 traditional caseworker-specific process from which these
8 central offices have converted; and

9 (5) any issues affecting eligibility determinations
10 related to the Department of Human Services' staff
11 completing Medicaid eligibility determinations instead of
12 the designated single-state Medicaid agency in Illinois,
13 the Department of Healthcare and Family Services.

14 The Auditor General's report shall include any and all
15 other areas or issues which are identified through an annual
16 review. Paragraphs (1) through (5) of this subsection shall not
17 be construed to limit the scope of the annual review and the
18 Auditor General's authority to thoroughly and completely
19 evaluate any and all processes, policies, and procedures
20 concerning compliance with federal and State law requirements
21 on eligibility determinations for Medicaid long-term care
22 services and supports.

23 (h) The Department of Healthcare and Family Services shall
24 adopt any rules necessary to administer and enforce any
25 provision of this Section. Rulemaking shall not delay the full
26 implementation of this Section.

1 ~~(g) The Department shall adopt rules necessary to~~
2 ~~administer and enforce any provision of this Section.~~
3 ~~Rulemaking shall not delay the full implementation of this~~
4 ~~Section.~~

5 (i) ~~(h)~~ Beginning on June 29, 2018, provisional
6 eligibility, in the form of a recipient identification number
7 and any other necessary credentials to permit an applicant to
8 receive benefits, must be issued to any applicant who has not
9 received a final eligibility determination on his or her
10 application for Medicaid or Medicaid long-term care benefits or
11 a notice of an opportunity for a hearing within the federally
12 prescribed deadlines for the processing of such applications.
13 The Department must maintain the applicant's provisional
14 Medicaid enrollment status until a final eligibility
15 determination is approved or the applicant's appeal has been
16 adjudicated and eligibility is denied. The Department or the
17 managed care organization, if applicable, must reimburse
18 providers for services rendered during an applicant's
19 provisional eligibility period.

20 (1) Claims for services rendered to an applicant with
21 provisional eligibility status must be submitted and
22 processed in the same manner as those submitted on behalf
23 of beneficiaries determined to qualify for benefits.

24 (2) An applicant with provisional enrollment status
25 must have his or her benefits paid for under the State's
26 fee-for-service system until the State makes a final

1 determination on the applicant's Medicaid or Medicaid
2 long-term care application. If an individual is enrolled
3 with a managed care organization for community benefits at
4 the time the individual's provisional status is issued, the
5 managed care organization is only responsible for paying
6 benefits covered under the capitation payment received by
7 the managed care organization for the individual.

8 (3) The Department, within 10 business days of issuing
9 provisional eligibility to an applicant, must submit to the
10 Office of the Comptroller for payment a voucher for all
11 retroactive reimbursement due. The Department must clearly
12 identify such vouchers as provisional eligibility
13 vouchers.

14 (Source: P.A. 99-153, eff. 7-28-15; 100-380, eff. 8-25-17;
15 100-665, eff. 8-2-18; 100-1141, eff. 11-28-18.)

16 Section 99. Effective date. This Act takes effect upon
17 becoming law.