Rep. Jay Hoffman

Filed: 5/15/2018

AMENDMENT TO SENATE BILL 2913

AMENDMENT NO. _____. Amend Senate Bill 2913 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Public Aid Code is amended by changing Sections 11-5.4 and 11-6 and by adding Section 5-5g as follows:

(305 ILCS 5/5-5g new)

Sec. 5-5g. Long-term care patient; resident status. Long-term care providers shall submit all changes in resident status, including, but not limited to, death, discharge, changes in patient credit, third party liability, and Medicare coverage, to the Department through the Medical Electronic Data Interchange System, the Recipient Eligibility Verification System, or the Electronic Data Interchange System established under 89 Ill. Adm. Code 140.55(b) in compliance with the schedule below:

(1) 15 calendar days after a resident's death;

(2) 15 calendar days after a resident's discharge;

(3) 45 calendar days after being informed of a change in the resident's income;

(4) 45 calendar days after being informed of a change in a resident's third party liability;

(5) 45 calendar days after a resident's move to exceptional care services; and

(6) 45 calendar days after a resident's need for services requiring reimbursement under the ventilator or traumatic brain injury enhanced rate.

(305 ILCS 5/11-5.4)

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

(a) The Department of Healthcare and Family Services must serve as the lead agency assuming primary responsibility for the full implementation of this Section, including the establishment and operation of the system. ~~An expedited long-term care eligibility determination and enrollment system shall be established to reduce long-term care determinations to 90 days or fewer by July 1, 2014 and streamline the long-term care enrollment process. Establishment of the system shall be a joint venture of the Department of Human Services and Healthcare and Family Services and the Department on Aging. The Governor shall name a lead agency no later than 30 days after~~

~~the effective date of this amendatory Act of the 98th General Assembly to assume responsibility for the full implementation of the establishment and maintenance of the system. Project outcomes shall include an enhanced eligibility determination tracking system accessible to providers and a centralized application review and eligibility determination with all applicants reviewed within 90 days of receipt by the State of a complete application. If the Department of Healthcare and Family Services' Office of the Inspector General determines that there is a likelihood that a non-allowable transfer of assets has occurred, and the facility in which the applicant resides is notified, an extension of up to 90 days shall be permissible.~~

(b) The Department of Healthcare and Family Services must establish policies and procedures to ensure prospective compliance with the federal deadlines for Medicaid and Medicaid long-term care benefits eligibility determinations required under 42 U.S.C. 1396a(a)(8) and 42 CFR 435.912, which must include, but need not be limited to, the following:

(1) On or before January 1, 2019, ~~December 31, 2015,~~ a streamlined application and enrollment process shall be put in place which must include, but need not be limited to, the following: ~~based on the following principles:~~

(A) ~~(1)~~ Minimize the burden on applicants by collecting only the data necessary to determine eligibility for medical services, long-term care

services, and spousal impoverishment offset.

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

(C) ~~(3)~~ Provide online prompts to alert the applicant that information is missing or not complete.

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

(2) The Department of Healthcare and Family Services must expedite the eligibility processing system for applicants meeting specified guidelines, regardless of the age of the application. The guidelines must include, but need not be limited to, the following individually or collectively:

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

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

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

(D) For applicants or recipients with verified income at or below 100% of the federal poverty level

when the declared value of their countable resources is no greater than the allowable amounts pursuant to Section 5-2 of this Code for classes of eligible persons for whom a resource limit applies. Such simplified verification policies shall apply to community cases as well as long-term care cases.

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

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

(c) The Department of Healthcare and Family Services must adopt policies and procedures to improve communication between long-term care benefits central office personnel, applicants and their representatives, and facilities in which the applicants reside. Such policies and procedures must at a minimum permit applicants and their representatives and the

facility in which the applicants reside to speak directly to an individual trained to take telephone inquiries and provide appropriate responses in real time.

~~(b) The Department shall, on or before July 1, 2014, assess the feasibility of incorporating all information needed to determine eligibility for long term care services, including asset transfer and spousal impoverishment financials, into the State's integrated eligibility system identifying all resources needed and reasonable timeframes for achieving the specified integration.~~

~~(c) The lead agency shall file interim reports with the Chairs and Minority Spokespersons of the House and Senate Human Services Committees no later than September 1, 2013 and on February 1, 2014. The Department of Healthcare and Family Services shall include in the annual Medicaid report for State Fiscal Year 2014 and every fiscal year thereafter information concerning implementation of the provisions of this Section.~~

~~(d) No later than August 1, 2014, the Auditor General shall report to the General Assembly concerning the extent to which the timeframes specified in this Section have been met and the extent to which State staffing levels are adequate to meet the requirements of this Section.~~

~~(e) The Department of Healthcare and Family Services, the Department of Human Services, and the Department on Aging shall take the following steps to achieve federally established timeframes for eligibility determinations for Medicaid and~~

~~long-term care benefits and shall work toward the federal goal of real time determinations:~~

~~(1) The Departments shall review, in collaboration with representatives of affected providers, all forms and procedures currently in use, federal guidelines either suggested or mandated, and staff deployment by September 30, 2014 to identify additional measures that can improve long term care eligibility processing and make adjustments where possible.~~

~~(2) No later than June 30, 2014, the Department of Healthcare and Family Services shall issue vouchers for advance payments not to exceed $50,000,000 to nursing facilities with significant outstanding Medicaid liability associated with services provided to residents with Medicaid applications pending and residents facing the greatest delays. Each facility with an advance payment shall state in writing whether its own recoupment schedule will be in 3 or 6 equal monthly installments, as long as all advances are recouped by June 30, 2015.~~

~~(3) The Department of Healthcare and Family Services' Office of Inspector General and the Department of Human Services shall immediately forgo resource review and review of transfers during the relevant look-back period for applications that were submitted prior to September 1, 2013. An applicant who applied prior to September 1, 2013, who was denied for failure to cooperate in providing~~

~~required information, and whose application was incorrectly reviewed under the wrong look-back period rules may request review and correction of the denial based on this subsection. If found eligible upon review, such applicants shall be retroactively enrolled.~~

~~(4) As soon as practicable, the Department of Healthcare and Family Services shall implement policies and promulgate rules to simplify financial eligibility verification in the following instances: (A) for applicants or recipients who are receiving Supplemental Security Income payments or who had been receiving such payments at the time they were admitted to a nursing facility and (B) for applicants or recipients with verified income at or below 100% of the federal poverty level when the declared value of their countable resources is no greater than the allowable amounts pursuant to Section 5-2 of this Code for classes of eligible persons for whom a resource limit applies. Such simplified verification policies shall apply to community cases as well as long-term care cases.~~

~~(5) As soon as practicable, but not later than July 1, 2014, the Department of Healthcare and Family Services and the Department of Human Services shall jointly begin a special enrollment project by using simplified eligibility verification policies and by redeploying caseworkers trained to handle long term care cases to prioritize those~~

~~cases, until the backlog is eliminated and processing time is within 90 days. This project shall apply to applications for long-term care received by the State on or before May 15, 2014.~~

~~(6) As soon as practicable, but not later than September 1, 2014, the Department on Aging shall make available to long term care facilities and community providers upon request, through an electronic method, the information contained within the Interagency Certification of Screening Results completed by the pre-screener, in a form and manner acceptable to the Department of Human Services.~~

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

(e) ~~(8)~~ Notwithstanding any other provision of this Code,

the Department of Human Services and the Department of Healthcare and Family Services' Office of the Inspector General shall, upon request, allow an applicant additional time to submit information and documents needed as part of a review of available resources or resources transferred during the look-back period. The initial extension shall not exceed 30 days. A second extension of 30 days may be granted upon request. Any request for information issued by the State to an applicant shall include the following: an explanation of the information required and the date by which the information must be submitted; a statement that failure to respond in a timely manner can result in denial of the application; a statement that the applicant or the facility in the name of the applicant may seek an extension; and the name and contact information of a caseworker in case of questions. Any such request for information shall also be sent to the facility. In deciding whether to grant an extension, the Department of Human Services or the Department of Healthcare and Family Services' Office of the Inspector General shall take into account what is in the best interest of the applicant. The time limits for processing an application shall be tolled during the period of any extension granted under this subsection.

(f) ~~(9)~~ The Department of Human Services and the Department of Healthcare and Family Services must jointly compile data on pending applications, denials, appeals, and redeterminations into a monthly report, which shall be posted on each

Department's website for the purposes of monitoring long-term care eligibility processing. The report must specify the number of applications and redeterminations pending long-term care eligibility determination and admission and the number of appeals of denials in the following categories:

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

(B) Percentage of applications and redeterminations pending in the Department of Human Services' Family Community Resource Centers, in the Department of Human Services' long-term care hubs, with the Department of Healthcare and Family Services' Office of Inspector General, and those applications which are being tolled due to requests for extension of time for additional information.

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

(g) ~~(f)~~ Beginning on July 1, 2017, the Auditor General shall report every 3 years to the General Assembly on the performance and compliance of the Department of Healthcare and Family Services, the Department of Human Services, and the Department on Aging in meeting the requirements of this Section and the federal requirements concerning eligibility determinations for Medicaid long-term care services and

supports, and shall report any issues or deficiencies and make recommendations. The Auditor General shall, at a minimum, review, consider, and evaluate the following:

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

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

(3) the accuracy and completeness of the report required under paragraph (9) of subsection (e);

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

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

The Auditor General's report shall include any and all other areas or issues which are identified through an annual review. Paragraphs (1) through (5) of this subsection shall not

be construed to limit the scope of the annual review and the Auditor General's authority to thoroughly and completely evaluate any and all processes, policies, and procedures concerning compliance with federal and State law requirements on eligibility determinations for Medicaid long-term care services and supports.

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

(Source: P.A. 99-153, eff. 7-28-15; 100-380, eff. 8-25-17.)

(305 ILCS 5/11-6) (from Ch. 23, par. 11-6)

Sec. 11-6. Decisions on applications. Within 10 days after a decision is reached on an application, the applicant shall be notified in writing of the decision. If the applicant resides in a facility licensed under the Nursing Home Care Act or a supportive living facility authorized under Section 5-5.01a, the facility shall also receive written notice of the decision, provided that the notification is related to a Department payment for services received by the applicant in the facility. Only facilities enrolled in and subject to a provider agreement under the medical assistance program under Article V may receive such notices of decisions. The Department shall consider eligibility for, and the notice shall contain a decision on, each of the following assistance programs for

which the client may be eligible based on the information contained in the application: Temporary Assistance for ~~to~~ Needy Families, Medical Assistance, Aid to the Aged, Blind and Disabled, General Assistance (in the City of Chicago), and food stamps. No decision shall be required for any assistance program for which the applicant has expressly declined in writing to apply. If the applicant is determined to be eligible, the notice shall include a statement of the amount of financial aid to be provided and a statement of the reasons for any partial grant amounts. If the applicant is determined ineligible for any public assistance the notice shall include the reason why the applicant is ineligible and a list of all missing supporting documents and information and the date the documents were requested. If the application for any public assistance is denied, the notice shall include a statement defining the applicant's right to appeal the decision. The Illinois Department, by rule, shall determine the date on which assistance shall begin for applicants determined eligible. That date may be no later than 30 days after the date of the application.

Under no circumstances may any application be denied solely to meet an application-processing deadline.

(Source: P.A. 96-206, eff. 1-1-10; revised 10-4-17.)

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