SB3762

LRB101 17784 KTG 70319 b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

SB3762

Introduced 2/14/2020, by Sen. Dave Syverson

SYNOPSIS AS INTRODUCED:

305 ILCS 5/11-5.4

Amends the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services, the Department of Human Services, and the Department on Aging to establish a Long-Term Care Eligibility Advisory Committee to assist the State in eliminating problems surrounding long-term care eligibility determinations and enrollment in Medicaid long-term care. Contains provisions concerning the composition of the Committee, Committee meetings, and Committee reporting requirements. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

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 (a-1) On or before October 1, 2020, the Department of
14 Healthcare and Family Services, with the assistance of the
15 Department of Human Services and the Department on Aging, shall
16 establish a Long-Term Care Eligibility Advisory Committee to
17 assist the State in eliminating problems surrounding long-term
18 care eligibility determinations and enrollment in Medicaid
19 long-term care. The Committee shall be composed of 10 citizen
20 members and 8 legislative members, all of whom shall serve in a
21 voting capacity, with 2 citizen members and 2 members of the
22 General Assembly appointed by each of the 4 legislative leaders
23 and an additional 2 citizen members appointed by the Governor.

1 The Committee shall elect a voting member as Chair to work with
2 the Department of Healthcare and Family Services, the
3 Department of Human Services, and the Department on Aging to
4 guide the work of the Committee. Voting members shall, by lot,
5 determine whether initial appointments are for 2-year or 4-year
6 terms with no more than 50% of each legislative leader's
7 appointees serving an initial 2-year term. The Director of
8 Healthcare and Family Services, the Director of Aging, and the
9 Secretary of Human Services, or their designees, shall serve in
10 a nonvoting capacity. The Committee shall meet every 6 weeks
11 until backlogs of Medicaid applications and requests for
12 long-term care benefits have been eliminated and shall meet
13 quarterly thereafter. Voting members shall also serve on one or
14 more workgroups. Additional individuals may be asked to serve
15 on the workgroups. The Committee shall oversee joint reports to
16 the Governor and the General Assembly. The reports shall be
17 prepared by the Department of Healthcare and Family Services,
18 the Department of Human Services, and the Department on Aging
19 beginning January 1, 2020 and every quarter thereafter. The
20 first report shall include an assessment of each of the
21 provisions of this Section and all provisions of this Code that
22 pertain to long-term care eligibility determination and
23 enrollment issues.
24 (b) Streamlined application enrollment process; expedited
25 eligibility process. The streamlined application and
26 enrollment process must include, but need not be limited to,

1 the following:
2 (1) On or before July 1, 2019, a streamlined
3 application and enrollment process shall be put in place
4 which must include, but need not be limited to, the
5 following:
6 (A) Minimize the burden on applicants by
7 collecting only the data necessary to determine
8 eligibility for medical services, long-term care
9 services, and spousal impoverishment offset.
10 (B) Integrate online data sources to simplify the
11 application process by reducing the amount of
12 information needed to be entered and to expedite
13 eligibility verification.
14 (C) Provide online prompts to alert the applicant
15 that information is missing or not complete.
16 (D) Provide training and step-by-step written
17 instructions for caseworkers, applicants, and
18 providers.
19 (2) The State must expedite the eligibility process for
20 applicants meeting specified guidelines, regardless of the
21 age of the application. The guidelines, subject to federal
22 approval, must include, but need not be limited to, the
23 following individually or collectively:
24 (A) Full Medicaid benefits in the community for a
25 specified period of time.
26 (B) No transfer of assets or resources during the

1 federally prescribed look-back period, as specified in
2 federal law.
3 (C) Receives Supplemental Security Income payments
4 or was receiving such payments at the time of admission
5 to a nursing facility.
6 (D) For applicants or recipients with verified
7 income at or below 100% of the federal poverty level
8 when the declared value of their countable resources is
9 no greater than the allowable amounts pursuant to
10 Section 5-2 of this Code for classes of eligible
11 persons for whom a resource limit applies. Such
12 simplified verification policies shall apply to
13 community cases as well as long-term care cases.
14 (3) Subject to federal approval, the Department of
15 Healthcare and Family Services must implement an ex parte
16 renewal process for Medicaid-eligible individuals residing
17 in long-term care facilities. "Renewal" has the same
18 meaning as "redetermination" in State policies,
19 administrative rule, and federal Medicaid law. The ex parte
20 renewal process must be fully operational on or before
21 January 1, 2019. If an individual has transferred to
22 another long-term care facility, any annual notice
23 concerning redetermination of eligibility must be sent to
24 the long-term care facility where the individual resides as
25 well as to the individual.
26 (4) The Department of Human Services must use the

1 standards and distribution requirements described in this
2 subsection and in Section 11-6 for notification of missing
3 supporting documents and information during all phases of
4 the application process: initial, renewal, and appeal.
5 (c) The Department of Human Services must adopt policies
6 and procedures to improve communication between long-term care
7 benefits central office personnel, applicants and their
8 representatives, and facilities in which the applicants
9 reside. Such policies and procedures must at a minimum permit
10 applicants and their representatives and the facility in which
11 the applicants reside to speak directly to an individual
12 trained to take telephone inquiries and provide appropriate
13 responses.
14 (d) Effective 30 days after the completion of 3 regionally
15 based trainings, nursing facilities shall submit all
16 applications for medical assistance online via the Application
17 for Benefits Eligibility (ABE) website. This requirement shall
18 extend to scanning and uploading with the online application
19 any required additional forms such as the Long Term Care
20 Facility Notification and the Additional Financial Information
21 for Long Term Care Applicants as well as scanned copies of any
22 supporting documentation. Long-term care facility admission
23 documents must be submitted as required in Section 5-5 of this
24 Code. No local Department of Human Services office shall refuse
25 to accept an electronically filed application. No Department of
26 Human Services office shall request submission of any document

1 in hard copy.
2 (e) Notwithstanding any other provision of this Code, the
3 Department of Human Services and the Department of Healthcare
4 and Family Services' Office of the Inspector General shall,
5 upon request, allow an applicant additional time to submit
6 information and documents needed as part of a review of
7 available resources or resources transferred during the
8 look-back period. The initial extension shall not exceed 30
9 days. A second extension of 30 days may be granted upon
10 request. Any request for information issued by the State to an
11 applicant shall include the following: an explanation of the
12 information required and the date by which the information must
13 be submitted; a statement that failure to respond in a timely
14 manner can result in denial of the application; a statement
15 that the applicant or the facility in the name of the applicant
16 may seek an extension; and the name and contact information of
17 a caseworker in case of questions. Any such request for
18 information shall also be sent to the facility. In deciding
19 whether to grant an extension, the Department of Human Services
20 or the Department of Healthcare and Family Services' Office of
21 the Inspector General shall take into account what is in the
22 best interest of the applicant. The time limits for processing
23 an application shall be tolled during the period of any
24 extension granted under this subsection.
25 (f) The Department of Human Services and the Department of
26 Healthcare and Family Services must jointly compile data on

1 pending applications, denials, appeals, and redeterminations
2 into a monthly report, which shall be posted on each
3 Department's website for the purposes of monitoring long-term
4 care eligibility processing. The report must specify the number
5 of applications and redeterminations pending long-term care
6 eligibility determination and admission and the number of
7 appeals of denials in the following categories:

8 (A) Length of time applications, redeterminations, and
9 appeals are pending - 0 to 45 days, 46 days to 90 days, 91
10 days to 180 days, 181 days to 12 months, over 12 months to
11 18 months, over 18 months to 24 months, and over 24 months.

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

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

22 (g) Beginning on July 1, 2017, the Auditor General shall
23 report every 3 years to the General Assembly on the performance
24 and compliance of the Department of Healthcare and Family
25 Services, the Department of Human Services, and the Department
26 on Aging in meeting the requirements of this Section and the

1 federal requirements concerning eligibility determinations for
2 Medicaid long-term care services and supports, and shall report
3 any issues or deficiencies and make recommendations. The
4 Auditor General shall, at a minimum, review, consider, and
5 evaluate the following:

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

9 (2) compliance with federal regulations on the timely
10 determination of eligibility as provided under 42 CFR
11 435.912;

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

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

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

26 The Auditor General's report shall include any and all

1 other areas or issues which are identified through an annual
2 review. Paragraphs (1) through (5) of this subsection shall not
3 be construed to limit the scope of the annual review and the
4 Auditor General's authority to thoroughly and completely
5 evaluate any and all processes, policies, and procedures
6 concerning compliance with federal and State law requirements
7 on eligibility determinations for Medicaid long-term care
8 services and supports.
9 (h) The Department of Healthcare and Family Services shall
10 adopt any rules necessary to administer and enforce any
11 provision of this Section. Rulemaking shall not delay the full
12 implementation of this Section.
13 (i) Beginning on June 29, 2018, provisional eligibility for
14 medical assistance under Article V of this Code, in the form of
15 a recipient identification number and any other necessary
16 credentials to permit an applicant to receive covered services
17 under Article V, must be issued to any applicant who has not
18 received a determination on his or her application for Medicaid
19 and Medicaid long-term care services filed simultaneously or,
20 if already Medicaid enrolled, application for Medicaid
21 long-term care services under Article V of this Code within the
22 federally prescribed timeliness requirements for
23 determinations on such applications. The Department of
24 Healthcare and Family Services must maintain the applicant's
25 provisional eligibility status until a determination is made on
26 the individual's application for long-term care services. The

1 Department of Healthcare and Family Services or the managed
2 care organization, if applicable, must reimburse providers for
3 services rendered during an applicant's provisional
4 eligibility period.

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

9 (2) An applicant with provisional eligibility status
10 must have his or her long-term care benefits paid for under
11 the State's fee-for-service system during the period of
12 provisional eligibility. If an individual otherwise
13 eligible for medical assistance under Article V of this
14 Code is enrolled with a managed care organization for
15 community benefits at the time the individual's
16 provisional eligibility for long-term care services is
17 issued, the managed care organization is only responsible
18 for paying benefits covered under the capitation payment
19 received by the managed care organization for the
20 individual.

21 (3) The Department of Healthcare and Family Services,
22 within 10 business days of issuing provisional eligibility
23 to an applicant, must submit to the Office of the
24 Comptroller for payment a voucher for all retroactive
25 reimbursement due. The Department of Healthcare and Family
26 Services must clearly identify such vouchers as

1 provisional eligibility vouchers.
2 (Source: P.A. 100-380, eff. 8-25-17; 100-665, eff. 8-2-18;
3 100-1141, eff. 11-28-18; 101-101, eff. 1-1-20; 101-209, eff.
4 8-5-19; 101-265, eff. 8-9-19; 101-559, eff. 8-23-19; revised
5 9-19-19.)

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