AN ACT concerning public aid.

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

Section 5. The Illinois Public Aid Code is amended by changing Section 11-5.1 and by adding Section 5-30.2 as follows:

(305 ILCS 5/5-30.2 new)

Sec. 5-30.2. Monthly reports; managed care enrollment.

(a) As used in this Section, "Medicaid Managed Care Entity" means a Managed Care Organization (MCO), a Managed Care Community Network (MCCN), an Accountable Care Entity (ACE), or a Care Coordination Entity (CCE) contracted by the Department.

(b) As soon as practical if the data is reasonably available, but no later than January 1, 2017, the Department shall publish monthly reports on its website on the enrollment of persons in the State's medical assistance program. In addition, as soon as practical if the data is reasonably available, but no later than January 1, 2017, the Department shall publish monthly reports on its website on the enrollment of recipients of medical assistance into a Medicaid Managed Care Entity contracted by the Department. As soon as practical if the data is reasonably available, but no later than January 1, 2017, the monthly reports shall include all of the following

information for the medical assistance program generally and, separately, for each Medicaid Managed Care Entity contracted by the Department:

(1) Total enrollment.

(2) The number of persons enrolled in the medical assistance program under items 18 and 19 of Section 5-2.

(3) The number of children enrolled.

(4) The number of parents and caretakers of minor children enrolled.

(5) The number of women enrolled on the basis of pregnancy.

(6) The number of seniors enrolled.

(7) The number of persons enrolled on the basis of disability.

(c) As soon as practical if the data is reasonably available, but no later than January 1, 2017, the Department shall publish monthly reports on its website detailing the percentage of persons enrolled in each Medicaid Managed Care Entity that was assigned using an auto-assignment algorithm. This percentage should also report the type of enrollee who was assigned using an auto-assignment algorithm, including, but not limited to, persons enrolled in the medical assistance program in each of the groups listed in subsection (b) of this Section.

(d) As soon as practical if the data is reasonably available, but no later than January 1, 2017, monthly

enrollment reports for each Medicaid Managed Care Entity shall include data on the 2 most recently available months and data comparing the most recently available month to that month in the prior year.

(e) As soon as practical if the data is reasonably available, but no later than January 1, 2017, monthly enrollment reports for each Medicaid Managed Care Entity shall include a breakdown of language preference for enrollees by English, Spanish, and the next 4 most commonly used languages.

(f) The Department must annually publish on its website each Medicaid Managed Care Entity's quality metrics outcomes and must make public an independent annual quality review report on the State's Medicaid managed care delivery system.

(305 ILCS 5/11-5.1)

Sec. 11-5.1. Eligibility verification. Notwithstanding any other provision of this Code, with respect to applications for medical assistance provided under Article V of this Code, eligibility shall be determined in a manner that ensures program integrity and complies with federal laws and regulations while minimizing unnecessary barriers to enrollment. To this end, as soon as practicable, and unless the Department receives written denial from the federal government, this Section shall be implemented:

(a) The Department of Healthcare and Family Services or its designees shall:

(1) By no later than July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants for medical assistance under this Code. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section.

(2) By no later than October 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the continued eligibility of recipients at their annual review of eligibility for medical assistance under this Code. Such verification shall take the form of pay stubs, business or income and expense records for self-employed persons, letters from employers, and any other valid documentation of income including data obtained electronically by the Department or its designees from other sources as described in subsection (b) of this Section. The Department shall send a notice to recipients at least 60 days prior to the end of their period of eligibility that informs them of the requirements for continued eligibility. If a recipient does not fulfill the requirements for continued eligibility by the deadline established in the notice a

notice of cancellation shall be issued to the recipient and coverage shall end on the last day of the eligibility period. A recipient's eligibility may be reinstated without requiring a new application if the recipient fulfills the requirements for continued eligibility prior to the end of the third month following the last date of coverage (or longer period if required by federal regulations). Nothing in this Section shall prevent an individual whose coverage has been cancelled from reapplying for health benefits at any time.

(3) By no later than July 1, 2011, require verification of Illinois residency.

(b) The Department shall establish or continue cooperative arrangements with the Social Security Administration, the Illinois Secretary of State, the Department of Human Services, the Department of Revenue, the Department of Employment Security, and any other appropriate entity to gain electronic access, to the extent allowed by law, to information available to those entities that may be appropriate for electronically verifying any factor of eligibility for benefits under the Program. Data relevant to eligibility shall be provided for no other purpose than to verify the eligibility of new applicants or current recipients of health benefits under the Program. Data shall be requested or provided for any new applicant or current recipient only insofar as that individual's circumstances are relevant to that individual's or another

individual's eligibility.

(c) Within 90 days of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services shall send notice to current recipients informing them of the changes regarding their eligibility verification.

(d) As soon as practical if the data is reasonably available, but no later than January 1, 2017, the Department shall compile on a monthly basis data on eligibility redeterminations of beneficiaries of medical assistance provided under Article V of this Code. This data shall be posted on the Department's website, and data from prior months shall be retained and available on the Department's website. The data compiled and reported shall include the following:

(1) The total number of redetermination decisions made in a month and, of that total number, the number of decisions to continue or change benefits and the number of decisions to cancel benefits.

(2) A breakdown of enrollee language preference for the total number of redetermination decisions made in a month and, of that total number, a breakdown of enrollee language preference for the number of decisions to continue or change benefits, and a breakdown of enrollee language preference for the number of decisions to cancel benefits. The language breakdown shall include, at a minimum, English, Spanish, and the next 4 most commonly used

languages.

(3) The percentage of cancellation decisions made in a month due to each of the following:

(A) The beneficiary's ineligibility due to excess income.

(B) The beneficiary's ineligibility due to not being an Illinois resident.

(C) The beneficiary's ineligibility due to being deceased.

(D) The beneficiary's request to cancel benefits.

(E) The beneficiary's lack of response after notices mailed to the beneficiary are returned to the Department as undeliverable by the United States Postal Service.

(F) The beneficiary's lack of response to a request for additional information when reliable information in the beneficiary's account, or other more current information, is unavailable to the Department to make a decision on whether to continue benefits.

(G) Other reasons tracked by the Department for the purpose of ensuring program integrity.

(4) If a vendor is utilized to provide services in support of the Department's redetermination decision process, the total number of redetermination decisions made in a month and, of that total number, the number of decisions to continue or change benefits, and the number of

decisions to cancel benefits (i) with the involvement of the vendor and (ii) without the involvement of the vendor.

(5) Of the total number of benefit cancellations in a month, the number of beneficiaries who return from cancellation within one month, the number of beneficiaries who return from cancellation within 2 months, and the number of beneficiaries who return from cancellation within 3 months. Of the number of beneficiaries who return from cancellation within 3 months, the percentage of those cancellations due to each of the reasons listed under paragraph (3) of this subsection.

(Source: P.A. 98-651, eff. 6-16-14.)

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

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Statutes amended in order of appearance