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Rep. Norine K. Hammond

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AMENDMENT TO HOUSE BILL 2814

AMENDMENT NO. ______. Amend House Bill 2814 by replacing everything after the enacting clause with the following:

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

(305 ILCS 5/11-5.4)

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

(a) 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

1 amendatory Act of the 98th General Assembly to assume
2 responsibility for the full implementation of the
3 establishment and maintenance of the system. Project outcomes
4 shall include an enhanced eligibility determination tracking
5 system accessible to providers and a centralized application
6 review and eligibility determination with all applicants
7 reviewed within 90 days of receipt by the State of a complete
8 application. If the Department of Healthcare and Family
9 Services' Office of the Inspector General determines that there
10 is a likelihood that a non-allowable transfer of assets has
11 occurred, and the facility in which the applicant resides is
12 notified, an extension of up to 90 days shall be permissible.
13 On or before December 31, 2015, a streamlined application and
14 enrollment process shall be put in place based on the following
15 principles:

16 (1) Minimize the burden on applicants by collecting
17 only the data necessary to determine eligibility for
18 medical services, long-term care services, and spousal
19 impoverishment offset.

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

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

26 (b) The Department shall, on or before July 1, 2014, assess

1 the feasibility of incorporating all information needed to
2 determine eligibility for long-term care services, including
3 asset transfer and spousal impoverishment financials, into the
4 State's integrated eligibility system identifying all
5 resources needed and reasonable timeframes for achieving the
6 specified integration.

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

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

19 (e) The Department of Healthcare and Family Services, the
20 Department of Human Services, and the Department on Aging shall
21 take the following steps to achieve federally established
22 timeframes for eligibility determinations for Medicaid and
23 long-term care benefits and shall work toward the federal goal
24 of real time determinations:

25 (1) The Departments shall review, in collaboration
26 with representatives of affected providers, all forms and

1 procedures currently in use, federal guidelines either
2 suggested or mandated, and staff deployment by September
3 30, 2014 to identify additional measures that can improve
4 long-term care eligibility processing and make adjustments
5 where possible.
6 (2) No later than June 30, 2014, the Department of
7 Healthcare and Family Services shall issue vouchers for
8 advance payments not to exceed $50,000,000 to nursing
9 facilities with significant outstanding Medicaid liability
10 associated with services provided to residents with
11 Medicaid applications pending and residents facing the
12 greatest delays. Each facility with an advance payment
13 shall state in writing whether its own recoupment schedule
14 will be in 3 or 6 equal monthly installments, as long as
15 all advances are recouped by June 30, 2015.
16 (3) The Department of Healthcare and Family Services'
17 Office of Inspector General and the Department of Human
18 Services shall immediately forgo resource review and
19 review of transfers during the relevant look-back period
20 for applications that were submitted prior to September 1,
21 2013. An applicant who applied prior to September 1, 2013,
22 who was denied for failure to cooperate in providing
23 required information, and whose application was
24 incorrectly reviewed under the wrong look-back period
25 rules may request review and correction of the denial based
26 on this subsection. If found eligible upon review, such

1 applicants shall be retroactively enrolled.
2 (4) As soon as practicable, the Department of
3 Healthcare and Family Services shall implement policies
4 and promulgate rules to simplify financial eligibility
5 verification in the following instances: (A) for
6 applicants or recipients who are receiving Supplemental
7 Security Income payments or who had been receiving such
8 payments at the time they were admitted to a nursing
9 facility and (B) for applicants or recipients with verified
10 income at or below 100% of the federal poverty level when
11 the declared value of their countable resources is no
12 greater than the allowable amounts pursuant to Section 5-2
13 of this Code for classes of eligible persons for whom a
14 resource limit applies. Such simplified verification
15 policies shall apply to community cases as well as
16 long-term care cases.
17 (5) As soon as practicable, but not later than July 1,
18 2014, the Department of Healthcare and Family Services and
19 the Department of Human Services shall jointly begin a
20 special enrollment project by using simplified eligibility
21 verification policies and by redeploying caseworkers
22 trained to handle long-term care cases to prioritize those
23 cases, until the backlog is eliminated and processing time
24 is within 90 days. This project shall apply to applications
25 for long-term care received by the State on or before May
26 15, 2014.

1 (6) As soon as practicable, but not later than
2 September 1, 2014, the Department on Aging shall make
3 available to long-term care facilities and community
4 providers upon request, through an electronic method, the
5 information contained within the Interagency Certification
6 of Screening Results completed by the pre-screener, in a
7 form and manner acceptable to the Department of Human
8 Services.
9 (7) Effective 30 days after the completion of 3
10 regionally based trainings, nursing facilities shall
11 submit all applications for medical assistance online via
12 the Application for Benefits Eligibility (ABE) website.
13 This requirement shall extend to scanning and uploading
14 with the online application any required additional forms
15 such as the Long Term Care Facility Notification and the
16 Additional Financial Information for Long Term Care
17 Applicants as well as scanned copies of any supporting
18 documentation. Long-term care facility admission documents
19 must be submitted as required in Section 5-5 of this Code.
20 No local Department of Human Services office shall refuse
21 to accept an electronically filed application.
22 (8) Notwithstanding any other provision of this Code,
23 the Department of Human Services and the Department of
24 Healthcare and Family Services' Office of the Inspector
25 General shall, upon request, allow an applicant additional
26 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.

(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 ~~0 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.

(f) On and after July 1, 2017, the Department of Healthcare and Family Services, the Department of Human Services, and the Department on Aging must, at a minimum, take the following actions to protect the right of Medicaid beneficiaries to receive Medicaid services, especially long-term care services and supports, promptly without any delay caused by the agency's administrative procedures as mandated under 42 CFR 435.930:

(1) For a beneficiary aged 65 years or older who is enrolled in Medicaid at the time he or she applies for Medicaid long-term care services and supports and who has received a Determination of Need indicating the need for such services, the Departments must begin paying for Medicaid long-term care services and supports no later than the 46th day after the date upon which the beneficiary applied for such services. Payments for Medicaid long-term care services and supports must begin even if the review of the beneficiary's income and assets is incomplete and the amount of the beneficiary's income and assets to be applied to the cost of services has not been determined. The Department of Healthcare and Family Services shall apply the beneficiary's excess income and assets prospectively to the cost of care once the final amounts are determined. Delay in reviewing the available income and assets beyond the 45th day after the date upon which the beneficiary applied for Medicaid long-term care services and supports may not delay the furnishing of such services nor the payment for such services by the Department of Healthcare and Family Services.

(2) For a beneficiary aged 64 years or younger who is enrolled in Medicaid at the time he or she applies for Medicaid long-term care services and supports, whose Medicaid eligibility is based upon a disability, and who has received a Determination of Need indicating the need

1 for Medicaid long-term care services and supports, the
2 Departments must begin paying for Medicaid long-term care
3 services and supports no later than the 91st day after the
4 date upon which the beneficiary applied for such services.
5 Payments for Medicaid long-term care services and supports
6 must begin even if the review of the beneficiary's income
7 and assets is incomplete and the amount of the
8 beneficiary's income and assets to be applied to the cost
9 of services has not been determined. The Department of
10 Healthcare and Family Services shall apply the
11 beneficiary's excess income and assets prospectively to
12 the cost of care once the final amounts are determined.
13 Delay in reviewing the available income and assets beyond
14 the 90th day after the date upon which the beneficiary
15 applied for Medicaid long-term care services and supports
16 may not delay the furnishing of such services nor the
17 payment for such services by the Department of Healthcare
18 and Family Services. The deadlines specified in this
19 paragraph are the federally required timeliness standards
20 set forth under 42 CFR 435.912.
21 (3) For an applicant who is not enrolled in Medicaid at
22 the time he or she applies for Medicaid long-term care
23 services and supports and who has received a Determination
24 of Need indicating the need for such services, the
25 Departments must begin paying for Medicaid long-term care
26 services and supports immediately once the applicant is

determined eligible for Medicaid services. Payments for community services and Medicaid long-term care services and supports must begin even if the review of the applicant's income and assets is incomplete and the amount of the applicant's income and assets to be applied to the cost of services has not been determined. The Department of Healthcare and Family Services shall apply the applicant's excess income and assets prospectively to the cost of services once the final amounts are determined. Delay in reviewing the available income and assets beyond the 45th day after the date upon which the applicant applied for Medicaid enrollment may not delay the furnishing of such services nor the payment for such services by the Department of Healthcare and Family Services.

As used in this subsection, "Determination of Need" means the current and any future assessment tool adopted by and used by the State of Illinois to assess the amount, intensity, or level of services needed to properly care for the medical, physical, and behavioral health needs of any individual requesting Medicaid long-term care services and supports.

For the purposes of this subsection, the process of determining the amount of an individuals' income and assets to be applied to the cost of the individual's care refers to the federal regulations concerning the post-eligibility treatment of income as provided under 42 CFR 435.733.

(g) Beginning on July 1, 2017, the Auditor General shall

report annually 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 as opposed to the traditional caseworker-specific process from which these central offices have converted;

(5) the use of technology systems including the Integrated Eligibility System, the Application for Benefits Eligibility website, the Medicaid Management

1 Information System, and any other technology issues
2 related to eligibility determinations;
3 (6) the effect of staffing levels and personnel
4 policies in relation to eligibility determinations; and
5 (7) any issues affecting eligibility determinations
6 that are related to the authority over staff completing
7 Medicaid eligibility determinations residing with the
8 Department of Human Services instead of the designated
9 single-state Medicaid agency in Illinois, the Department
10 of Healthcare and Family Services.
11 The Auditor General's report shall include any and all
12 other areas or issues which are identified through an annual
13 review. Paragraphs 1 through 7 of this subsection shall not be
14 construed to limit the scope of the annual review and the
15 Auditor General's authority to thoroughly and completely
16 evaluate any and all processes, policies, and procedures
17 concerning compliance with federal and State law requirements
18 on eligibility determinations for Medicaid long-term care
19 services and supports.
20 (Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14;
21 99-153, eff. 7-28-15.)

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