SB3297

LRB10118060KTG70135b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

SB3297

Introduced 2/11/2020, by Sen. Laura Fine

SYNOPSIS AS INTRODUCED:

See Index

Amends the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act. In provisions concerning income verification to determine if an applicant is eligible for the benefits provided under those Acts, provides that a month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. Amends the Illinois Public Aid Code. Removes a provision that set rates or payments for home health visits at $72 for dates of service in and after July 1, 2014. Removes a provision that set rates or payments for the certified nursing assistant component of the home health agency rate at $20 for dates of service on and after July 1, 2014. Requires the Department of Healthcare and Family Services to adopt, by rule, a model similar to the psychiatric Collaborative Care Model required under the Illinois Insurance Code. In a provision concerning assessments for long-term care facilities, provides that the Department of Healthcare and Family Services shall provide a self-reporting notice of the assessment form that a long-term care facility completes for the required period and submits with its assessment payment to the Department. In a provision concerning income verification to determine if an applicant is eligible for the medical assistance benefits provided under the Code, provides that a month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. Repeals a provision requiring the Department to conduct an annual audit of the County Provider Trust Fund. Amends the Illinois Health Information Exchange and Technology Act and the Regulatory Sunset Act. Provides that the Illinois Health Information Exchange and Technology Act is repealed on January 1, 2026 (rather than January 1, 2021). Effective immediately.

LRB101 18060 KTG 70135 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

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

Section 1. The Regulatory Sunset Act is amended by changing Sections 4.31 and 4.36 as follows:

(5 ILCS 80/4.31)

Sec. 4.31. Acts repealed on January 1, 2021. The following Acts are repealed on January 1, 2021:

The Crematory Regulation Act.

The Cemetery Oversight Act.

~~The Illinois Health Information Exchange and Technology Act.~~

The Radiation Protection Act of 1990.

(Source: P.A. 96-1041, eff. 7-14-10; 96-1331, eff. 7-27-10; incorporates P.A. 96-863, eff. 3-1-10; 97-333, eff. 8-12-11.)

(5 ILCS 80/4.36)

Sec. 4.36. Acts repealed on January 1, 2026. The following Acts are repealed on January 1, 2026:

The Barber, Cosmetology, Esthetics, Hair Braiding, and Nail Technology Act of 1985.

The Collection Agency Act.

The Hearing Instrument Consumer Protection Act.

The Illinois Athletic Trainers Practice Act.

The Illinois Dental Practice Act.

The Illinois Health Information Exchange and Technology Act.

The Illinois Roofing Industry Licensing Act.

The Illinois Physical Therapy Act.

The Professional Geologist Licensing Act.

The Respiratory Care Practice Act.

(Source: P.A. 99-26, eff. 7-10-15; 99-204, eff. 7-30-15; 99-227, eff. 8-3-15; 99-229, eff. 8-3-15; 99-230, eff. 8-3-15; 99-427, eff. 8-21-15; 99-469, eff. 8-26-15; 99-492, eff. 12-31-15; 99-642, eff. 7-28-16.)

Section 5. Amends the Illinois Health Information Exchange and Technology Act is amended by adding Section 996 as follows:

(20 ILCS 3860/996 new)

Sec. 996. Repeal. This Act is repealed as provided in the Regulatory Sunset Act.

Section 10. The Children's Health Insurance Program Act is amended by changing Section 7 as follows:

(215 ILCS 106/7)

Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for

benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that complies with federal law 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 to the Program. 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. <u>A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub.</u>

(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 under the Program. 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. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. The Department shall send a notice to the recipient at least 60 days prior to the end of the period of eligibility that informs them of the requirements for continued eligibility. Information the Department receives prior to the annual review, including information available to the Department as a result of the recipient's application for other non-health care benefits, that is sufficient to make a determination of continued eligibility for medical assistance or for benefits provided under the Program may be reviewed and verified, and subsequent action taken including client notification of continued eligibility for medical assistance or for benefits provided under the Program. The date of client notification establishes the date for subsequent annual eligibility reviews. 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 no later than the last day of the month following 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 will 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.

(Source: P.A. 101-209, eff. 8-5-19.)

Section 15. The Covering ALL KIDS Health Insurance Act is amended by changing Section 7 as follows:

(215 ILCS 170/7)

(Section scheduled to be repealed on October 1, 2024)

Sec. 7. Eligibility verification. Notwithstanding any other provision of this Act, with respect to applications for benefits provided under the Program, eligibility shall be determined in a manner that ensures program integrity and that complies with federal law 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 July 1, 2011, require verification of, at a minimum, one month's income from all sources required for determining the eligibility of applicants to the Program. 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. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub.

(2) By 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 under the Program. 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. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. 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. Information the Department receives prior to the annual review, including information available to the Department as a result of the recipient's application for other non-health care benefits, that is sufficient to make a determination of continued eligibility for benefits

provided under this Act, the Children's Health Insurance Program Act, or Article V of the Illinois Public Aid Code may be reviewed and verified, and subsequent action taken including client notification of continued eligibility for benefits provided under this Act, the Children's Health Insurance Program Act, or Article V of the Illinois Public Aid Code. The date of client notification establishes the date for subsequent annual eligibility reviews. 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 no later than the last day of the month following 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 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 will 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.

(Source: P.A. 101-209, eff. 8-5-19.)

Section 20. The Illinois Public Aid Code is amended by changing Sections 5-5e, 5-16.8, 5B-4, and 11-5.1 as follows:

(305 ILCS 5/5-5e)

Sec. 5-5e. Adjusted rates of reimbursement.

(a) Rates or payments for services in effect on June 30, 2012 shall be adjusted and services shall be affected as

required by any other provision of Public Act 97-689. In addition, the Department shall do the following:

(1) Delink the per diem rate paid for supportive living facility services from the per diem rate paid for nursing facility services, effective for services provided on or after May 1, 2011 and before July 1, 2019.

(2) Cease payment for bed reserves in nursing facilities and specialized mental health rehabilitation facilities; for purposes of therapeutic home visits for individuals scoring as TBI on the MDS 3.0, beginning June 1, 2015, the Department shall approve payments for bed reserves in nursing facilities and specialized mental health rehabilitation facilities that have at least a 90% occupancy level and at least 80% of their residents are Medicaid eligible. Payment shall be at a daily rate of 75% of an individual's current Medicaid per diem and shall not exceed 10 days in a calendar month.

(2.5) Cease payment for bed reserves for purposes of inpatient hospitalizations to intermediate care facilities for persons with <u>developmental</u> ~~development~~ disabilities, except in the instance of residents who are under 21 years of age.

(3) Cease payment of the $10 per day add-on payment to nursing facilities for certain residents with developmental disabilities.

(b) After the application of subsection (a),

notwithstanding any other provision of this Code to the contrary and to the extent permitted by federal law, on and after July 1, 2012, the rates of reimbursement for services and other payments provided under this Code shall further be reduced as follows:

(1) Rates or payments for physician services, dental services, or community health center services reimbursed through an encounter rate, and services provided under the Medicaid Rehabilitation Option of the Illinois Title XIX State Plan shall not be further reduced, except as provided in Section 5-5b.1.

(2) Rates or payments, or the portion thereof, paid to a provider that is operated by a unit of local government or State University that provides the non-federal share of such services shall not be further reduced, except as provided in Section 5-5b.1.

(3) Rates or payments for hospital services delivered by a hospital defined as a Safety-Net Hospital under Section 5-5e.1 of this Code shall not be further reduced, except as provided in Section 5-5b.1.

(4) Rates or payments for hospital services delivered by a Critical Access Hospital, which is an Illinois hospital designated as a critical care hospital by the Department of Public Health in accordance with 42 CFR 485, Subpart F, shall not be further reduced, except as provided in Section 5-5b.1.

(5) Rates or payments for Nursing Facility Services shall only be further adjusted pursuant to Section 5-5.2 of this Code.

(6) Rates or payments for services delivered by long term care facilities licensed under the ID/DD Community Care Act or the MC/DD Act and developmental training services shall not be further reduced.

(7) Rates or payments for services provided under capitation rates shall be adjusted taking into consideration the rates reduction and covered services required by Public Act 97-689.

(8) For hospitals not previously described in this subsection, the rates or payments for hospital services shall be further reduced by 3.5%, except for payments authorized under Section 5A-12.4 of this Code.

(9) For all other rates or payments for services delivered by providers not specifically referenced in paragraphs (1) through (8), rates or payments shall be further reduced by 2.7%.

(c) Any assessment imposed by this Code shall continue and nothing in this Section shall be construed to cause it to cease.

(d) Notwithstanding any other provision of this Code to the contrary, subject to federal approval under Title XIX of the Social Security Act, for dates of service on and after July 1, 2014, rates or payments for services provided for the purpose

of transitioning children from a hospital to home placement or other appropriate setting by a children's community-based health care center authorized under the Alternative Health Care Delivery Act shall be $683 per day.

(e) (Blank) ~~Notwithstanding any other provision of this Code to the contrary, subject to federal approval under Title XIX of the Social Security Act, for dates of service on and after July 1, 2014, rates or payments for home health visits shall be $72~~.

(f) (Blank) ~~Notwithstanding any other provision of this Code to the contrary, subject to federal approval under Title XIX of the Social Security Act, for dates of service on and after July 1, 2014, rates or payments for the certified nursing assistant component of the home health agency rate shall be $20~~.

(Source: P.A. 101-10, eff. 6-5-19; revised 9-12-19.)

(305 ILCS 5/5-16.8)

Sec. 5-16.8. Required health benefits. The medical assistance program shall (i) provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g.5, 356u, 356w, 356x, 356z.6, 356z.26, 356z.29, ~~and~~ 356z.32, ~~and~~ 356z.33, 356z.34, and 356z.35 of the Illinois Insurance Code and (ii) be subject to the provisions of Sections 356z.19, 364.01, 370c, and 370c.1 of the Illinois

Insurance Code.

The Department, by rule, shall adopt a model similar to the requirements of Section 356z.39 of the Illinois Insurance Code.

On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

To ensure full access to the benefits set forth in this Section, on and after January 1, 2016, the Department shall ensure that provider and hospital reimbursement for post-mastectomy care benefits required under this Section are no lower than the Medicare reimbursement rate.

(Source: P.A. 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; 101-81, eff. 7-12-19; 101-218, eff. 1-1-20; 101-281, eff. 1-1-20; 101-371, eff. 1-1-20; 101-574, eff. 1-1-20; revised 10-16-19.)

(305 ILCS 5/5B-4) (from Ch. 23, par. 5B-4)

Sec. 5B-4. Payment of assessment; penalty.

(a) The assessment imposed by Section 5B-2 shall be due and payable monthly, on the last State business day of the month for occupied bed days reported for the preceding third month prior to the month in which the tax is payable and due. A facility that has delayed payment due to the State's failure to reimburse for services rendered may request an extension on the

due date for payment pursuant to subsection (b) and shall pay the assessment within 30 days of reimbursement by the Department. The Illinois Department may provide that county nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their assessment obligation by certifying to the Illinois Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the assessment.

(a-5) The Illinois Department shall provide for an electronic submission process for each long-term care facility to report at a minimum the number of occupied bed days of the long-term care facility for the reporting period and other reasonable information the Illinois Department requires for the administration of its responsibilities under this Code. Beginning July 1, 2013, a separate electronic submission shall be completed for each long-term care facility in this State operated by a long-term care provider. The Illinois Department shall provide a self-reporting notice of the assessment form that the long-term care facility completes for the required period and submits with its assessment payment to the Illinois Department. ~~shall prepare an assessment bill stating the amount due and payable each month and submit it to each long-term care facility via an electronic process. Each assessment payment shall be accompanied by a copy of the assessment bill sent to the long-term care facility by the Illinois Department.~~ To the

extent practicable, the Department shall coordinate the assessment reporting requirements with other reporting required of long-term care facilities.

(b) The Illinois Department is authorized to establish delayed payment schedules for long-term care providers that are unable to make assessment payments when due under this Section due to financial difficulties, as determined by the Illinois Department. The Illinois Department may not deny a request for delay of payment of the assessment imposed under this Article if the long-term care provider has not been paid for services provided during the month on which the assessment is levied or the Medicaid managed care organization has not been paid by the State.

(c) If a long-term care provider fails to pay the full amount of an assessment payment when due (including any extensions granted under subsection (b)), there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment imposed by Section 5B-2 a penalty assessment equal to the lesser of (i) 5% of the amount of the assessment payment not paid on or before the due date plus 5% of the portion thereof remaining unpaid on the last day of each month thereafter or (ii) 100% of the assessment payment amount not paid on or before the due date. For purposes of this subsection, payments will be credited first to unpaid assessment payment amounts (rather than to penalty or interest), beginning with the most delinquent assessment

payments. Payment cycles of longer than 60 days shall be one factor the Director takes into account in granting a waiver under this Section.

(c-5) If a long-term care facility fails to file its assessment bill with payment, there shall, unless waived by the Illinois Department for reasonable cause, be added to the assessment due a penalty assessment equal to 25% of the assessment due. After July 1, 2013, no penalty shall be assessed under this Section if the Illinois Department does not provide a process for the electronic submission of the information required by subsection (a-5).

(d) Nothing in this amendatory Act of 1993 shall be construed to prevent the Illinois Department from collecting all amounts due under this Article pursuant to an assessment imposed before the effective date of this amendatory Act of 1993.

(e) Nothing in this amendatory Act of the 96th General Assembly shall be construed to prevent the Illinois Department from collecting all amounts due under this Code pursuant to an assessment, tax, fee, or penalty imposed before the effective date of this amendatory Act of the 96th General Assembly.

(f) No installment of the assessment imposed by Section 5B-2 shall be due and payable until after the Department notifies the long-term care providers, in writing, that the payment methodologies to long-term care providers required under Section 5-5.4 of this Code have been approved by the

Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services and the waivers under 42 CFR 433.68 for the assessment imposed by this Section, if necessary, have been granted by the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services. Upon notification to the Department of approval of the payment methodologies required under Section 5-5.4 of this Code and the waivers granted under 42 CFR 433.68, all installments otherwise due under Section 5B-4 prior to the date of notification shall be due and payable to the Department upon written direction from the Department within 90 days after issuance by the Comptroller of the payments required under Section 5-5.4 of this Code.

(Source: P.A. 100-501, eff. 6-1-18.)

(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. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub.

(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. Information the Department receives prior to the annual review, including information available to the Department as a result of the recipient's application for other non-Medicaid benefits, that is sufficient to make a determination of continued Medicaid eligibility may be reviewed and verified, and subsequent action taken including client notification of continued Medicaid eligibility. The date of client notification establishes the date for subsequent annual

Medicaid eligibility reviews. 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. A month's income may be verified by a single pay stub with the monthly income extrapolated from the time period covered by the pay stub. 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 no later than the last day of the month following 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.

The Department, with federal approval, may choose to adopt continuous financial eligibility for a full 12 months for adults on Medicaid.

(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.

(e) The Department shall conduct a complete review of the Medicaid redetermination process in order to identify changes that can increase the use of ex parte redetermination processing. This review shall be completed within 90 days after the effective date of this amendatory Act of the 101st General Assembly. Within 90 days of completion of the review, the Department shall seek written federal approval of policy changes the review recommended and implement once approved. The review shall specifically include, but not be limited to, use of ex parte redeterminations of the following populations:

(1) Recipients of developmental disabilities services.

(2) Recipients of benefits under the State's Aid to the Aged, Blind, or Disabled program.

(3) Recipients of Medicaid long-term care services and supports, including waiver services.

(4) All Modified Adjusted Gross Income (MAGI) populations.

(5) Populations with no verifiable income.

(6) Self-employed people.

The report shall also outline populations and circumstances in which an ex parte redetermination is not a recommended option.

(f) The Department shall explore and implement, as

practical and technologically possible, roles that stakeholders outside State agencies can play to assist in expediting eligibility determinations and redeterminations within 24 months after the effective date of this amendatory Act of the 101st General Assembly. Such practical roles to be explored to expedite the eligibility determination processes shall include the implementation of hospital presumptive eligibility, as authorized by the Patient Protection and Affordable Care Act.

(g) The Department or its designee shall seek federal approval to enhance the reasonable compatibility standard from 5% to 10%.

(h) Reporting. The Department of Healthcare and Family Services and the Department of Human Services shall publish quarterly reports on their progress in implementing policies and practices pursuant to this Section as modified by this amendatory Act of the 101st General Assembly.

(1) The reports shall include, but not be limited to, the following:

(A) Medical application processing, including a breakdown of the number of MAGI, non-MAGI, long-term care, and other medical cases pending for various incremental time frames between 0 to 181 or more days.

(B) Medical redeterminations completed, including: (i) a breakdown of the number of households that were redetermined ex parte and those that were not; (ii) the

reasons households were not redetermined ex parte; and (iii) the relative percentages of these reasons.

(C) A narrative discussion on issues identified in the functioning of the State's Integrated Eligibility System and progress on addressing those issues, as well as progress on implementing strategies to address eligibility backlogs, including expanding ex parte determinations to ensure timely eligibility determinations and renewals.

(2) Initial reports shall be issued within 90 days after the effective date of this amendatory Act of the 101st General Assembly.

(3) All reports shall be published on the Department's website.

(Source: P.A. 101-209, eff. 8-5-19.)

(305 ILCS 5/15-6 rep.)

Section 25. The Illinois Public Aid Code is amended by repealing Section 15-6.

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

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Statutes amended in order of appearance