HB4277

LRB100 15899 KTG 31012 b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB4277

by Rep. Norine K. Hammond

SYNOPSIS AS INTRODUCED:

305 ILCS 5/11-5.4

Amends the Illinois Public Aid Code. In order to protect the right of Medicaid beneficiaries to receive Medicaid long-term care services and supports (LTSS) promptly without any delay caused by administrative procedures, requires the Department of Healthcare and Family Services and other specified Departments to take the following actions: (i) for a Medicaid beneficiary aged 65 years or older who has received a Determination of Need indicating the need for LTSS services, the Departments must begin paying for such services no later than the 46th day after the date upon which the beneficiary applied for the services; (ii) for a Medicaid beneficiary aged 64 years or younger whose Medicaid eligibility is based upon a disability and who has received a Determination of Need indicating the need for LTSS services, the Departments must begin paying for such services no later than the 91st day after the date upon which the beneficiary applied for the services; (iii) for a Medicaid applicant who has received a Determination of Need indicating the need for LTSS services, the Departments must begin paying for such services immediately once the applicant is determined eligible for Medicaid; (iv) by July 1, 2018, the Department of Healthcare and Family Services, in conjunction with the State Comptroller, must develop a process to expedite payment claims for Medicaid services provided during the time any application for Medicaid eligibility or LTSS services is pending beyond federally required timeliness standards; and (v) by July 1, 2018, the Department of Healthcare and Family Services and the Department of Human Services must waive all deadline requirements for applications for Medicaid eligibility or LTSS services if pending beyond federally required timeliness standards. Makes other changes. Effective immediately.

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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 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 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. On or before December 31, 2015, a streamlined application and enrollment process shall be put in place based on the following principles:

(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.

(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.

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

(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.

(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.

(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.

(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.

(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.

(g) In order 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, on and after July 1, 2018, 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:

(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 for Medicaid long-term care services and supports, the Departments must begin paying for Medicaid long-term care services and supports no later than the 91st 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 90th 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. The deadlines specified in this paragraph are the federally required timeliness standards

set forth under 42 CFR 435.912.

(3) For an applicant who is not 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 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.

(4) By July 1, 2018, the Department of Healthcare and Family Services and the Department of Human Services may not require an applicant for Medicaid or Medicaid long-term care services and supports to submit a new application for benefits or services whenever a new entity or person is

designated or appointed to act as the applicant's legally authorized representative, representative payee, guardian, agent named in a power of attorney, or as any other personal representative who is authorized to make legal or health care decisions for the applicant.

(5) By July 1, 2018, the Department of Healthcare and Family Services, in conjunction with the State Comptroller, must develop a process to expedite payment for any claims for Medicaid services provided during the time any application for Medicaid eligibility or Medicaid long-term care services and supports is pending beyond federally required timeliness standards set forth under 42 CFR 435.912. The Department must also require managed care organizations contracted with the Department to follow the same expedited payment process.

(6) By July 1, 2018, the Department of Healthcare and Family Services and the Department of Human Services must develop a common form that permits a Medicaid applicant's legally authorized representative, representative payee, agent named in a power of attorney, guardian, or any other person or entity who is authorized to make legal or health care decisions for the applicant to make all Medicaid decisions including the right to file an appeal on the applicant's behalf under this Article.

(7) By July 1, 2018, the Department of Healthcare and Family Services and the Department of Human Services must

waive all deadline requirements for applications for Medicaid eligibility or Medicaid long-term care services and supports if pending beyond federally required timeliness standards set forth under 42 CFR 435.912.

(8) By July 1, 2018, the Department of Healthcare and Family Services and the Department of Human Services must develop a process to notify an applicant or their legally authorized representative of the receipt of their application and all supporting documentation. The notice should indicate any documentation required but not received.

(9) By July 1, 2018, in the case of a denial for missing information, the Department of Healthcare and Family Services and the Department of Human Services must notify an applicant or their legally authorized representative of any and all documentation or information that was missing and provide information on when the information was requested.

(10) The Department of Healthcare and Family Services and the Department of Human Services may adopt rules as allowed by the Illinois Administrative Procedure Act to implement the requirements of this subsection (g); however, the requirements under this subsection (g) must be implemented by all Departments even if the proposed rules are not yet adopted by the implementation date of July 1, 2018.

As used in this subsection, "Determination of Need" means the current and any future assessment tool adopted by and used by the State 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 individual's 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.

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

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