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) An expedited long-term care eligibility determination
10 and enrollment system shall be established to reduce long-term
11 care determinations to 90 days or fewer by July 1, 2014 and
12 streamline the long-term care enrollment process.
13 Establishment of the system shall be a joint venture of the
14 Department of Human Services and Healthcare and Family Services
15 and the Department on Aging. The Governor shall name a lead
16 agency no later than 30 days after the effective date of this
17 amendatory Act of the 98th General Assembly to assume
18 responsibility for the full implementation of the
19 establishment and maintenance of the system. Project outcomes
20 shall include an enhanced eligibility determination tracking
21 system accessible to providers and a centralized application
22 review and eligibility determination with all applicants
23 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

1 Chairs and Minority Spokespersons of the House and Senate Human
2 Services Committees no later than September 1, 2013 and on
3 February 1, 2014. The Department of Healthcare and Family
4 Services shall include in the annual Medicaid report for State
5 Fiscal Year 2014 and every fiscal year thereafter information
6 concerning implementation of the provisions of this Section.

7 (d) No later than August 1, 2014, the Auditor General shall
8 report to the General Assembly concerning the extent to which
9 the timeframes specified in this Section have been met and the
10 extent to which State staffing levels are adequate to meet the
11 requirements of this Section.

12 (e) The Department of Healthcare and Family Services, the
13 Department of Human Services, and the Department on Aging shall
14 take the following steps to achieve federally established
15 timeframes for eligibility determinations for Medicaid and
16 long-term care benefits and shall work toward the federal goal
17 of real time determinations:

18 (1) The Departments shall review, in collaboration
19 with representatives of affected providers, all forms and
20 procedures currently in use, federal guidelines either
21 suggested or mandated, and staff deployment by September
22 30, 2014 to identify additional measures that can improve
23 long-term care eligibility processing and make adjustments
24 where possible.

25 (2) No later than June 30, 2014, the Department of
26 Healthcare and Family Services shall issue vouchers for

1 advance payments not to exceed $50,000,000 to nursing
2 facilities with significant outstanding Medicaid liability
3 associated with services provided to residents with
4 Medicaid applications pending and residents facing the
5 greatest delays. Each facility with an advance payment
6 shall state in writing whether its own recoupment schedule
7 will be in 3 or 6 equal monthly installments, as long as
8 all advances are recouped by June 30, 2015.

9 (3) The Department of Healthcare and Family Services'
10 Office of Inspector General and the Department of Human
11 Services shall immediately forgo resource review and
12 review of transfers during the relevant look-back period
13 for applications that were submitted prior to September 1,
14 2013. An applicant who applied prior to September 1, 2013,
15 who was denied for failure to cooperate in providing
16 required information, and whose application was
17 incorrectly reviewed under the wrong look-back period
18 rules may request review and correction of the denial based
19 on this subsection. If found eligible upon review, such
20 applicants shall be retroactively enrolled.

21 (4) As soon as practicable, the Department of
22 Healthcare and Family Services shall implement policies
23 and promulgate rules to simplify financial eligibility
24 verification in the following instances: (A) for
25 applicants or recipients who are receiving Supplemental
26 Security Income payments or who had been receiving such

1 payments at the time they were admitted to a nursing
2 facility and (B) for applicants or recipients with verified
3 income at or below 100% of the federal poverty level when
4 the declared value of their countable resources is no
5 greater than the allowable amounts pursuant to Section 5-2
6 of this Code for classes of eligible persons for whom a
7 resource limit applies. Such simplified verification
8 policies shall apply to community cases as well as
9 long-term care cases.

10 (5) As soon as practicable, but not later than July 1,
11 2014, the Department of Healthcare and Family Services and
12 the Department of Human Services shall jointly begin a
13 special enrollment project by using simplified eligibility
14 verification policies and by redeploying caseworkers
15 trained to handle long-term care cases to prioritize those
16 cases, until the backlog is eliminated and processing time
17 is within 90 days. This project shall apply to applications
18 for long-term care received by the State on or before May
19 15, 2014.

20 (6) As soon as practicable, but not later than
21 September 1, 2014, the Department on Aging shall make
22 available to long-term care facilities and community
23 providers upon request, through an electronic method, the
24 information contained within the Interagency Certification
25 of Screening Results completed by the pre-screener, in a
26 form and manner acceptable to the Department of Human

1 Services.

2 (7) Effective 30 days after the completion of 3
3 regionally based trainings, nursing facilities shall
4 submit all applications for medical assistance online via
5 the Application for Benefits Eligibility (ABE) website.
6 This requirement shall extend to scanning and uploading
7 with the online application any required additional forms
8 such as the Long Term Care Facility Notification and the
9 Additional Financial Information for Long Term Care
10 Applicants as well as scanned copies of any supporting
11 documentation. Long-term care facility admission documents
12 must be submitted as required in Section 5-5 of this Code.
13 No local Department of Human Services office shall refuse
14 to accept an electronically filed application.

15 (8) Notwithstanding any other provision of this Code,
16 the Department of Human Services and the Department of
17 Healthcare and Family Services' Office of the Inspector
18 General shall, upon request, allow an applicant additional
19 time to submit information and documents needed as part of
20 a review of available resources or resources transferred
21 during the look-back period. The initial extension shall
22 not exceed 30 days. A second extension of 30 days may be
23 granted upon request. Any request for information issued by
24 the State to an applicant shall include the following: an
25 explanation of the information required and the date by
26 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) The Department shall adopt rules necessary to

administer and enforce any provision of this Section. Rulemaking shall not delay the full implementation of this Section.

(h) Beginning on June 29, 2018, provisional eligibility, in the form of a recipient identification number and any other necessary credentials to permit an applicant to receive benefits, must be issued to any applicant who has not received a final eligibility determination on his or her application for Medicaid or Medicaid long-term care benefits or a notice of an opportunity for a hearing within the federally prescribed deadlines for the processing of such applications. The Department must maintain the applicant's provisional Medicaid enrollment status until a final eligibility determination is approved or the applicant's appeal has been adjudicated and eligibility is denied. The Department or the managed care organization, if applicable, must reimburse providers for services rendered during an applicant's provisional eligibility period.

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

(2) An applicant with provisional enrollment status must have his or her benefits paid for under the State's fee-for-service system until the State makes a final determination on the applicant's Medicaid or Medicaid

long-term care application. If an individual is enrolled with a managed care organization for community benefits at the time the individual's provisional status is issued, the managed care organization is only responsible for paying benefits covered under the capitation payment received by the managed care organization for the individual.

(3) The Department, within 10 business days of issuing provisional eligibility to an applicant, must submit to the Office of the Comptroller for payment a voucher for all retroactive reimbursement due. The Department must clearly identify such vouchers as provisional eligibility vouchers.

(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.