Rep. Norine K. Hammond

Filed: 4/23/2018

AMENDMENT TO HOUSE BILL 4771

AMENDMENT NO. _____. Amend House Bill 4771 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 and by adding Section 5-5g as follows:

(305 ILCS 5/5-5g new)

Sec. 5-5g. Long-term care patient; resident status. Long-term care providers shall submit all changes in resident status, including, but not limited to, death, discharge, changes in patient credit, third party liability, and Medicare coverage, to the Department through the Medical Electronic Data Interchange System, the Recipient Eligibility Verification System, or the Electronic Data Interchange System established under 89 Ill. Adm. Code 140.55(b) in compliance with the schedule below:

(1) 15 calendar days after a resident's death;

(2) 15 calendar days after a resident's discharge;

(3) 45 calendar days after being informed of a change in the resident's income;

(4) 45 calendar days after being informed of a change in a resident's third party liability;

(5) 45 calendar days after a resident's move to exceptional care services; and

(6) 45 calendar days after a resident's need for services requiring reimbursement under the ventilator or traumatic brain injury enhanced rate.

(305 ILCS 5/11-5.4)

Sec. 11-5.4. Expedited long-term care eligibility determination, renewal, ~~and~~ enrollment, and payment.

(a) The General Assembly finds that it is in the best interest of the State to process on an expedited basis applications and renewal applications for Medicaid and Medicaid long-term care benefits that are submitted by or on behalf of elderly persons in need of long-term care services. It is the intent of the General Assembly that the provisions of this Section be liberally construed to permit the maximum number of applicants to benefit, regardless of the age of the application, and for the State to complete all processing as required under 42 U.S.C. 1396a(a)(8) and 42 CFR 435. ~~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.~~

(a-5) As used in this Section:

"Department" means the Department of Healthcare and Family Services.

"Managed care organization" has the meaning ascribed to that term in Section 5-30.1 of this Code.

(b) The Department of Healthcare and Family Services must serve as the lead agency assuming primary responsibility for the full implementation of this Section, including the establishment and operation of the system. ~~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) Beginning on June 29, 2018, provisional eligibility, in the form of a recipient identification number and any other necessary credentials to permit an individual to receive benefits, must be issued to any individual who has not received a final eligibility determination on the individual's 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 individual's provisional Medicaid enrollment status until a final eligibility determination is approved or the individual's appeal has been adjudicated and eligibility is denied. The Department or the managed care organization, if applicable, must reimburse providers for all services rendered during an individual's provisional eligibility period.

(1) The Department must immediately notify the managed care organization, if applicable, in which the individual is an enrollee of the enrollee's change in status.

(2) The Department or the managed care organization, when applicable, must begin processing claims for services rendered by the end of the month in which the individual is given provisional eligibility status. Claims for services rendered must be submitted and processed by the Department and managed care organizations in the same manner as those submitted on behalf of individuals determined to qualify for benefits.

(3) An individual with provisional enrollment status, who is not enrolled in a managed care organization at the time the individual's provisional status is issued, must continue to have his or her benefits paid for under the State's fee-for-service system until such time as the State makes a final determination on the individual's Medicaid

application.

(4) The Department, within 10 business days of issuing provisional eligibility to an individual not covered by a managed care organization, must submit to the Office of the Comptroller for payment a voucher for all retroactive reimbursement due and the State Comptroller must place such vouchers on expedited payment status. However, if the provisional enrollee is enrolled with a managed care organization, the Department must submit the same to the managed care organization and the managed care organization must pay the provider on an expedited basis. ~~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) The Department must establish, by rule, policies and procedures to ensure prospective compliance with the federal deadlines for Medicaid and Medicaid long-term care benefits eligibility determinations required under 42 U.S.C. 1396a(a)(8) and 42 CFR 435.912, which must include, but need not be limited to, the following:

(1) The Department, assisted by the Department of Human

Services and the Department on Aging, must establish, no later than January 1, 2019, a streamlined application and enrollment process that includes, but is not limited to, the following:

(A) collect only the data necessary to determine eligibility for medical services, long-term care services, and spousal impoverishment offset;

(B) integrate online data and other third party data sources to simplify the application process by reducing the amount of information needed to be entered and to expedite eligibility verification;

(C) provide online prompts to alert the applicant that information is missing or incomplete; and

(D) provide training and step-by-step written instructions for caseworkers, applicants, and providers.

(2) The Department must expedite the eligibility processing system for applicants meeting certain guidelines, regardless of the age of the application. The guidelines must be established by rule and shall include, but not be limited to, the following individually or collectively:

(A) Full Medicaid benefits in the community for a specified period of time.

(B) No transfer of assets or resources during the federally prescribed look-back time period, as

specified by federal law.

(C) Receives Supplemental Security Income payments or was receiving such payments at the time the applicant was admitted to a nursing facility.

(D) Verified income at or below 100% of the federal poverty level when the declared value of the applicant's 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.

(3) The Department must establish, by rule, renewal policies and procedures to reduce the likelihood of unnecessary interruptions in services as a result of improper denials of individuals who would otherwise be approved.

(A) Effective January 1, 2019, the Department must implement a paperless passive redetermination protocol that provides for the electronic verification of all necessary information including bank accounts.

(B) A resident of a facility whose previous renewal application showed an income of no greater than the federal poverty level and who has no discernible means of generating income greater than the federal poverty level must be deemed to qualify for renewal. The resident and the facility must not receive an application for renewal and must instead receive

notification of the resident's renewal.

(C) An individual for whom the processing of a renewal application exceeds federally prescribed timeframes must be deemed to meet renewal guidelines and the Department must notify the individual and the facility in which the individual resides. The Department must also immediately notify the managed care organization in which the individual is enrolled, if applicable. Both the Department and the managed care organization must accept claims for services rendered to the individual without an interruption in benefits to the enrollee and payment for all services rendered to providers.

(4) The Department of Human Services must not penalize an applicant for having an attorney complete a Medicaid application on the applicant's behalf or for seeking to understand the applicant's rights under federal and State Medicaid laws and regulations. This must include targeting applications and applicants so described for additional scrutiny by the Department of Healthcare and Family Services' Office of the Inspector General.

(5) The Department of Healthcare and Family Services' Office of the Inspector General must review applications for long-term care benefits when the Office obtains credible evidence that an applicant has transferred assets with the intent of defrauding the State. If proof of the

allegations does not exist, the application must be released by the Office and must be assigned to the appropriate caseworker for an expedited review.

(6) The Department of Human Services must implement a process to notify an applicant, the applicant's legally authorized representative, and the facility where the applicant resides of the receipt of an initial or renewal application and supporting documentation within 5 business days of the date the application or supporting documents are submitted. The notices must indicate any documentation required, but not received, and provide instructions for submission.

(7) The Department must make available one release form that permits the applicant to grant permission to a third party to pursue approval of Medicaid and Medicaid long-term care benefits, track the status of applications, and pursue a post-denial appeal on behalf of the applicant, which must remain in force after the applicant's death.

(8) The Department must develop one eligibility system for both Modified Adjusted Gross Income (MAGI) and non-MAGI applicants by incorporating Affordable Care Act upgrades with the goal of establishing real time approval of applications for Medicaid services and Medicaid long-term care benefits, as permissible.

(9) The Department must have operational a fully electronic application process that encompasses initial

applications, admission packets, renewals, and appeals no later than 12 months after the effective date of this amendatory Act of the 100th General Assembly. The Department must not require submission of any application or supporting documentation in hard copy. ~~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) Within 6 months after the effective date of this amendatory Act of the 100th General Assembly, the Department must adopt policies and procedures to improve communication between long-term care benefits central office personnel, applicants, or the applicants' representatives, and facilities in which the applicants reside. The Department must establish, by rule, policies and procedures that are necessary to meet the requirements of this Section, which must include, but need not be limited to, the following:

(1) The establishment of a centralized, caseworker-based processing system with contact numbers for caseworkers and supervisors that are made readily available to all affected providers and are prominently displayed on all communications with applicants, beneficiaries, and providers.

(2) Allowing facilities access to the State's

integrated eligibility system for tracking the status of applications for applicants who have signed appropriate releases, and the development and distribution of applicable instructional materials and release forms. ~~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.~~

(f) The Department must establish policies and procedures to improve accountability and provide for the expedited payment of services rendered, which must include, but need not be limited to, the following:

(1) The Department must apply the most current resident income data entered into the Department's Medical

Electronic Data Interchange (MEDI) system to the payment of a claim even if a caseworker has not completed a review.

(2) The Department and the Department of Human Services must notify the applicant, or the applicant's legal representative, and the facility submitting the initial, renewal, or appeal application of all missing supporting documentation or information and the date of the request when an application, renewal, or appeal is denied for failure to submit such documentation and information.

(g) No later than January 1, 2019, the Department of Healthcare and Family Services must investigate the public-private partnerships in use in Ohio, Michigan, and Minnesota aimed at redeploying caseworkers to targeted high-Medicaid facilities for the purpose of expediting initial Medicaid and Medicaid long-term care benefits applications, renewals, asset discovery, and all other things related to enrollment, reimbursement, and application processing. No later than March 1, 2019, the Department of Healthcare and Family Services must post on the long-term care pages of the Department's website the agencies' joint recommendations and must assist provider groups in educating their members on such partnerships.

(h) The Director of Healthcare and Family Services, in coordination with the Secretary of Human Services and the Director of Aging, must host a provider association meeting every 6 weeks, beginning no later than 30 days after the

effective date of this amendatory Act of the 100th General Assembly, until all applications that are 45 days or older have been adjudicated and the application process has been reduced to 45 or fewer days, at which time the meetings shall be held quarterly, for those associations representing facilities licensed under the Nursing Home Care Act and certified as a supportive living program. Each agency must be represented by senior staff with hands-on knowledge of the processing of applications for Medicaid and Medicaid long-term care benefits, renewals, and such ancillary issues as income and address adjustments, release forms, and screening reports. Agenda items must be solicited from the associations.

(i) The Department must not delay the implementation of the presumptive eligibility, as ordered by Koss v. Norwood, Case No. 17 C 2762 (N.D. Ill. Mar. 29, 2018), in anticipation of this amendatory Act of the 100th General Assembly.

(j) As mandated by federal regulations under 42 CFR 435.912, the Department and the Department of Human Services must not deny applications for Medicaid or Medicaid long-term care benefits to comply with the federal timeliness standards or avoid authorizing provisional eligibility under this Section. To ensure compliance, the percentage of denials in a given month must not increase by more than 1% of the denial rate that occurred in the same month of the preceding year.

(k) The Department of Human Services must prioritize processing applications on a last-in, first-out basis. The

Department is expressly prohibited from prioritizing the processing of applications from individuals who have been issued provisional eligibility status over other applicants.

(l) Unless otherwise specified, all provisions of this amendatory Act of the 100th General Assembly must be fully operational by January 1, 2019.

(m) Nothing in this Section shall defeat the provisions contained in the State Prompt Payment Act or the timely pay provisions contained in Section 368a of the Illinois Insurance Code.

(n) The Department must offer regionally based training covering all aspects of this Section and must include long-term care provider associations in the design and presentation of the training. The training shall be recorded and posted on the Department's website to allow new employees to be trained and older employers to complete refresher courses.

(o) The Department and the Department of Human Services must not require an applicant for Medicaid or Medicaid long-term care benefits to submit a new application solely because there is a change in the applicant's legal representative.

(p) The Department and the Department of Human Services must implement the requirements of this Section even if the proposed rules are not yet adopted by the dates specified in this Section. If The Department is required to adopt rules under this Section or if the Department determines that rules

are necessary to achieve full implementation, the Department must adopt policies and procedures to allow for full implementation by the date specified in this Section and must publish all policies and procedures on the Department's website. The Department must submit proposed permanent rules for public comment no later than January 1, 2019.

(q) ~~(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.

(r) ~~(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.

(s) ~~(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:

(1) ~~(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.

(2) ~~(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.

(3) ~~(C)~~ Status of pending applications, denials, appeals, and redeterminations.

(4) For applications, redeterminations, and appeals pending more than 45 days, the reason for the delay as required by federal regulations under 42 CFR 435.912.

(t) ~~(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.

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