SB1573

LRB101 07820 KTG 52871 b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

SB1573

Introduced 2/15/2019, by Sen. John G. Mulroe

SYNOPSIS AS INTRODUCED:

305 ILCS 5/11-5.4

Amends the Illinois Public Aid Code. Makes technical changes to specify in provisions concerning provisional eligibility for long-term care services that: (i) the Department of Healthcare and Family Services 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; (ii) the Department of Healthcare and Family Services or the managed care organization, if applicable, must reimburse providers for services rendered during an applicant's provisional eligibility period; (iii) the Department of Healthcare and Family Services must submit payment vouchers for all retroactive reimbursement due to the Office of the Comptroller within 10 business days of issuing provisional eligibility to an applicant; and (iv) the Department of Healthcare and Family Services must adopt rules.

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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) Establishment of the expedited long-term care eligibility determination and enrollment system shall be a joint venture of the Departments of Human Services and Healthcare and Family Services and the Department on Aging.

(b) Streamlined application enrollment process; expedited eligibility process. The streamlined application and enrollment process must include, but need not be limited to, the following:

(1) On or before July 1, 2019, a streamlined application and enrollment process shall be put in place which must include, but need not be limited to, the following:

(A) 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.

(B) Integrate online 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 not complete.

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

(2) The State must expedite the eligibility process for applicants meeting specified guidelines, regardless of the age of the application. The guidelines, subject to federal approval, must include, but need 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 period, as specified in federal law.

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

(D) 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.

(3) Subject to federal approval, the Department of Healthcare and Family Services must implement an ex parte renewal process for Medicaid-eligible individuals residing in long-term care facilities. "Renewal" has the same meaning as "redetermination" in State policies, administrative rule, and federal Medicaid law. The ex parte renewal process must be fully operational on or before January 1, 2019.

(4) The Department of Human Services must use the standards and distribution requirements described in this subsection and in Section 11-6 for notification of missing supporting documents and information during all phases of the application process: initial, renewal, and appeal.

(c) The Department of Human Services must adopt policies and procedures to improve communication between long-term care benefits central office personnel, applicants and their representatives, and facilities in which the applicants reside. Such policies and procedures must at a minimum permit applicants and their representatives and the facility in which the applicants reside to speak directly to an individual trained to take telephone inquiries and provide appropriate

responses.

(d) 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. No Department of Human Services office shall request submission of any document in hard copy.

(e) 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.

(f) 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.

(g) 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.

(h) The Department of Healthcare and Family Services shall adopt any rules necessary to administer and enforce any provision of this Section. Rulemaking shall not delay the full implementation of this Section.

~~(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.~~

(i) ~~(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 of Healthcare and Family Services 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 of Healthcare and Family Services 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 of Healthcare and Family Services, 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 of Healthcare and Family Services must clearly identify such vouchers as provisional eligibility vouchers.

(Source: P.A. 99-153, eff. 7-28-15; 100-380, eff. 8-25-17; 100-665, eff. 8-2-18; 100-1141, eff. 11-28-18.)