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 11-5.1 and by adding Sections 5-1.6, 5-13.1 and 11-5.5 as follows:

(305 ILCS 5/5-1.6 new)

Sec. 5-1.6. Continuous eligibility; ex parte redeterminations.

(a) By July 1, 2022, the Department of Healthcare and Family Services shall seek a State Plan amendment or any federal waivers necessary to make changes to the medical assistance program. The Department shall apply for federal approval to implement 12 months of continuous eligibility for adults participating in the medical assistance program. The Department shall secure federal financial participation in accordance with this Section for expenditures made by the Department in State Fiscal Year 2023 and every State fiscal year thereafter.

(b) By July 1, 2022, the Department of Healthcare and Family Services shall seek a State Plan amendment or any federal waivers or approvals necessary to make changes to the medical assistance redetermination process for people without

any income at the time of redetermination. These changes shall seek to allow all people without income to be considered for ex parte redetermination. If there is no non-income related disqualifying information for medical assistance recipients without any income, then a person without any income shall be redetermined ex parte. Within 60 days after receiving federal approval or guidance, the Department of Healthcare and Family Services and the Department of Human Services shall make necessary technical and rule changes to implement changes to the redetermination process. The percentage of medical assistance recipients whose eligibility is renewed through the ex parte redetermination process shall be reported monthly by the Department of Healthcare and Family Services on its website in accordance with subsection (d) of Section 11-5.1 of this Code as well as shared in all Medicaid Advisory Committee meetings and Medicaid Advisory Committee Public Education Subcommittee meetings.

(305 ILCS 5/5-13.1 new)

Sec. 5-13.1. Cost-effectiveness waiver, hardship waivers, and making information about waivers more accessible.

(a) It is the intent of the General Assembly to ease the burden of liens and estate recovery for correctly paid benefits for participants, applicants, and their families and heirs, and to make information about waivers more widely available.

(b) The Department shall waive estate recovery under Sections 3-9 and 5-13 where recovery would not be cost-effective, would work an undue hardship, or for any other just reason, and shall make information about waivers and estate recovery easily accessible.

(1) Cost-effectiveness waiver. Subject to federal approval, the Department shall waive any claim against the first $25,000 of any estate to prevent substantial and unreasonable hardship. The Department shall consider the gross assets in the estate, including, but not limited to, the net value of real estate less mortgages or liens with priority over the Department's claims. The Department may increase the cost-effectiveness threshold in the future.

(2) Undue hardship waiver. The Department may develop additional hardship waiver standards in addition to those already employed, including, but not limited to, waivers aimed at preserving income-producing real property or a modest home as defined by rule.

(3) Accessible information. The Department shall make information about estate recovery and hardship waivers easily accessible. The Department shall maintain information about how to request a hardship waiver on its website in English, Spanish, and the next 4 most commonly used languages, including a short guide and simple form to facilitate requesting hardship exemptions in each language. On an annual basis, the Department shall

publicly report on the number of estate recovery cases that are pursued and the number of undue hardship exemptions granted, including demographic data of the deceased beneficiaries where available.

(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. In addition to the other data required under this subsection, the Department shall compile on a monthly basis data on the percentage of beneficiaries whose eligibility is renewed through ex parte redeterminations as described in subsection (b) of Section 5-1.6 of this Code, subject to federal approval of the changes made in subsection (b) of Section 5-1.6 by this amendatory Act

of the 102nd General Assembly. 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.

(i) It is the determination of the General Assembly that the Department must include seniors and persons with disabilities in ex parte renewals. It is the determination of the General Assembly that the Department must use its asset verification system to assist in the determination of whether an individual's coverage can be renewed using the ex parte process. If a State Plan amendment is required, the Department shall pursue such State Plan amendment by July 1, 2022. Within 60 days after receiving federal approval or guidance, the Department of Healthcare and Family Services and the Department of Human Services shall make necessary technical and rule changes to implement these changes to the

redetermination process.

(Source: P.A. 101-209, eff. 8-5-19; 101-649, eff. 7-7-20.)

(305 ILCS 5/11-5.5 new)

Sec. 11-5.5. Streamlining enrollment into the Medicare Savings Program.

(a) The Department shall investigate how to align the Medicare Part D Low-Income Subsidy and Medicare Savings Program eligibility criteria.

(b) The Department shall issue a report making recommendations on how to streamline enrollment into Medicare Savings Program benefits by July 1, 2022.

(c) Within 90 days after issuing its report, the Department shall seek public feedback on those recommendations and plans.

(d) By July 1, 2023, the Department shall implement the necessary changes to streamline enrollment into the Medicare Savings Program. The Department may adopt any rules necessary to implement the provisions of this paragraph.

(305 ILCS 5/3-10 rep.)

(305 ILCS 5/3-10.1 rep.)

(305 ILCS 5/3-10.2 rep.)

(305 ILCS 5/3-10.3 rep.)

(305 ILCS 5/3-10.4 rep.)

(305 ILCS 5/3-10.5 rep.)

(305 ILCS 5/3-10.6 rep.)

(305 ILCS 5/3-10.7 rep.)

(305 ILCS 5/3-10.8 rep.)

(305 ILCS 5/3-10.9 rep.)

(305 ILCS 5/3-10.10 rep.)

(305 ILCS 5/5-13.5 rep.)

Section 10. The Illinois Public Aid Code is amended by repealing Sections 3-10, 3-10.1, 3-10.2, 3-10.3, 3-10.4, 3-10.5, 3-10.6, 3-10.7, 3-10.8, 3-10.9, and 3-10.10, and 5-13.5.

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