Rep. Greg Harris

Filed: 2/10/2022

AMENDMENT TO HOUSE BILL 4343

AMENDMENT NO. _____. Amend House Bill 4343 by replacing everything after the enacting clause with the following:

"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 experiencing homelessness and for people without any income at the time of application or redetermination. These changes shall seek to move all people experiencing homelessness and people without income into an automated redetermination process, commonly referred to as ex parte redetermination. Within 60 days of 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. Upon the receipt of federal approval or guidance, the Department of Healthcare and Family Services and the Department of Human Services shall produce internal guidance to all agency staff to inform them of these changes. 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. The Department shall waive recovery in cases in which it is not cost-effective for the Department to recover from an estate. The estate does not need to assert undue hardship. When the estate is not valued at a minimum cost-effectiveness threshold of $25,000, it is not cost-effective to pursue recovery. When this cost-effectiveness threshold is not met, the Department shall not file a claim or otherwise pursue recovery. In determining whether an estate meets this cost-effectiveness threshold, 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 shall pursue a State Plan amendment to establish this cost-effectiveness threshold of $25,000, and may increase the cost-effectiveness threshold in the future.

(2) Undue hardship waiver. The estate may apply for a waiver of estate recovery due to undue hardship. The Department shall find that an undue hardship exists when: (i) the estate subject to recovery is an income-producing asset of survivors, such as a family farm, day care, barbershop, or other family business; (ii) the estate subject to recovery is a homestead of modest value defined as roughly half the average home value in the county; (iii) pursuing recovery would cause an heir or beneficiary of the estate to become or remain eligible for a public benefit program, such as the Supplemental Security Income program, the Temporary Assistance for Needy Families Program, or the Supplemental Nutrition Assistance Program; or (iv) any other circumstance justifies such waiver, including, but not limited to, harms posed to any remaining heirs or beneficiaries. The Department shall develop additional hardship waiver standards in addition to those set forth in this paragraph, including waivers to ensure that the Department does not force the sale of a home but instead works to find solutions that allow family

members to remain in a home.

(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. The Department shall publicly report on the Department's estate recovery and waiver activities on its website.

(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 additional 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. Federal regulations require ex parte renewals for recipients of benefits under the State's Aid to the Aged, Blind or Disabled (AABD) program, but the

Department conducts few, if any, AABD ex parte renewals. This leaves individuals in the AABD population subject to loss of coverage and gaps in care, although the income in an AABD household is often stable and can be electronically verified. It is the determination of the General Assembly that the Department must use its asset verification system, accept the data provided about an individual's assets, and automatically renew the individual's coverage. If a State Plan amendment is required, the Department shall pursue such State Plan amendment by July 1, 2022. Within 60 days of 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) It is the determination of the General Assembly that Medicare Savings Programs (MSPs) are under enrolled in the State due to beneficiaries' lack of awareness of the programs and MSPs' cumbersome eligibility determination and enrollment processes. To achieve efficiencies in the enrollment process and to simplify outreach to potential beneficiaries, the Department shall investigate how to align the Medicare Part D

Low-Income Subsidy (LIS) and Medicare Savings Program eligibility criteria. It is the intent of the General Assembly that under-enrollment be reduced while the Department maintains current rules that are more generous than the federal standard, and use the LIS leads data that it receives from the Social Security Administration to automate or streamline enrollment into MSP benefits.

(b) The Department shall issue a report making recommendations on alignment and outreach by July 1, 2022. The report shall address the following, at a minimum:

(1) the eligibility criteria and definitions that the Department proposes to change to make full use of LIS leads data, including, but not limited to, eligibility criteria governing family size, income and asset disregards, treatment of in-kind support, accepting the burial set aside without documentation, consideration of the value of a second vehicle, disregarding the cash value of a life insurance policy, and any other differences between the processes used to determine what is counted as income or assets between MSP and LIS;

(2) any other eligibility changes or program improvements the Department will adopt, including, but not limited to, removing the asset test for MSPs or implementing improvements to make better use of the LIS leads data transmitted to the Department, and

(3) the Department's plan for targeted outreach to

increase MSP enrollment.

(c) Within 60 days of issuing its report, the Department shall seek public feedback on those recommendations and plans.

(d) By October 31, 2022, in response to the report and public feedback, the Department shall change the MSP eligibility criteria to facilitate the use of LIS leads data to automate or streamline enrollment into MSP benefits. 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.".