SB3136

LRB102 20901 KTG 29785 b

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

SB3136

Introduced 1/12/2022, by Sen. Mike Simmons

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-1.6 new
305 ILCS 5/11-5.1

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services to seek a State Plan amendment or any federal waivers necessary to implement 12 months of continuous eligibility for adults participating in the medical assistance program. Requires the Department to secure federal financial participation in accordance with the amendatory Act for expenditures made in State Fiscal Year 2023 and every State fiscal year thereafter. Requires the Department to seek a State Plan amendment or any federal waivers or approvals necessary to implement an ex parte redetermination process for persons experiencing homelessness or who are without income at the time of application or redetermination. Requires the Department and the Department of Human Services to make necessary technical and rule changes to implement the ex parte redetermination process. Requires the Department to report on a monthly basis on its website the percentage of medical assistance recipients whose eligibility is renewed through the ex parte redetermination process. Requires the Department to share the data with the Medicaid Advisory Committee and the Medicaid Advisory Committee Public Education Subcommittee. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

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 11-5.1 and by adding Section 5-1.6 as
6 follows:

7 (305 ILCS 5/5-1.6 new)
8 Sec. 5-1.6. Continuous eligibility; ex parte
9 redeterminations.
10 (a) By July 1, 2022, the Department of Healthcare and
11 Family Services shall seek a State Plan amendment or any
12 federal waivers necessary to make changes to the medical
13 assistance program. The Department shall apply for federal
14 approval to implement 12 months of continuous eligibility for
15 adults participating in the medical assistance program. The
16 Department shall secure federal financial participation in
17 accordance with this Section for expenditures made by the
18 Department in State Fiscal Year 2023 and every State fiscal
19 year thereafter.
20 (b) By July 1, 2022, the Department of Healthcare and
21 Family Services shall seek a State Plan amendment or any
22 federal waivers or approvals necessary to make changes to the
23 medical assistance redetermination process for people

1 experiencing homelessness and for people without any income at
2 the time of application or redetermination. These changes
3 shall seek to move all people experiencing homelessness and
4 people without income into an automated redetermination
5 process, commonly referred to as ex parte redetermination.
6 Within 60 days of receiving federal approval or guidance, the
7 Department of Healthcare and Family Services and the
8 Department of Human Services shall make necessary technical
9 and rule changes to implement changes to the redetermination
10 process. Upon the receipt of federal approval or guidance, the
11 Department of Healthcare and Family Services and the
12 Department of Human Services shall produce internal guidance
13 to all agency staff to inform them of these changes. The
14 percentage of medical assistance recipients whose eligibility
15 is renewed through the ex parte redetermination process shall
16 be reported monthly by the Department of Healthcare and Family
17 Services on its website in accordance with subsection (d) of
18 Section 11-5.1 of this Code as well as shared in all Medicaid
19 Advisory Committee meetings and Medicaid Advisory Committee
20 Public Education Subcommittee meetings.

21 (305 ILCS 5/11-5.1)
22 Sec. 11-5.1. Eligibility verification. Notwithstanding any
23 other provision of this Code, with respect to applications for
24 medical assistance provided under Article V of this Code,
25 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

1 information available to the Department as a result of the
2 recipient's application for other non-Medicaid benefits,
3 that is sufficient to make a determination of continued
4 Medicaid eligibility may be reviewed and verified, and
5 subsequent action taken including client notification of
6 continued Medicaid eligibility. The date of client
7 notification establishes the date for subsequent annual
8 Medicaid eligibility reviews. Such verification shall take
9 the form of pay stubs, business or income and expense
10 records for self-employed persons, letters from employers,
11 and any other valid documentation of income including data
12 obtained electronically by the Department or its designees
13 from other sources as described in subsection (b) of this
14 Section. A month's income may be verified by a single pay
15 stub with the monthly income extrapolated from the time
16 period covered by the pay stub. The Department shall send
17 a notice to recipients at least 60 days prior to the end of
18 their period of eligibility that informs them of the
19 requirements for continued eligibility. If a recipient
20 does not fulfill the requirements for continued
21 eligibility by the deadline established in the notice a
22 notice of cancellation shall be issued to the recipient
23 and coverage shall end no later than the last day of the
24 month following the last day of the eligibility period. A
25 recipient's eligibility may be reinstated without
26 requiring a new application if the recipient fulfills the

1 requirements for continued eligibility prior to the end of
2 the third month following the last date of coverage (or
3 longer period if required by federal regulations). Nothing
4 in this Section shall prevent an individual whose coverage
5 has been cancelled from reapplying for health benefits at
6 any time.
7 (3) By no later than July 1, 2011, require
8 verification of Illinois residency.
9 The Department, with federal approval, may choose to adopt
10 continuous financial eligibility for a full 12 months for
11 adults on Medicaid.
12 (b) The Department shall establish or continue cooperative
13 arrangements with the Social Security Administration, the
14 Illinois Secretary of State, the Department of Human Services,
15 the Department of Revenue, the Department of Employment
16 Security, and any other appropriate entity to gain electronic
17 access, to the extent allowed by law, to information available
18 to those entities that may be appropriate for electronically
19 verifying any factor of eligibility for benefits under the
20 Program. Data relevant to eligibility shall be provided for no
21 other purpose than to verify the eligibility of new applicants
22 or current recipients of health benefits under the Program.
23 Data shall be requested or provided for any new applicant or
24 current recipient only insofar as that individual's
25 circumstances are relevant to that individual's or another
26 individual's eligibility.

1 (c) Within 90 days of the effective date of this
2 amendatory Act of the 96th General Assembly, the Department of
3 Healthcare and Family Services shall send notice to current
4 recipients informing them of the changes regarding their
5 eligibility verification.
6 (d) As soon as practical if the data is reasonably
7 available, but no later than January 1, 2017, the Department
8 shall compile on a monthly basis data on eligibility
9 redeterminations of beneficiaries of medical assistance
10 provided under Article V of this Code. In additional to the
11 other data required under this subsection, the Department
12 shall compile on a monthly basis data on the percentage of
13 beneficiaries whose eligibility is renewed through ex parte
14 redeterminations as described in subsection (b) of Section
15 5-1.6 of this Code, subject to federal approval of the changes
16 made in subsection (b) of Section 5-1.6 by this amendatory Act
17 of the 102nd General Assembly. This data shall be posted on the
18 Department's website, and data from prior months shall be
19 retained and available on the Department's website. The data
20 compiled and reported shall include the following:
21 (1) The total number of redetermination decisions made
22 in a month and, of that total number, the number of
23 decisions to continue or change benefits and the number of
24 decisions to cancel benefits.
25 (2) A breakdown of enrollee language preference for
26 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.

1 (G) Other reasons tracked by the Department for
2 the purpose of ensuring program integrity.
3 (4) If a vendor is utilized to provide services in
4 support of the Department's redetermination decision
5 process, the total number of redetermination decisions
6 made in a month and, of that total number, the number of
7 decisions to continue or change benefits, and the number
8 of decisions to cancel benefits (i) with the involvement
9 of the vendor and (ii) without the involvement of the
10 vendor.
11 (5) Of the total number of benefit cancellations in a
12 month, the number of beneficiaries who return from
13 cancellation within one month, the number of beneficiaries
14 who return from cancellation within 2 months, and the
15 number of beneficiaries who return from cancellation
16 within 3 months. Of the number of beneficiaries who return
17 from cancellation within 3 months, the percentage of those
18 cancellations due to each of the reasons listed under
19 paragraph (3) of this subsection.
20 (e) The Department shall conduct a complete review of the
21 Medicaid redetermination process in order to identify changes
22 that can increase the use of ex parte redetermination
23 processing. This review shall be completed within 90 days
24 after the effective date of this amendatory Act of the 101st
25 General Assembly. Within 90 days of completion of the review,
26 the Department shall seek written federal approval of policy

1 changes the review recommended and implement once approved.
2 The review shall specifically include, but not be limited to,
3 use of ex parte redeterminations of the following populations:
4 (1) Recipients of developmental disabilities services.
5 (2) Recipients of benefits under the State's Aid to
6 the Aged, Blind, or Disabled program.
7 (3) Recipients of Medicaid long-term care services and
8 supports, including waiver services.
9 (4) All Modified Adjusted Gross Income (MAGI)
10 populations.
11 (5) Populations with no verifiable income.
12 (6) Self-employed people.
13 The report shall also outline populations and
14 circumstances in which an ex parte redetermination is not a
15 recommended option.
16 (f) The Department shall explore and implement, as
17 practical and technologically possible, roles that
18 stakeholders outside State agencies can play to assist in
19 expediting eligibility determinations and redeterminations
20 within 24 months after the effective date of this amendatory
21 Act of the 101st General Assembly. Such practical roles to be
22 explored to expedite the eligibility determination processes
23 shall include the implementation of hospital presumptive
24 eligibility, as authorized by the Patient Protection and
25 Affordable Care Act.
26 (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

1 after the effective date of this amendatory Act of the
2 101st General Assembly.
3 (3) All reports shall be published on the Department's
4 website.
5 (Source: P.A. 101-209, eff. 8-5-19; 101-649, eff. 7-7-20.)

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