DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Rights and Responsibilities

2) Code Citation: 89 Ill. Adm. Code 102

3)

Section Numbers:	Proposed Action:
102.80	Amendment
102.210	Amendment

4) Statutory Authority: Authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and implementing the federal Deficit Reduction Act of 2005 (PL 109-171)

5) Complete Description of the Subjects and Issues Involved: In conjunction with the rulemaking affecting 89 Ill. Adm. Code 120 that also appears in this issue of the *Illinois Register*, these amendments implement the provisions of the Deficit Reduction Act of 2005 (PL 109-171, 2006 S 1932) (DRA).

Because of the complexity of the policy represented here, the Department encourages all interested parties to review these rules carefully. Furthermore, in the spirit of open communication and transparency, the Department has scheduled an open public hearing to receive, ideas, questions and concerns on the topic. See number 12 below for details.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? No

11) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.

12) Time, Place, and manner in which interested persons may comment on this proposed rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Jeanette Badrov
General Counsel
Illinois Department of Healthcare and Family Services
201 South Grand Avenue E., 3rd Floor
Springfield IL 62763-0002

217/782-1233

The Department requests the submission of written comments within 45 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

In addition, the Department is scheduling a public hearing to receive ideas, questions and concerns on the subject of this proposed rule (and those changes proposed for Part 120). The public hearing will be for the sole purpose of gathering public comments on the proposed amendments. The Department may, at its discretion, respond to questions as time permits. If any person requires special accommodations, please notify Jeanette Badrov (see above for contact information) at least five business days in advance of the hearing, if possible.

Date, Time and Location of Public Hearing:
Monday, September 13, 2010
9:00 AM to 12:00 PM
Michael A. Bilandic Building, RM 500
160 North LaSalle Street
Chicago, Illinois

Persons interested in presenting testimony at this hearing are advised that the Illinois Department of Healthcare and Family Services will adhere to the following procedures in the conduct of the hearing:

a) No oral testimony shall exceed an aggregate of 5 minutes.

b) Each person presenting oral testimony shall provide to the hearing officer a written, legible (preferably typed) copy of such testimony at the time the oral testimony is presented.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

c) No oral testimony will be accepted without a written copy of the testimony being provided.

d) No person will be recognized to speak for a second time until all persons wishing to testify have done so.

e) In order to provide for a balanced presentation of views and to facilitate the orderly conduct of the hearing, the hearing officer may impose such other rules of procedures, including the order of call of witnesses, as she/he deems necessary.

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this rulemaking was summarized: January 2010

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES~~PUBLIC AID~~
SUBCHAPTER a: GENERAL PROVISIONS

PART 102
RIGHTS AND RESPONSIBILITIES

Section
102.1 Incorporation by Reference
102.10 Rights of Clients
102.20 Nondiscrimination
102.21 Voter Registration
102.25 Grievance Rights of Clients
102.30 Confidentiality of Case Information
102.35 Case Records
102.40 Freedom of Choice
102.50 Reporting Change of Circumstances
102.60 Referral Requirements
102.63 Reporting Child Abuse/Neglect
102.66 Suitability of Home
102.70 Notice to Client
102.80 Right to Appeal
102.81 Continuation of Assistance Pending Appeal
102.82 Time Limit for Filing an Appeal
102.83 Examining Department Records
102.84 Child Care
102.90 Voluntary Repayment of Assistance
102.100 Excess Assistance (Recodified)
102.110 Recoupment of Overpayments (Recodified)
102.120 Correction of Underpayments
102.200 Recovery of Assistance
102.210 Estate Claims
102.220 Real Property Liens
102.230 Filing and Renewal of Liens
102.235 Liens on Property of Institutionalized Recipients
102.240 Foreclosure of Liens
102.250 Release of Liens
102.260 Personal Injury Claims
102.270 Convictions of Fraud – Eligibility

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

102.280 Single Conviction of Fraud – Administrative Review Board

AUTHORITY: Implementing Article XI and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Art. XI and 12-13] and implementing the federal Deficit Reduction Act of 2005.

SOURCE: Filed and effective December 31, 1977; peremptory rule at 2 Ill. Reg. 52, p. 449, effective December 13, 1978; amended at 2 Ill. Reg. 52, p. 462, December 23, 1978; peremptory amendment at 3 Ill. Reg. 11, p. 39, effective March 1, 1979; amended at 3 Ill. Reg. 41, p. 167, effective October 1, 1979; amended at 3 Ill Reg. 43, p. 196, effective October 15, 1979; amended at 5 Ill. Reg. 8035, effective July 27, 1981; amended at 5 Ill. Reg. 10775, effective October 1, 1981; amended at 6 Ill. Reg. 894, effective January 7, 1982; codified at 7 Ill. Reg. 5706; amended at 7 Ill. Reg. 8350, effective July 1, 1983; amended at 8 Ill. Reg. 18910, effective September 26, 1984; amended at 9 Ill. Reg. 327, effective December 31, 1984; amended at 9 Ill. Reg. 3730, effective March 13, 1985; amended at 9 Ill. Reg. 6812, effective April 26, 1985; amended at 9 Ill. Reg. 7162, effective May 1, 1985; amended at 9 Ill. Reg. 13091, effective August 16, 1985; amended at 9 Ill. Reg. 14704, effective September 13, 1985; amended at 9 Ill. Reg. 15912, effective October 4, 1985; amended at 10 Ill. Reg. 3981, effective February 22, 1986; amended at 10 Ill. Reg. 14795, effective August 29, 1986; amended at 10 Ill. Reg. 19088, effective October 24, 1986; Sections 102.100 and 102.110 recodified to 89 Ill. Adm. Code 165 at 10 Ill. Reg. 21094; amended at 11 Ill. Reg. 14067, effective August 10, 1987; amended at 11 Ill. Reg. 18239, effective October 30, 1987; amended at 12 Ill. Reg. 3735, effective February 5, 1988; amended at 13 Ill. Reg. 3940, effective March 10, 1989; amended at 14 Ill. Reg. 13279, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 20078, effective December 3, 1990, for a maximum of 150 days; amended at 15 Ill. Reg. 7202, effective April 30, 1991; amended at 18 Ill. Reg. 273, effective December 28, 1993; amended at 18 Ill. Reg. 8938, effective June 3, 1994; amended at 19 Ill. Reg. 1108, effective January 26, 1995; emergency amendment at 19 Ill. Reg. 12320, effective August 14, 1995, for a maximum of 150 days; amended at 20 Ill. Reg. 883, effective December 29, 1995; amended at 21 Ill. Reg. 619, effective January 1, 1997; emergency amendment at 21 Ill. Reg. 4037, effective March 14, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 7438, effective June 1, 1997; amended at 21 Ill. Reg. 11955, effective August 13, 1997; amended at 24 Ill. Reg. 10294, effective July 1, 2000; amended at 25 Ill. Reg. 16111, effective December 1, 2001; amended at 34 Ill. Reg. _____, effective _____.

Section 102.80 Right to Appeal

a) Any individual who applies for or receives financial or medical assistance, social services or food stamps benefits shall have the right to appeal any of the

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

following:

1) Refusal to accept an application or reapplication;

2) Failure to act on an application within the mandated time period;

3) A decision to deny an application;

4) A decision to reduce, suspend, terminate or in any way change the amount of assistance/food stamps or manner in which it is provided;

5) Failure to make a decision or take appropriate action on any request which the client makes;

6) A decision affecting the basis of issuance of food stamps with which the client disagrees;

7) A decision to deny the payment for a medical service or item that requires prior approval;

8) A decision granting prior approval request for a lesser or different medical service or item than was originally requested;

9) An issue of Department policy, if the client is aggrieved by its application; ~~or~~

10) The determination of the amount of a premium that may be charged to a client under any medical assistance program. The Department's determination of the amount of a premium shall remain in force during the appeal process; or~~.~~

11) A denial of a request for a hardship waiver under Sections 120.379(i), 120.385(c)(3) and 120.388(r) of this Part.

b) The appeal may be filed by the client or the client's authorized representative. For food stamp clients, the request for a hearing may be made orally or in writing, and the appeal process is initiated effective with the date of the request.

(Source: Amended at 34 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section 102.210 Estate Claims

a) Definitions in this Section are as follows:

1) "Estate" – all real and personal property within an individual's estate as provided in Illinois probate law. For a decedent who received benefits under a qualified long term care insurance policy in connection with which assets were disregarded (see subsection (f), the term "estate" includes all real and personal property in which the individual had legal title or interest at the time of death (to the extent of such interest), including assets conveyed to a survivor, heir or assignee of the deceased person through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement.

2) "Beneficiary" – any person nominated in a will to receive an interest in property other than in a fiduciary capacity.

3) "Heir" – any person entitled under the statutes to an interest in property of a decedent.

b) The Department's claim against the estate of a deceased recipient or against the estate of the recipient's deceased spouse, regardless of the order of death, shall encompass:

1) All income maintenance assistance paid out at any time; and

2) All medical assistance paid out:

A) at any time for a permanently institutionalized recipient whose real property is subject to the Department's lien; or

B) except the costs of Community Care Program (CCP) services, prior to October 1, 1993, for a recipient while 65 years of age or older; or

C) on or after October 1, 1993, for a recipient while 55 years of age or older; or

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

D) for Medicare cost sharing expenses of a Qualified Medicare Beneficiary (QMB).

c) The claim shall apply to assistance provided to or in behalf of a recipient on or after the following dates:

Assistance Program	Effective Date
1) AABD (Aged) (AABD(A))	1) 1963
2) AABD (Blind) and (Disabled) (AABD(B) and (D))	2) November 1963
3) MANG (Aged), (Blind), and (Disabled) (MANG(A),(B), and (D))	3) January 1, 1966

d) The Department shall not enforce a claim for medical assistance against any property, real or personal, of a deceased recipient while one or more of the following relatives survives: spouse of decedent, child under 21, or child over 21 who is blind or permanently and totally disabled.

e) The Department shall not enforce a claim for income maintenance assistance against homestead property of a deceased recipient while the homestead is occupied by one or more of the surviving relatives previously specified.

f) The Department shall not enforce a claim against the estate of a decedent to the extent assets were disregarded because the person was covered under a qualified long term care policy as provided under Section 120.382(c) of this Part.

gf) To avoid undue hardship, the Department will waive its right to recover from a decedent's estate if pursuing recovery would cause an heir or beneficiary of the estate to become or remain eligible for a public benefit program, such as SSI, TANF or Food Stamps. The Department may limit the scope of its waiver to that portion of the estate that the heir or beneficiary would receive and pursue recovery against the balance of the estate, if any. The Department will not waive recovery despite undue hardship if payment of the claims of other estate creditors that are equal or inferior in priority to the Department's claim will exhaust the estate and defeat the purpose of the waiver. The Department will provide written notice to heirs and beneficiaries known to the Department of the opportunity, time

frame and method to request a waiver of estate recovery based on undue hardship.

hg) The Department may defer or waive enforcement of its claim for income maintenance assistance if it determines that:

1) The deceased recipient is survived by a dependent spouse and minor child or children; or

2) Rehabilitative training for employment or other means of self-support for the surviving spouse or children is feasible, and deferment or waiver will facilitate achievement of self-support status and prevent or reduce the likelihood of return to dependency on public assistance of the spouse or children.

(Source: Amended at 34 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Medical Assistance Programs

2) Code Citation: 89 Ill. Adm. Code 120

3)

Section Numbers:	Proposed Action:
120.10	Amendment
120.20	Amendment
120.40	Repeal
120.60	Amendment
120.61	Amendment
120.62	Repeal
120.63	Repeal
120.65	Repeal
120.308	Amendment
120.347	Amendment
120.379	Amendment
120.380	Amendment
120.381	Amendment
120.382	Amendment
120.384	Amendment
120.385	Amendment
120.387	Amendment
120.388	New Section
120.TABLE B	Repeal

4) Statutory Authority: Authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13] and implementing the federal Deficit Reduction Act of 2005 (PL 109-171)

5) Complete Description of the Subjects and Issues Involved: In conjunction with the rulemaking affecting 89 Ill. Adm. Code 102 that also appears in this issue of the *Illinois Register*, these amendments implement the provisions of the Deficit Reduction Act of 2005 (PL 109-171, 2006 S 1932) (DRA) and other provisions of federal law relating to the medical assistance programs, financial eligibility for long term care and transfers of assets. The rulemaking also clarifies existing rules and cleans up outdated and redundant rules in Part 120.

In a separate, companion rulemaking to follow, the Department will clarify that the cost of community care services funded by the Department on Aging may be used to meet spenddown for Medicaid eligibility.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

In preparing this rule filing, the Department is mindful of its statutory mandate that the medical assistance program, funded with taxpayer dollars, is the payer of last resort for those individuals who have no other means to pay for the cost of their long term care services. Consequently and taking into account allowances to prevent spousal impoverishment and other specific exceptions, these proposed rules are predicated on the principle that individuals should use their own income and assets to pay for their care before turning to the State for that support.

Because of the complexity of the policy represented here, the Department encourages all interested parties to review these rules carefully. Furthermore, in the interests of open communication and transparency, the Department has scheduled an open public hearing to receive ideas, questions and concerns on the topic. See item 12 below for details.

6) Published studies or reports, and sources of underlying data, used to compose this rulemaking: None

7) Will this rulemaking replace any emergency rulemaking currently in effect? No

8) Does this rulemaking contain an automatic repeal date? No

9) Does this rulemaking contain incorporations by reference? No

10) Are there any other proposed rulemakings pending on this Part? Yes

Section Numbers:	Proposed Action:	Illinois Register Citation:
120.318	Amendment	34 Ill. Reg. 2631; February 19, 2010
120.400	Amendment	34 Ill. Reg. 2631; February 19, 2010

11) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.

12) Time, Place, and Manner in Which Interested Persons May Comment on this Proposed Rulemaking: Any interested parties may submit comments, data, views, or arguments concerning this proposed rulemaking. All comments must be in writing and should be addressed to:

Jeanette Badrov
Illinois Department of Healthcare and Family Services
201 South Grand Avenue E., 3rd Floor

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Springfield IL 62763-0002

217/782-1233

The Department requests the submission of written comments within 45 days after the publication of this Notice. The Department will consider all written comments it receives during the first notice period as required by Section 5-40 of the Illinois Administrative Procedure Act [5 ILCS 100/5-40].

In addition, the Department is scheduling a public hearing to receive ideas, questions and concerns on the subject of this proposed rule (and those changes proposed for Part 102). The public hearing will be for the sole purpose of gathering public comments on the proposed amendments. The Department may, at its discretion, respond to questions as time permits. If any person requires special accommodations, please notify Jeanette Badrov (see above for contact information) at least five business days in advance of the hearing, if possible.

Date, Time and Location of Public Hearing:
Monday, September 13, 2010
9:00 AM to 12:00 PM
Michael A. Bilandic Building, RM 500
160 North LaSalle Street
Chicago, Illinois

Persons interested in presenting testimony at this hearing are advised that the Illinois Department of Healthcare and Family Services will adhere to the following procedures in the conduct of the hearing:

a) No oral testimony shall exceed an aggregate of 5 minutes.

b) Each person presenting oral testimony shall provide to the hearing officer a written, legible (preferably typed) copy of such testimony at the time the oral testimony is presented. No oral testimony will be accepted without a written copy of the testimony being provided.

c) No person will be recognized to speak for a second time until all persons wishing to testify have done so.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

d) In order to provide for a balanced presentation of views and to facilitate the orderly conduct of the hearing, the hearing officer may impose such other rules of procedures, including the order of call of witnesses, as she/he deems necessary.

13) Initial Regulatory Flexibility Analysis:

A) Types of small businesses, small municipalities and not-for-profit corporations affected: None

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: None

14) Regulatory Agenda on which this Rulemaking was Summarized: January 2010

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 120
MEDICAL ASSISTANCE PROGRAMS

SUBPART A: GENERAL PROVISIONS

Section
120.1 Incorporation by Reference

SUBPART B: ASSISTANCE STANDARDS

Section
120.10 Eligibility for~~For~~ Medical Assistance
120.11 MANG(P) Eligibility
120.12 Healthy Start – Medicaid Presumptive Eligibility Program For Pregnant Women
120.14 Presumptive Eligibility for Children
120.20 MANG(AABD) Income Standard
120.30 MANG(C) Income Standard
120.31 MANG(P) Income Standard
120.32 FamilyCare Assist
120.34 FamilyCare Share and FamilyCare Premium Level 1
120.40 Exceptions To Use Of MANG Income Standard (Repealed)
120.50 AMI Income Standard (Repealed)

SUBPART C: FINANCIAL ELIGIBILITY DETERMINATION

Section
120.60 Community Cases ~~Other Than Long Term Care, Pregnant Women and Certain Children~~
120.61 Long Term Care~~Cases in Intermediate Care, Skilled Nursing Care and DMHDD – MANG(AABD) and All Other Licensed Medical Facilities~~
120.62 Department of Mental Health and Developmental Disabilities (DMHDD) Approved Home and Community Based Residential Settings Under 89 Ill. Adm. Code 140.643 (Repealed)
120.63 Department of Mental Health and Developmental Disabilities (DMHDD) Approved Home and Community Based Residential Settings (Repealed)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

SUBPART D: MEDICARE PREMIUMS

SUBPART E: RECIPIENT RESTRICTION PROGRAM

SUBPART F: MIGRANT MEDICAL PROGRAM

SUBPART G: AID TO THE MEDICALLY INDIGENT

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

SUBPART H: MEDICAL ASSISTANCE – NO GRANT (MANG) ELIGIBILITY FACTORS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

120.317	Supplemental Payments
120.318	Institutional Status
120.319	Assignment of Rights to Medical Support and Collection of Payment
120.320	Cooperation in Establishing Paternity and Obtaining Medical Support
120.321	Good Cause for Failure to Cooperate in Establishing Paternity and Obtaining Medical Support
120.322	Proof of Good Cause for Failure to Cooperate in Establishing Paternity and Obtaining Medical Support
120.323	Suspension of Paternity Establishment and Obtaining Medical Support Upon Finding Good Cause
120.324	Health Insurance Premium Payment (HIPP) Program
120.325	Health Insurance Premium Payment (HIPP) Pilot Program
120.326	Foster Care Program
120.327	Social Security Numbers
120.328	Compliance with Employment and Work Activity Requirements (Suspended; Repealed)
120.329	Compliance with Non-Economic Eligibility Requirements of Article IV (Suspended; Repealed)
120.330	Unearned Income
120.332	Budgeting Unearned Income
120.335	Exempt Unearned Income
120.336	Education Benefits
120.338	Incentive Allowance
120.340	Unearned Income In-Kind
120.342	Child Support and Spousal Maintenance Payments
120.345	Earmarked Income
120.346	Medicaid Qualifying Trusts
120.347	Treatment of Trusts and Annuities
120.350	Lump Sum Payments and Income Tax Refunds
120.355	Protected Income
120.360	Earned Income
120.361	Budgeting Earned Income
120.362	Exempt Earned Income
120.363	Earned Income Disregard – MANG(C)
120.364	Earned Income Exemption
120.366	Exclusion From Earned Income Exemption
120.370	Recognized Employment Expenses
120.371	Income From Work/Study/Training Programs
120.372	Earned Income From Self-Employment

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

SUBPART I: SPECIAL PROGRAMS

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

120.TABLE B Life Expectancy (Repealed)

AUTHORITY: Implementing Articles III, IV, V and VI and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and VI and 12-13] and implementing the federal Deficit Reduction Act of 2005.

SOURCE: Filed effective December 30, 1977; peremptory amendment at 2 Ill. Reg. 17, p. 117, effective February 1, 1978; amended at 2 Ill. Reg. 31, p. 134, effective August 5, 1978; emergency amendment at 2 Ill. Reg. 37, p. 4, effective August 30, 1978, for a maximum of 150 days; peremptory amendment at 2 Ill. Reg. 46, p. 44, effective November 1, 1978; peremptory amendment at 2 Ill. Reg. 46, p. 56, effective November 1, 1978; emergency amendment at 3 Ill. Reg. 16, p. 41, effective April 9, 1979, for a maximum of 150 days; emergency amendment at 3 Ill. Reg. 28, p. 182, effective July 1, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 33, p. 399, effective August 18, 1979; amended at 3 Ill. Reg. 33, p. 415, effective August 18, 1979; amended at 3 Ill. Reg. 38, p. 243, effective September 21, 1979; peremptory amendment at 3 Ill. Reg. 38, p. 321, effective September 7, 1979; amended at 3 Ill. Reg. 40, p. 140, effective October 6, 1979; amended at 3 Ill. Reg. 46, p. 36, effective November 2, 1979; amended at 3 Ill. Reg. 47, p. 96, effective November 13, 1979; amended at 3 Ill. Reg. 48, p. 1, effective November 15, 1979; peremptory amendment at 4 Ill. Reg. 9, p. 259, effective February 22, 1980; amended at 4 Ill. Reg. 10, p. 258, effective February 25, 1980; amended at 4 Ill. Reg. 12, p. 551, effective March 10, 1980; amended at 4 Ill. Reg. 27, p. 387, effective June 24, 1980; emergency amendment at 4 Ill. Reg. 29, p. 294, effective July 8, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 37, p. 797, effective September 2, 1980; amended at 4 Ill. Reg. 37, p. 800, effective September 2, 1980; amended at 4 Ill. Reg. 45, p. 134, effective October 27, 1980; amended at 5 Ill. Reg. 766, effective January 2, 1981; amended at 5 Ill. Reg. 1134, effective January 26, 1981; peremptory amendment at 5 Ill. Reg. 5722, effective June 1, 1981; amended at 5 Ill. Reg. 7071, effective June 23, 1981; amended at 5 Ill. Reg. 7104, effective June 23, 1981; amended at 5 Ill. Reg. 8041, effective July 27, 1981; amended at 5 Ill. Reg. 8052, effective July 24, 1981; peremptory amendment at 5 Ill. Reg. 8106, effective August 1, 1981; peremptory amendment at 5 Ill. Reg. 10062, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10079, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10095, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10113, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10124, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 10131, effective October 1, 1981; amended at 5 Ill. Reg. 10730, effective October 1, 1981; amended at 5 Ill. Reg. 10733, effective October 1, 1981; amended at 5 Ill. Reg. 10760, effective October 1, 1981; amended at 5 Ill. Reg. 10767, effective October 1, 1981; peremptory amendment at 5 Ill. Reg. 11647, effective October 16, 1981; peremptory amendment at 6 Ill. Reg. 611, effective January 1, 1982; amended at 6 Ill. Reg. 1216, effective January 14, 1982; emergency amendment at 6 Ill. Reg. 2447, effective March 1, 1982, for a maximum of 150 days;

peremptory amendment at 6 Ill. Reg. 2452, effective February 11, 1982; peremptory amendment at 6 Ill. Reg. 6475, effective May 18, 1982; peremptory amendment at 6 Ill. Reg. 6912, effective May 20, 1982; emergency amendment at 6 Ill. Reg. 7299, effective June 2, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 8115, effective July 1, 1982; amended at 6 Ill. Reg. 8142, effective July 1, 1982; amended at 6 Ill. Reg. 8159, effective July 1, 1982; amended at 6 Ill. Reg. 10970, effective August 26, 1982; amended at 6 Ill. Reg. 11921, effective September 21, 1982; amended at 6 Ill. Reg. 12293, effective October 1, 1982; amended at 6 Ill. Reg. 12318, effective October 1, 1982; amended at 6 Ill. Reg. 13754, effective November 1, 1982; amended at 7 Ill. Reg. 394, effective January 1, 1983; codified at 7 Ill. Reg. 6082; amended at 7 Ill. Reg. 8256, effective July 1, l983; amended at 7 Ill. Reg. 8264, effective July 5, l983; amended (by adding Section being codified with no substantive change) at 7 Ill. Reg. 14747; amended (by adding Sections being codified with no substantive change) at 7 Ill. Reg. 16108; amended at 8 Ill. Reg. 5253, effective April 9, 1984; amended at 8 Ill. Reg. 6770, effective April 27, 1984; amended at 8 Ill. Reg. 13328, effective July 16, 1984; amended (by adding Sections being codified with no substantive change) at 8 Ill. Reg. 17897; amended at 8 Ill. Reg. 18903, effective September 26, 1984; peremptory amendment at 8 Ill. Reg. 20706, effective October 3, 1984; amended at 8 Ill. Reg. 25053, effective December 12, 1984; emergency amendment at 9 Ill. Reg. 830, effective January 3, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 4515, effective March 25, 1985; amended at 9 Ill. Reg. 5346, effective April 11, 1985; amended at 9 Ill. Reg. 7153, effective May 6, 1985; amended at 9 Ill. Reg. 11346, effective July 8, 1985; amended at 9 Ill. Reg. 12298, effective July 25, 1985; amended at 9 Ill. Reg. 12823, effective August 9, 1985; amended at 9 Ill. Reg. 15903, effective October 4, 1985; amended at 9 Ill. Reg. 16300, effective October 10, 1985; amended at 9 Ill. Reg. 16906, effective October 18, 1985; amended at 10 Ill. Reg. 1192, effective January 10, 1986; amended at 10 Ill. Reg. 3033, effective January 23, 1986; amended at 10 Ill. Reg. 4907, effective March 7, 1986; amended at 10 Ill. Reg. 6966, effective April 16, 1986; amended at 10 Ill. Reg. 10688, effective June 3, 1986; amended at 10 Ill. Reg. 12672, effective July 14, 1986; amended at 10 Ill. Reg. 15649, effective September 19, 1986; amended at 11 Ill. Reg. 3992, effective February 23, 1987; amended at 11 Ill. Reg. 7652, effective April 15, 1987; amended at 11 Ill. Reg. 8735, effective April 20, 1987; emergency amendment at 11 Ill. Reg. 12458, effective July 10, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 14034, effective August 14, 1987; amended at 11 Ill. Reg. 14763, effective August 26, 1987; amended at 11 Ill. Reg. 20142, effective January 1, 1988; amended at 11 Ill. Reg. 20898, effective December 14, 1987; amended at 12 Ill. Reg. 904, effective January 1, 1988; amended at 12 Ill. Reg. 3516, effective January 22, 1988; amended at 12 Ill. Reg. 6234, effective March 22, 1988; amended at 12 Ill. Reg. 8672, effective May 13, 1988; amended at 12 Ill. Reg. 9132, effective May 20, 1988; amended at 12 Ill. Reg. 11483, effective June 30, 1988; emergency amendment at 12 Ill. Reg. 11632, effective July 1, 1988, for a maximum of 150 days; emergency amendment at 12 Ill. Reg. 11839, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12835, effective July 22, 1988; emergency amendment at 12 Ill. Reg.

13243, effective July 29, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 17867, effective October 30, 1988; amended at 12 Ill. Reg. 19704, effective November 15, 1988; amended at 12 Ill. Reg. 20188, effective November 23, 1988; amended at 13 Ill. Reg. 116, effective January 1, 1989; amended at 13 Ill. Reg. 2081, effective February 3, 1989; amended at 13 Ill. Reg. 3908, effective March 10, 1989; emergency amendment at 13 Ill. Reg. 11929, effective June 27, 1989, for a maximum of 150 days; emergency expired November 25, 1989; emergency amendment at 13 Ill. Reg. 12137, effective July 1, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 15404, effective October 6, 1989; emergency amendment at 13 Ill. Reg. 16586, effective October 2, 1989, for a maximum of 150 days; emergency expired March 1, 1990; amended at 13 Ill. Reg. 17483, effective October 31, 1989; amended at 13 Ill. Reg. 17838, effective November 8, 1989; amended at 13 Ill. Reg. 18872, effective November 17, 1989; amended at 14 Ill. Reg. 760, effective January 1, 1990; emergency amendment at 14 Ill. Reg. 1494, effective January 2, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 4233, effective March 5, 1990; emergency amendment at 14 Ill. Reg. 5839, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 6372, effective April 16, 1990; amended at 14 Ill. Reg. 7637, effective May 10, 1990; amended at 14 Ill. Reg. 10396, effective June 20, 1990; amended at 14 Ill. Reg. 13227, effective August 6, 1990; amended at 14 Ill. Reg. 14814, effective September 3, 1990; amended at 14 Ill. Reg. 17004, effective September 30, 1990; emergency amendment at 15 Ill. Reg. 348, effective January 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 5302, effective April 1, 1991; amended at 15 Ill. Reg. 10101, effective June 24, 1991; amended at 15 Ill. Reg. 11973, effective August 12, 1991; amended at 15 Ill. Reg. 12747, effective August 16, 1991; amended at 15 Ill. Reg. 14105, effective September 11, 1991; amended at 15 Ill. Reg. 14240, effective September 23, 1991; amended at 16 Ill. Reg. 139, effective December 24, 1991; amended at 16 Ill. Reg. 1862, effective January 20, 1992; amended at 16 Ill. Reg. 10034, effective June 15, 1992; amended at 16 Ill. Reg. 11582, effective July 15, 1992; amended at 16 Ill. Reg. 17290, effective November 3, 1992; amended at 17 Ill. Reg. 1102, effective January 15, 1993; amended at 17 Ill. Reg. 6827, effective April 21, 1993; amended at 17 Ill. Reg. 10402, effective June 28, 1993; amended at 18 Ill. Reg. 2051, effective January 21, 1994; amended at 18 Ill. Reg. 5934, effective April 1, 1994; amended at 18 Ill. Reg. 8718, effective June 1, 1994; amended at 18 Ill. Reg. 11231, effective July 1, 1994; amended at 19 Ill. Reg. 2905, effective February 27, 1995; emergency amendment at 19 Ill. Reg. 9280, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 11931, effective August 11, 1995; amended at 19 Ill. Reg. 15079, effective October 17, 1995; amended at 20 Ill. Reg. 5068, effective March 20, 1996; amended at 20 Ill. Reg. 15993, effective December 9, 1996; emergency amendment at 21 Ill. Reg. 692, effective January 1, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 7423, effective May 31, 1997; amended at 21 Ill. Reg. 7748, effective June 9, 1997; amended at 21 Ill. Reg. 11555, effective August 1, 1997; amended at 21 Ill. Reg. 13638, effective October 1, 1997; emergency amendment at 22 Ill. Reg. 1576, effective January 5, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 7003,

effective April 1, 1998; amended at 22 Ill. Reg. 8503, effective May 1, 1998; amended at 22 Ill. Reg. 16291, effective August 28, 1998; emergency amendment at 22 Ill. Reg. 16640, effective September 1, 1998, for a maximum of 150 days; amended at 22 Ill. Reg. 19875, effective October 30, 1998; amended at 23 Ill. Reg. 2381, effective January 22, 1999; amended at 23 Ill. Reg. 11301, effective August 27, 1999; amended at 24 Ill. Reg. 7361, effective May 1, 2000; emergency amendment at 24 Ill. Reg. 10425, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15075, effective October 1, 2000; amended at 24 Ill. Reg. 18309, effective December 1, 2000; amended at 25 Ill. Reg. 8783, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 10533, effective August 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 16098, effective December 1, 2001; amended at 26 Ill. Reg. 409, effective December 28, 2001; emergency amendment at 26 Ill. Reg. 8583, effective June 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 9843, effective June 26, 2002; emergency amendment at 26 Ill. Reg. 11029, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 15051, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16288, effective October 25, 2002; amended at 27 Ill. Reg. 4708, effective February 25, 2003; emergency amendment at 27 Ill. Reg. 10793, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18609, effective November 26, 2003; amended at 28 Ill. Reg. 4701, effective March 3, 2004; amended at 28 Ill. Reg. 6139, effective April 1, 2004; emergency amendment at 28 Ill. Reg. 6610, effective April 19, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 7152, effective May 3, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11149, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12921, effective September 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13621, effective September 28, 2004; amended at 28 Ill. Reg. 13760, effective October 1, 2004; amended at 28 Ill. Reg. 14541, effective November 1, 2004; amended at 29 Ill. Reg. 820, effective January 1, 2005; amended at 29 Ill. Reg. 10195, effective June 30, 2005; amended at 29 Ill. Reg. 14939, effective September 30, 2005; emergency amendment at 30 Ill. Reg. 521, effective January 1, 2006, for a maximum of 150 days; amended at 30 Ill. Reg. 10314, effective May 26, 2006; emergency amendment at 30 Ill. Reg. 15029, effective September 1, 2006, for a maximum of 150 days; amended at 31 Ill. Reg. 2629, effective January 28, 2007; emergency amendment at 31 Ill. Reg. 7323, effective May 1, 2007, for a maximum of 150 days; amended at 31 Ill. Reg. 11667, effective August 1, 2007; amended at 31 Ill. Reg. 12756, effective August 27, 2007; emergency amendment at 31 Ill. Reg. 15854, effective November 7, 2007, for a maximum of 150 days; emergency rule suspended at 31 Ill. Reg. 16060, effective November 13, 2007; emergency rule repealed, effective May 10, 2008; peremptory amendment at 32 Ill. Reg. 7212, effective April 21, 2008; peremptory amendment suspended at 32 Ill. Reg. 8450, effective May 21, 2008; peremptory amendment repealed under Section 5-125 of the Illinois Administrative Procedure Act, effective November 16, 2008; amended at 32 Ill. Reg. 17428, effective November 1, 2008; peremptory amendment at 32 Ill. Reg. 18889, effective November 18, 2008; peremptory amendment suspended at 32 Ill. Reg. 18906, effective

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

November 19, 2008; suspension withdrawn by the Joint Committee on Administrative Rules at 33 Ill. Reg. 6551, effective April 28, 2009; peremptory amendment repealed by emergency rulemaking at 33 Ill. Reg. 6712, effective April 28, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 1681, effective February 1, 2009; amended at 33 Ill. Reg. 2289, effective March 1, 2009; emergency amendment at 33 Ill. Reg. 5802, effective April 2, 2009, for a maximum of 150 days; emergency expired August 29, 2009; emergency amendment at 33 Ill. Reg. 10785, effective June 30, 2009, for a maximum of 150 days; amended at 33 Ill. Reg. 12703, effective September 7, 2009; amended at 33 Ill. Reg. 15707, effective November 2, 2009; amended at 33 Ill. Reg. 17070, effective December 2, 2009; amended at 34 Ill. Reg. 889, effective December 30, 2009; amended at 34 Ill. Reg. _____, effective _____.

SUBPART B: ASSISTANCE STANDARDS

Section 120.10 Eligibility forFor Medical Assistance

a) Eligibility for medical assistance exists when a personclient meets the non-financial requirements of the program and the person'sclient's countable nonexempt income (Sections 120.330 and 120.360) is equal to or less than the applicable Medical Assistance − No Grant (MANG) standard and, for AABD MANG, countable nonexempt resourcesassets are not in excess of the applicable resourceasset disregards (Section 120.382120.380). Persons receiving basic maintenance grants under Article III or IV of the Public Aid Code are eligible for medical assistance. Financial eligibility for medical assistance for other persons living in the community is determined according to Section 120.60 of this Part, unless otherwise specified. Financial eligibility for medical assistance for persons receiving long-term care services, as defined in Section 120.61(a) of this Part, is determined according to that Section, unless otherwise specified.

b) For AABD MANG, a person'sthe client's countable income and resourcesassets include the person's countableclient's nonexempt income and resourcesassets and the countablenonexempt income and resourcesassets of all persons included in the Medical Assistance standard. The person'sclient's responsible relativesrelative(s) living with the child must be included in the standard. The personclient has the option to request that a dependent child under age 18 in the home who is not included in the MANG unit be included in the MANG standard.

c) For TANF (Temporary Assistance for Needy Families) MANG, a person'sthe client's countable income includes the person'sclient's nonexempt income and the nonexempt income of all persons included in the Medical Assistance standard.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

The person'sclient's responsible relativesrelative(s) living with the child must be included in the standard. The personclient has the option to request that a dependent child under age 18 in the home who is not included in the MANG unit be included in the MANG standard.

d) For AABD MANG, if a person'sthe client's countable nonexempt income is greater than the applicable MANG standard and/or countable nonexempt resourcesassets are over the applicable resourceasset disregard, the personclient must meet the spenddown obligation determined for the applicable time period before becoming eligible to receive medical assistance.

e) For TANF MANG, if a person'sthe client's countable nonexempt income is greater than the applicable MANG standard, the personclient must meet the spenddown obligation determined for the applicable time period before becoming eligible to receive medical assistance.

f) A one month eligibility period is used for personsclients receiving long-term care services (as defined in Section 120.61(a) of this Part)in an intermediate care facility (ICF) or skilled nursing facility (SNF) or in a Department of Human Services facility. Nonexempt income and nonexempt resourcesassets over the resourceasset disregard are applied toward the cost of care on a monthly basis, as provided in Section 120.61 of this Part.

g) Newborns

1) When the Department becomes aware of the birth of a child to a recipient of a TANF or AABD grant or related medical assistance or medical assistance due to the mother's pregnancy, the child shall be deemed to have applied for medical assistance only, without written request, if the mother had been receiving TANF or AABD related medical assistance or medical assistance due to her pregnancy on the date of birth of the child.

2) The newborn shall be eligible to receive medical assistance for a period of time as determined in Section 120.400.

(Source: Amended at 34 Ill. Reg. _____, effective _____)

Section 120.20 MANG(AABD) Income Standard

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~a)~~The monthly countable income standard is 100 percent of the Federal Poverty Level Income Guidelines, as published annually in the Federal Register, for the appropriate family size.

~~b)~~ ~~A client receiving care in a public tuberculosis hospital is not considered to be receiving long term care. Such a client's financial eligibility for MANG is determined by use of the Aid to the Aged, Blind or Disabled MANG(AABD) Income Standard.~~

~~c)~~ ~~The MANG(AABD) Income Standard is used in the determination of financial eligibility for MANG of a client living in a residential home or facility which is not licensed as a medical care facility or as a sheltered care facility. The cost of maintenance and/or care in such a facility is not an allowable medical expense. Regardless of the amount the client may be paying for care and/or maintenance in the facility, the client's nonexempt income and assets in excess of the MANG(AABD) Standard are considered available for payment for medical care not provided in the facility.~~

~~d)~~ ~~MANG~~

~~1)~~ ~~A recipient residing in a Department of Human Services (DHS) State psychiatric hospital or developmental center is allowed $30 per month in lieu of any other MANG standard.~~

~~2)~~ ~~As soon as MANG(AABD) clients become residents of a DHS facility (see subsection (d)(1) of this Section), a skilled nursing facility, an intermediate care facility, or other facility, their eligibility for MANG is determined separately from persons remaining in the home.~~

~~3)~~ ~~When eligibility is based on being temporarily discharged from a DHS facility (see subsection (d)(1) of this Section) for the purpose of obtaining medical care in a general hospital, the amount which the recipient is obligated to pay DHS for care and maintenance is to be allowed in addition to the $30.~~

~~4)~~ ~~Clients in a long term facility are allowed deductions from their non-SSI income to meet the needs of their community spouse, dependent family members and dependent children under the age of 21 years who do not reside with the community spouse. Family members include dependent children under the age of 21 years, dependent adult children, dependent~~

~~parents or dependent siblings of either spouse who reside with the spouse in the community. To calculate the amount of non-SSI income to be deducted, use the:~~

~~A)~~ ~~Community Spouse Maintenance Needs Allowance (as described at Ill. Adm. Code 120.61) if the deduction is for a spouse in the community;~~

~~B)~~ ~~Family Maintenance Needs Allowance (as described in Ill. Adm. Code 120.61), if the deduction is for dependent family members residing with the community spouse; and~~

~~C)~~ ~~Temporary Assistance for Needy Families (TANF) cash grant standard if the deduction is for dependent children under the age of 21 years who do not reside with the community spouse.~~

(Source: Amended at 34 Ill. Reg. _____, effective _____)

Section 120.40 Exceptions To Use Of MANG Income Standard MANG(AABD) (Repealed)

~~a)~~ ~~An individual receiving long-term care in a licensed group care facility is allowed $30 per month in lieu of the MANG standard.~~

~~b)~~ ~~Spouses sharing a room in a long term care facility, including a DMHDD facility or other medical care facility are considered residing together, if it is to their advantage when determining eligibility. For spouses considered residing together allow sixty dollars ($60) per month for each individual in lieu of the MANG standard.~~

~~c)~~ ~~A client 65 years of age and over receiving care in a State mental hospital is considered to be receiving long-term care.~~

~~d)~~ ~~Children under age 21 are considered to be receiving long-term care if they are residing in one of the following settings:~~

~~1)~~ ~~Skilled nursing and intermediate care facilities approved for participation.~~

~~2)~~ ~~Psychiatric hospitals approved for participation.~~

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

(Source: Repealed at 34 Ill. Reg. _____, effective _____)

SUBPART C: FINANCIAL ELIGIBILITY DETERMINATION

Section 120.60 Community Cases ~~Other Than Long Term Care, Pregnant Women and Certain Children~~

The following subsections apply to persons or family units who reside in the community or community-based residential facilities or settings (such as a Community Living Facility, Special Home Placement, Home Individual Program or Community and Residential Alternatives (59 Ill. Adm. Code 120.10) ~~all cases other than those receiving care in licensed intermediate care facilities, licensed skilled nursing facilities, Department of Human Services (DHS) facilities, or DHS approved community based residential settings under 89 Ill. Adm. Code 140.643, or pregnant women and children under age 19 who do not qualify as mandatory categorically needy~~.

a) The eligibility period shall begin with:

1) the first day of the month of application;

2) the first day of any month, prior to the month of application, in which the person~~client~~ meets financial and non-financial eligibility requirements up to three months prior to the month of application, if the person~~client~~ so desires; or

3) the first day of a month, after the month of application, in which the person~~client~~ meets non-financial eligibility requirements.

b) Eligibility Without Spenddown for MANG

1) For MANG AABD ~~MANG~~, if the person's countable~~client's nonexempt~~ income available during the eligibility period is equal to or below the applicable MANG AABD income standard (Section~~Sections~~ 120.20 ~~and 120.30~~) and nonexempt resources~~assets~~ are not in excess of the applicable resource~~asset~~ disregard (Section 120.382), the person~~client~~ is eligible for medical assistance from the first day of the eligibility period. The Department will pay for covered services received during the entire eligibility period.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

2) For TANF MANG, if the person's countable~~client's nonexempt~~ income available during the eligibility period is equal to or below the applicable MANG standard (Sections 120.20 and 120.30), the person~~client~~ is eligible for medical assistance from the first day of the eligibility period. The Department will pay for covered services received during the entire eligibility period.

3) The person~~client~~ is responsible for reporting any changes that occur during the eligibility period that~~which~~ might affect eligibility for medical assistance. If changes occur, appropriate action shall be taken by the Department, including termination of eligibility for medical assistance. If changes in income, resources~~assets~~ or family composition occur that would make the person~~client~~ a spenddown case, a spenddown obligation will be determined and subsection (c) of this Section will apply.

4) A redetermination of eligibility will be made at least every 12 months.

c) Eligibility with Spenddown for MANG

1) For ~~AABD~~ MANG AABD community cases, if the person's countable~~client's nonexempt~~ income available during the applicable eligibility period is greater than the applicable MANG AABD income standard and/or nonexempt resources~~assets~~ are over the applicable resource~~asset~~ disregard, the person~~client~~ must meet the spenddown obligation determined for the eligibility period before becoming eligible to receive medical assistance. The spenddown obligation is the ~~sum of the~~ amount by which the person's countable~~client's nonexempt~~ income exceeds the MANG AABD income standard and/or~~and~~ the amount of nonexempt resources~~assets~~ in excess of the applicable resource~~asset~~ disregard (see Section 120.384).

2) For TANF MANG, if a person's countable~~the client's nonexempt~~ income available during the applicable eligibility period is greater than the applicable MANG standard (see Sections 120.20 and 120.30 of this Part), the person~~client~~ must meet the spenddown obligation determined for the eligibility period before becoming eligible to receive medical assistance. The spenddown obligation is the amount by which the person's countable~~client's nonexempt~~ income exceeds the MANG standard.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

3) A personThe client meets the spenddown obligation by incurring or paying for medical expenses in an amount equal to the spenddown obligation. PersonsAABD MANG clients also have the option of meeting their income or resource spenddown by paying or having a third-party pay the amount of their spenddown obligation to the Department.

A) Incurred expenses are expenses for medical or remedial services:

i) recognized under State law;

ii) rendered to the person, the person's family, or a financially responsible relative;

iii) for which the person is liable in the current month for which eligibility is being sought or was liable in any of the 3-month retroactive eligibility period described in subsection (a) of this Section; and

iv) for which no third party is liable in whole or in part unless the third party is a State program.

B)A) Incurred medicalMedical expenses shall be applied to the spenddown obligation in the following order:

i) Expenses for necessary medical or remedial services, as funded by DHS from sources other than federal funds. TheSuch expenses shall be based on the service provider's usual and customary charges to the public. TheSuch expenses shall not be based on any nominal amount the provider may assess the personclient. These charges are considered incurred the first day of the month, regardless of the day the services are actually provided.

ii) Payments made for medical expenses within the previous six months. Payments are considered incurred the first day of the month of payment.

iii) Unpaid medical expenses. These are considered as of the date of service and are applied in chronological order.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

C)~~B)~~ If multiple medical expenses are incurred on the same day, the expenses shall be applied in the following order:

i) Health insurance deductibles (including Medicare and other co-insurance charges).

ii) All copayment charges incurred or paid on spenddown met day.

iii) Expenses for medical services and/or items not covered by the Department's Medical Assistance Program.

iv) Cost share amounts incurred for in-home care services by individuals receiving services through the Department on Aging (DonA).

v) Expenses incurred for in-home care services by individuals receiving or purchasing services from private providers.

vi) Expenses incurred for medical services or items covered by the Department's Medical Assistance Program. If more than one covered service is received on the day, the charges will be considered in order of amount. The bill for the smallest amount will be considered first.

D)~~C)~~ If a service is provided during the eligibility period but payment may be made by a third party, such as an insurance company, the medical expense will not be considered towards spenddown until the bill is adjudicated. When adjudicated, that part determined to be the responsibility of the person~~client~~ shall be considered as incurred on the date of service.

E)~~D)~~ AABD MANG spenddown persons~~clients~~ may choose to pay or to have a third-party pay the amount of their spenddown obligation to the Department to meet spenddown. The following rules will govern when persons~~clients~~ or third parties choose to pay the spenddown:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

i) Payments to the Department will be applied to the spenddown obligation after all other medical expenses have been applied per subsections (c)(3)(A), ~~and~~ (B) and (C) of this Section.

ii) Excess payments will be credited forward to meet the spenddown obligation of a subsequent month for which the person~~client~~ chooses to meet spenddown.

iii) The spenddown obligation may be met using a combination of medical expenses and amounts paid.

4) After application for medical assistance for cases eligible with a spenddown obligation that~~who~~ do not have a QMB or MANG(P) member, an additional eligibility determination will be made.

A) For TANF MANG, if countable income is greater than the income standard (Section 120.30), and for AABD MANG, if countable income is greater than the income standard or countable resources~~assets~~ are greater than the resource~~asset~~ disregard (Section 120.382(d)), a person will not be enrolled in spenddown unless:

i) the person does not have a spenddown obligation for any month of the 12-month enrollment period;

ii) medical expenses equal the spenddown obligation for at least one month of the 12-month enrollment period; or

iii) the person is on a waiting list or would be on a waiting list to receive a transplant if he or she had a source of payment.

B) Cases that meet any of these conditions will be notified, in writing, of the spenddown obligation. The person~~client~~ will also be notified that his or her case will be reviewed beginning in the sixth month of the 12-month enrollment period. If the person~~client~~ has not had medical eligibility in one of the last three months at the time of review (including the month of review), the case will terminate unless the case contains a person who is on a waiting list

or who would be on a waiting list to receive a transplant if he or she had a source of payment. A new application will be required if the person~~client~~ wishes continued medical assistance.

C) When proof of incurred medical expenses equal to the spenddown obligation is provided to the local office, eligibility for medical assistance shall begin effective the first day that the spenddown obligation is met. The Department will pay for covered services received from that date until the end of the eligibility period. The person~~client~~ shall be responsible, directly to the provider, for payment for services provided prior to the time the person~~client~~ meets the spenddown obligation.

5) Cases with a spenddown obligation that do not have a QMB, a MANG(P) member or a person on a waiting list or who would be on a waiting list to receive a transplant if he or she had a source of payment, will be reviewed beginning in the sixth month of enrollment to determine if they have had medical eligibility within the last three months, including the month of review. If so, enrollment will continue. If not, enrollment will be terminated and the person~~client~~ will be advised that if he or she wishes continued medical assistance, a reapplication must be filed. Upon reapplication, a new 12-month enrollment period will be established (assuming non-financial factors of eligibility are met). If appropriate, a new spenddown obligation will be created.

A) If the person~~client~~ files a reapplication prior to four months after the end of the period of enrollment, the person~~client~~ will be sent through a special abbreviated intake procedure making use of current case record material to verify factors of eligibility not subject to change.

B) Cases that remain eligible in the tenth month of the enrollment period or that have a QMB, a MANG(P) member or a person on a waiting list or who would be on a waiting list to receive a transplant if he or she had a source of payment, will remain enrolled and will be redetermined once every 12 months.

6) The person~~client~~ is responsible for reporting any changes that occur during the enrollment period that might affect eligibility for medical assistance.

If changes occur, appropriate action shall be taken by the Department, including termination of eligibility for medical assistance.

7) For ~~AABD~~ MANG AABD, if changes in income, resources~~assets~~ or family composition occur, appropriate adjustments to the spenddown obligation and date of eligibility for medical assistance shall be made by the Department. The person~~client~~ will be notified, in writing, of the new spenddown obligation.

A) If income decreases, or resources~~assets~~ fall below the applicable resource~~asset~~ disregard and, as a result, the person~~client~~ has already met the new spenddown obligation, eligibility for medical assistance shall be backdated to the appropriate date.

B) If income or resources~~assets~~ increase and, as a result, the person~~client~~ has not produced proof of incurred medical expenses equal to the new spenddown obligation, the written notification of the new spenddown amount will also inform the person~~client~~ that eligibility for medical assistance will be interrupted until proof of medical expenses equal to the new spenddown obligation is produced.

8) For TANF MANG, if changes in income or family composition occur, appropriate adjustments to the spenddown obligation and date of eligibility for medical assistance shall be made by the Department. The person~~client~~ will be notified, in writing, of the new spenddown obligation.

A) If income decreases and, as a result, the person~~client~~ has already met the new spenddown obligation, eligibility for medical assistance shall be backdated to the appropriate date.

B) If income increases and, as a result, the person~~client~~ has not produced proof of incurred medical expenses equal to the new spenddown obligation, the written notification of the new spenddown amount will also inform the person~~client~~ that eligibility for medical assistance will be interrupted until proof of medical expenses equal to the new spenddown obligation is produced.

9) Reconciliation of Amounts Paid-in to Meet Spenddown

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

A) The Department will reconcile payments received to meet an income spenddown obligation for a given month against the amount of claims paid for services received in that month and refund any excess spenddown paid to the personclient. Excess amounts paid for a calendar month will be determined and refunded to the personclient six calendar quarters later. Refund payments will be made once per quarter.

B) The Department will reconcile payments received to meet a resourcean asset spenddown obligation against the amount of all claims paid during the individual's period of enrollment for medical assistance. Excess amounts paid will be determined and refunded to the individual six calendar quarters after the individual's enrollment for medical assistance ends.

C) When payments are received to meet both a resourcean asset and an income spenddown obligation, the Department will first reconcile the amount of claims paid to amounts paid toward the resourceasset spenddown. If the total amount of claims paid have not met or exceeded the amount paid to meet the resourceasset spenddown by the time the individual's enrollment ends, the excess resourceasset payments shall be handled per subsection (c)(3)(C)(B) of this Section. Once the amount of claims paid equals or exceeds the amount paid toward the resourceasset spenddown, the remaining amount of claims paid will be compared against the amount paid to meet the income spenddown per subsection (c)(3)(B)(A) of this Section.

10) The Department will refund payment amounts received for any months in which the personclient is no longer in spenddown status and the payment cannot be used to meet a spenddown obligation. These payment amounts shall not be subject to reconciliation under subsection (c)(9) of this Section. Refunds shall be processed within six months after the case status changed.

(Source: Amended at 34 Ill. Reg. _____, effective _____)

Section 120.61 Long Term CareCases in Intermediate Care, Skilled Nursing Care and

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~**DMHDD-MANG (AABD) and All Other Licensed Medical Facilities**~~

This Section applies to persons residing in long term care facilities or State-certified, State-licensed, or State-contracted residential care programs who, as a condition of eligibility for medical assistance, are required to pay all of their income, less certain protected amounts, for the cost of their own care.

a) The term "long term care facility" refers to:

1) an institution (or a distinct part of an institution) that meets the definition of a "nursing facility" as that term is defined in 42 USC 1396r;

2) licensed Intermediate Care Facilities (ICF and ICF/DD), licensed Skilled Nursing Facilities (SNF and SNF/Ped) and licensed hospital-based long term care facilities (see 89 Ill. Adm. Code 148.50(c)); and

3) Supportive Living Facilities (SLF) and Community Integrated Living Facilities (CILA).~~The policy set forth in subsections (b), (c), (d) and (e) below applies to cases receiving care in Licensed Intermediate Care Facilities, Licensed Skilled Nursing Facilities, or Department of Mental Health and Developmental Disabilities (DMHDD) Facilities. The policy set forth in subsection (f) below applies to cases receiving care in Licensed Intermediate Care Facilities, Licensed Skilled Nursing Facilities, DMHDD Facilities and all other Licensed Medical Facilities (see 89 Ill. Adm. Code 140.642).~~

b) The eligibility period shall begin with:~~Treatment of Resources~~

1) the first day of the month of application;

2) up to three months prior to the month of application for any month in which the person meets both financial and non-financial eligibility requirements. Eligibility will be effective the first day of a retroactive month if the person meets eligibility requirements at any time during that month; or

3) the first day of a month, after the month of application, in which the person meets non-financial and financial eligibility requirements.

c) Eligibility Without Spenddown

1) A one-month eligibility period will be used. If a person's nonexempt income available during the eligibility period is equal to or below the applicable income standard and nonexempt resources are not in excess of the applicable resource disregard (see Section 120.382 of this Part), the person is eligible for medical assistance from the first day of the eligibility period without a spenddown. ~~All nonexempt income and non-exempt assets over the applicable asset disregard (Section 120.382) shall be applied towards the cost of care on a monthly basis. Non-exempt income (see Section 120.360) and assets (see 120.381) are applied towards the cost of care beginning with the first full calendar month of anticipated stay in the facility. Non-exempt income shall be applied toward the cost of care first. If insufficient to meet the cost of care at the private pay rate, then non-exempt assets over the applicable asset disregard shall be used.~~

2) A person eligible under this subsection (c) is responsible for reporting any changes that occur during the eligibility period that might affect eligibility for medical assistance. If changes occur, appropriate action shall be taken by the Department, including termination of eligibility for medical assistance. If changes in income, resources or family composition occur that would make the person a spenddown case, a spenddown obligation will be determined and subsection (d) of this Section will apply. ~~When a client transfers between non-DMHDD facilities or transfers to a DMHDD facility, non-exempt income and/or excess assets are applied first toward the cost of care at the first facility and any balance is applied toward the cost of care at the second facility. If the client transfers from a DMHDD facility to a non-DMHDD facility, non-exempt income and/or excess assets are not applied toward the cost of care at the non-DMHDD facility for the month the transfer occurs. If the client is discharged from a DMHDD facility or non-DMHDD facility to his/her residence in the community or to a community based residential setting (such as Community Living Facility, Special Home Placement, Supported Living Arrangement, Home Individual Program, Community Residential Alternatives as defined at 59 Ill. Adm. Code 120.10), the MANG Community Income Standard is used (see Section 120.20) beginning with the month of discharge from the DMHDD facility or non-DMHDD. 3)If non-exempt income and non-exempt assets over the applicable asset disregard are greater than the Department's rate for cost of care, no~~

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~payment will be made to the facility. However, the client may become eligible for Medical Assistance for other medical expenses by incurring medical expenses equal to the spend-down obligation. The private rate of the facility may be applied to the spend-down obligation in this instance.~~ A ~~full~~ redetermination of eligibility shall be made at least every 12~~twelve (12)~~ months.

d)~~c)~~ Eligibility with Spenddown~~Allow a deduction from the MANG client's income to meet the needs of dependent children under age 21 who do not reside with the community spouse, who do not have enough income to meet their needs and whose assets do not exceed the asset limit. To determine needs and asset limits:~~

1) If countable income available during the eligibility period exceeds the applicable income standard and/or nonexempt resources exceed the applicable resource disregard, a person has a spenddown obligation that must be met before financial eligibility for medical assistance can be established. The spenddown obligation is the amount by which the person's countable income exceeds the applicable income standard or nonexempt resources exceed the applicable resource disregard. ~~for dependent children, use AFDC MAG standard and asset disregard (see Sections 120.30 and 120.382).~~

2) A person meets the spenddown obligation by incurring or paying for medical expenses in an amount equal to the spenddown obligation. Medical expenses shall be applied to the spenddown obligation as provided in Section 120.60(c) of this Part.~~allow any payments made on medical bills for the children.~~

3) Projected expenses for services provided by a long term care facility that have not yet been incurred, but are reasonably expected to be, may also be used to meet a spenddown obligation. The amount of the projected expenses is based on the private pay rate of the long term care facility at which the person resides or is seeking admission.

4) A person who has both an income spenddown and a resource spenddown cannot apply the same incurred medical benefits to both. Incurred medical expenses are first applied to an income spenddown.

e)~~d)~~ Post-eligibility Treatment of Income. If non-financial and financial eligibility is

established, a person's total income, including income exempt and disregarded in determining eligibility, must be applied to the cost of the person's care, minus any applicable deductions provided under subsection (f) of this Section. ~~Allow deductions from the MANG clients non-SSI income for a Community Spouse Maintenance Needs Allowance and a Family Maintenance Needs Allowance for each dependent family member who does not have enough income to meet his/her needs. Family members include dependent children under age 21, dependent adult children, dependent parents or dependent siblings of either spouse who are living with the community spouse. To determine the amount of the deduction:~~

~~1)~~ ~~The deduction for the Community Spouse Maintenance Needs Allowance, as of October 1, 1989, is equal to the community spouse maintenance needs standard ($1,500) less any non-exempt monthly income of the community spouse. The amount established as the community spouse maintenance needs standard shall be increased for calendar years after 1989 by the same percentage as the percentage increase in the consumer price index for all urban consumers. The deduction is allowed only to the extent income of the institutionalized spouse is contributed to the community spouse. However, the deduction for the Community Spouse Maintenance Needs Allowance shall not be less than the amount ordered by the court for support of the community spouse or the amount determined as the result of the fair hearing.~~

~~2)~~ ~~The deduction for the Family Maintenance Needs Allowance for each dependent family member is equal to one-third of the difference between the family maintenance needs standard (122% of the Federal Poverty Level for two persons as of September 30, 1989, 133% as of July 1, 1991, and 150% as of July 1, 1992) and any non-exempt income of the family member.~~

f)~~e)~~ Post-eligibility Income Deductions. From a person's total income that is payable for a person's care, certain deductions are allowed. Allowed deductions shall increase the amount paid by the Department for residential services on behalf of the person, up to the Department's payment rate for the facility. Deductions shall be allowed for the following amounts in the following order:

1) SSI benefits paid under 42 USC 1382(e)(1)(E) or (G) and, for residents of Supportive Living Facilities, the minimum current SSI payment standard for an individual (or a couple, if spouses reside together), less the personal

needs allowance specified in subsection (f)(2)(C) of this Section, shall be deducted for room and board charges (see 89 Ill. Adm. Code 146.225(c) and (d));

2) a personal needs allowance:

A) for persons other than those specified in subsections (f)(2)(B) through (E), $30 per month;

B) for spouses residing together, $60 per couple per month ($30 per spouse);

C) for persons or spouses residing in Supportive Living Facilities, $90;

D) for persons residing in Community Integrated Living Arrangements (see 59 Ill. Adm. Code 115), $50; or

E) for veterans who have neither a spouse nor dependent child, or surviving spouses of veterans who do not have a dependent child, and whose monthly veterans' benefits are reduced to $90, a $90 income disregard is allowed in lieu of a personal allowance deduction. Persons allowed the $90 per month income disregard are not also permitted the $30 per month personal allowance;

3) a community spouse income allowance pursuant to Section 120.379(e) of this Part;

4) a family allowance pursuant to Section 120.379(e)(2) of this Part;

5) an amount to meet the needs of qualifying children (as defined in 26 USC 152) under age 21 who do not reside with either parent, who do not have enough income to meet their needs and whose resources do not exceed the resource limit. To determine needs and resource limits:

A) the MANG(C) and applicable resource disregard are used (see Sections 120.30 and 120.382 of this Part); and

B) any payments made on medical bills for the children can be deducted from the person's income;

6) amounts for incurred expenses for certain Medicare and health insurance cost sharing that are not subject to payment by a third party, limited to:

A) Medicare premiums, deductibles, or coinsurance charges not paid by Medicaid or another third party payor;

B) Other health insurance premiums, deductibles or coinsurance (cost sharing) charges provided the insurance meets the definition of a "health benefit plan" and is approved for providing that insurance in Illinois by the Illinois Department of Insurance.

i) "Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

ii) Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance (except for the month of admission to a long term care facility); dental only or vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

7) Expenses Not Subject to Third Party Payment for Necessary Medical Care Recognized under State Law, but Not a Covered Service under the Medical Assistance Program. "Necessary medical care" has the meaning described in 215 ILCS 105/2 and must be proved as such by a prescription, referral or statement from the patient's doctor or dentist. The

following are allowable deductions from a person's post-eligibility income for medically necessary services:

A) expenses incurred within the six months prior to the month of an application, provided those expenses remain a current liability to the person and were not used to meet a spenddown. Medical expenses incurred during a period of ineligibility resulting from a penalty imposed under Section 120.387 or 120.388 of this Part are not an allowable deduction;

B) expenses incurred for necessary medical services from a medical provider (subject to reasonable dollar limits on specific services) so long as the provider was not terminated, barred or suspended from participation in the Medical Assistance Program (pursuant to 89 Ill. Adm. Code 140.16, 140.17 or 140.18) at the time the medical services were provided; and

C) expenses for long term care services, subject to the limitations of this subsection (f)(7) and provided that the services were not provided by a facility to a person admitted during a time the facility was subject to the sanction of non-payment for new admissions (see 305 ILCS 5/12-4.25(I)(3));

8) Amounts to maintain a residence in the community for up to six months when:

A) the person does not have a spouse and/or dependent children in the home;

B) a physician has certified that the stay in the facility is temporary and the individual is expected to return home within six months;

C) the amount of the deduction is based on:

i) the rent or property expense allowed under the AABD MAG standard if the person was at home (see 89 Ill. Adm. Code 113.248); and

ii) the utility expenses that would be allowed under the AABD MAG standard if the person was at home (see 89 Ill. Adm. Code 113.249).

~~Allow a $90.00 per month income disregard for veterans, who have neither spouse nor dependent child, or surviving spouses, who do not have a dependent child, who reside in long term care facilities who receive reduced monthly veterans benefits in the amount of $90.00. Persons allowed the $90.00 per month income disregard are not also permitted the $30.00 per month personal allowance (see Section 120.40).~~

~~f) Deduction from MANG program~~

~~1) A deduction from the MANG program participant's income shall be permitted for up to six months to maintain a residence in the community when:~~

~~A) the individual does not have a spouse and/or dependent children in the home; and~~

~~B) a physician has certified that the stay in the facility is temporary and the individual is expected to return home within six months.~~

~~2) To determine the amount of the deduction include:~~

~~A) rent or property expense that would be allowed in the AABD MAG standard if the individual was at home; and~~

~~B) utility expenses that would be allowed in the AABD MAG standard if the individual was at home.~~

(Source: Amended at 34 Ill. Reg. _____, effective _____)

Section l20.62 Department of Mental Health and Developmental Disabilities (DMHDD) Approved Home and Community Based Residential Settings Under 89 Ill. Adm. Code 140.643 (Repealed)

~~a) Community-based Residential Settings~~

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~1) The following rule applies to individuals receiving in-home care services through the Department of Mental Health and Developmental Disabilities (DMHDD) in accord with 89 Ill. Adm. Code 140.643. The in-home care services are provided in the following community based residential settings.~~

~~A) Community Living Facilities (CLF)~~

~~B) Special Home Placements (SHP)~~

~~C) Supported Living Arrangement (SLA)~~

~~D) Home Individual Program (HIP)~~

~~E) Community Residential Alternatives (CRA)~~

~~2) A definition of the above quoted Home and Community based residential settings as well as a description of the Title XIX waiver services can be found at 59 Ill. Adm. Code 120.~~

~~b) A one-month eligibility period will be used. Eligibility begins the first day of the eligibility period or the day during the month that spend-down is met.~~

~~c) A one-person MANG Community Income Standard will be used (see Section 120.20).~~

~~d) The client shall be allowed an asset disregard in the amount for one client in accord with Section 120.382. Assets are considered in accord with 89 Ill. Adm. Code 113.140, 113.141, 113.142 and 113.154.~~

~~e) If the client has SSI income, the SSI income will be applied by DMHDD toward the cost of room and board. However, no payment will be made by the Department for the cost of room and board. The client shall be responsible directly to DMHDD for payment of room and board costs.~~

~~f) If the client's non-exempt income is greater than the MANG standard and/or non-exempt assets are over the applicable asset disregard, the client must meet the spend-down obligation determined for the eligibility period before becoming eligible to receive Medical Assistance. The spend-down obligation is the sum of~~

~~the amount by which the client's non-exempt income exceeds the MANG standard and the amount of non-exempt assets in excess of the applicable asset disregard.~~

~~g)~~ ~~The client may meet the spend-down by incurring Title XIX waiver (in-home care) services. Waiver services are considered incurred in total for the month on the first day of the month or the first day of stay for a month that the client resides in the approved residential setting if for less than an entire month. If the cost of waiver services equals or exceeds the spend-down amount, the spend-down obligation is met. DMHDD will provide the local office a statement of expected monthly charges for waiver services to ensure that the spend-down obligation is met.~~

~~h)~~ ~~If the client's non-exempt income is equal to or less than the MANG Standard and non-exempt assets are not in excess of the applicable asset disregard, the client is eligible for medical assistance from the first day of the eligibility period.~~

~~i)~~ ~~If the client's non-exempt income exceeds the MANG Standard and/or non-exempt assets are over the applicable asset disregard, eligibility for medical assistance shall begin effective the first day that the spend-down obligation is met. The Department will pay for covered services less the client's liability (excluding Title XIX waiver services) received from the date the spend-down obligation is met date until the end of the eligibility period. The client shall be responsible directly to the provider for payment for services provided prior to the time client meets the spend-down obligation.~~

~~j)~~ ~~A new application and/or a redetermination of eligibility will not be required for eligible clients who move from an institutional setting to an approved Home and Community based residential setting.~~

~~k)~~ ~~A case review is required for eligible cases placed in an approved residential setting.~~

~~l)~~ ~~A full redetermination of eligibility shall be made every twelve months.~~

(Source: Repealed at 34 Ill. Reg. _____, effective _____)

Section 120.63 Department of Mental Health and Developmental Disabilities (DMHDD) Approved Home and Community Based Residential Settings (Repealed)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~a)~~ ~~In-Home Care Services~~

~~1)~~ ~~This Section applies to individuals receiving remedial care services through the Department of Mental Health and Developmental Disabilities (DMHDD) in Home and Community Based Residential Settings approved by DMHDD. Remedial care services are those services (except for room and board) provided by DMHDD that are directed toward meeting the needs of disabled clients who are not receiving services through the Department's In-Home Care Program (see Section 120.62). The remedial care services are provided in the following Home and Community Based Residential Settings:~~

~~A)~~ ~~Community Living Facilities (CLF)~~

~~B)~~ ~~Special Home Placements (SHP)~~

~~C)~~ ~~Supported Living Arrangement (SLA)~~

~~D)~~ ~~Home Individual Program (HIP)~~

~~E)~~ ~~Community Residential Alternatives (CRA)~~

~~2)~~ ~~A definition of the Home and Community Based Residential Settings can be found at 59 Ill. Adm. Code 120.~~

~~b)~~ ~~A one-month eligibility period will be used. Eligibility begins the first day of the eligibility period or the day during the month that spend-down is met.~~

~~c)~~ ~~A one-person MANG Community Income Standard will be used (see Section 120.20).~~

~~d)~~ ~~The client shall be allowed an asset disregard in the amount for one client in accord with Section 120.382. Assets are considered in accord with 89 Ill. Adm. Code 113.140, 113.141, 113.142 and 113.154.~~

~~e)~~ ~~If the client has SSI income, the SSI income will be applied by DMHDD toward the cost of room and board. The client shall be responsible directly to DMHDD for payment of room and board costs. No payment will be made by the Department for the cost of room and board.~~

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~f)~~ ~~If the client's non-exempt income is greater than the MANG Standard and/or non-exempt assets are over the applicable asset disregard, the client must meet the spend-down obligation determined for the eligibility period before becoming eligible to receive medical assistance. The spend-down obligation is the sum of amount by which the client's non-exempt income exceeds the MANG Standard and the amount on non-exempt assets in excess of the applicable asset disregard.~~

~~g)~~ ~~The client may meet the spend-down by incurring costs for remedial care services. Remedial care costs are the cost of all services reported by DMHDD that exceed the MANG Community Income Standard and the Income Disregard amount. Remedial care services are considered incurred in total for the month on the first day of the month or the first day of stay for a month that the client resides in the approved residential setting if for less than an entire month. If the cost of remedial care services equal or exceeds the spend-down amount, the spend-down obligation is met. DMHDD will provide the local office a statement of expected monthly charges for remedial care services to ensure that the spend-down obligation is met.~~

~~h)~~ ~~If the client's non-exempt income is equal to or less than the MANG Standard and non-exempt assets are not in excess of the applicable asset disregard, the client is eligible for medical assistance from the first day of the eligibility period.~~

~~i)~~ ~~If the client's non-exempt income exceeds the MANG Standard and/or non-exempt assets are over the applicable asset disregard, eligibility for medical assistance shall begin effective the first day that the spend-down obligation is met. Covered services, less the client's liability, received from the spend-down met date until the end of the eligibility period will be paid for by the Department. The client shall be responsible directly to the provider for payment for services provided prior to the time client meets the spend-down obligation.~~

~~j)~~ ~~A new application and/or a redetermination of eligibility will not be required for eligible clients who move from an institutional setting to an approved Home and Community Based Residential Setting.~~

~~k)~~ ~~A case review is required for eligible cases placed in an approved Home and Community Based Residential Setting.~~

~~l)~~ ~~A full redetermination of eligibility shall be made every twelve months.~~

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

(Source: Repealed at 34 Ill. Reg. _____, effective _____)

Section 120.65 Department of Mental Health and Developmental Disabilities (DMHDD) Licensed Community-Integrated Living Arrangements (Repealed)

~~a) Community-Integrated Living Arrangement (CILA) Services~~

~~1) This Section applies to individuals receiving CILA services through an agency licensed by DMHDD. CILA services are provided in approved settings where eight or fewer individuals with mental retardation (MR) or mental illness (MI) reside under the supervision of the agency licensed by DMHDD. Individuals actively participate in choosing services designed to provide treatment, habilitation, training, rehabilitation and other community integrative supports and in choosing a home from among those living arrangements available to the general public and/or housing owned or leased by an agency licensed by DMHDD.~~

~~2) The standards and licensure requirements for community-integrated living arrangements are found at 59 Ill. Adm. Code 115.~~

~~b) A one-month eligibility period will be used. Eligibility begins the first day of the eligibility period or the day during the month that spend-down is met.~~

~~c) The appropriate MANG Community Income Standard will be used (see Section 120.20).~~

~~d) The individual shall be allowed an asset disregard in accordance with Section 120.382. Assets are considered in accordance with 89 Ill. Adm. Code 113.140, 113.141 and 113.142.~~

~~e) No payment will be made by the Department for the cost of room and board. The individual shall be responsible directly to the agency licensed by DMHDD for payment of any room and board costs.~~

~~f) If non-exempt income is greater than the MANG Standard and/or non-exempt assets are over the applicable asset disregard, the client must meet the spend-down determined for the eligibility period before becoming eligible to receive medical assistance. The spend-down is the sum of the amount by which the~~

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~client's non-exempt income exceeds the MANG standard and the amount of non-exempt assets in excess of the applicable asset disregard.~~

~~g)~~ ~~The client may meet the spend-down by incurring costs for CILA services. CILA services are considered incurred in total for the month on the first day of the month or the first day services are received if for less than an entire month. If the cost of CILA services equals or exceeds the spend-down amount, the spend-down is met. DMHDD will provide the local office with a statement of expected monthly charges for CILA services to ensure that the spend-down obligation is met.~~

~~h)~~ ~~If non-exempt income is equal to or less than the MANG Standard and non-exempt assets are not in excess of the applicable asset disregard, the client is eligible for medical assistance from the first day of the eligibility period.~~

~~i)~~ ~~If non-exempt income exceeds the MANG Standard and/or non-exempt assets are over the applicable asset disregard, eligibility for medical assistance shall begin effective the first day that the spend-down obligation is met. Covered services, less the client's liability, received from the spend-down met date until the end of the eligibility period will be paid for by the Department. The client shall be responsible directly to the provider for payment for services provided prior to the time the client meets spend-down.~~

~~j)~~ ~~A new application and/or a redetermination of eligibility will not be required for eligible clients who move from an institutional setting to an approved setting in which CILA services are received.~~

~~k)~~ ~~A full redetermination of eligibility shall be made every twelve months.~~

(Source: Repealed at 34 Ill. Reg. _____, effective _____)

SUBPART H: MEDICAL ASSISTANCE – NO GRANT (MANG) ELIGIBILITY FACTORS

Section 120.308 Client Cooperation

a) As a condition of eligibility, clients must cooperate:

1) in the determination of eligibility;

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

2) with Department programs conducted for the purposes of acquisition or verification of information upon which eligibility may depend; and

3) in applying for all financial benefits for which they may qualify and to avail themselves of thosesuch benefits at the earliest possible date.

b) Clients are required to avail themselves of all potential income and resources and to take appropriate action to receive such resources, including those described under Section 120.388(d)(2) of this Part.

c) When eligibility cannot be conclusively determined because the individual is unwilling or fails to provide essential information or to consent to verification, the client is ineligible.

d) At screening, applicants shall be informed, in writing, of any information they are to provide at the eligibility interview.

e) At the eligibility interview or at any time during the application process, when the applicant is requested to provide information in his or her possession, the Department will allow 10ten (10) days for the return of the requested information. The first day of the 10ten (10) day period is the calendar day following the date the information request form is sent or given to the applicant. The last day of the 10ten (10) day period shall be a work day and is to be indicated on the information request form. If the applicant does not provide the information by the date on the information request form, the application shall be denied on the following work day.

f) At the eligibility interview or at any time during the application process, when the applicant is requested to provide third party information, the Department shall allow 10 calendarten (10) days for the return of the requested information or for verification that the third party information has been requested. The first day of the 10ten (10) day period is the calendar day following the date the information request form is sent or given to the applicant. The last day of the 10ten (10) day period shall be a work day and willis to be indicated on the information request form. It is to be indicated on the information request form that the applicant shall provide written verification of the request for the third party information. If the applicant does not provide the information or the verification that the information was requested by the date on the information request form, the application shall be denied on the following work day.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Third party information is defined as information thatwhich must be provided by someone other than the applicant. An authorized representative or person applying on another's behalf is not a third party, but is treated as if he or she were the applicant.

2) The Department shall advise clients of the need to provide written verification of third party information requests and the consequences of failing to provide thatsuch verification.

3) If the applicant requests an extension either verbally or in writing in order to obtain third party information and provides written verification of the request for the third party information, such as a copy of the request that was sent to the third party, an extension of forty-five (45) days from the date of application shall be granted. The first day of the forty-five (45) day period is the calendar day following the date of application. The 45th day must be a work day.

4) If an applicant's attempt to obtain third party information is unsuccessful, upon the applicant's request, the Department will assist in securing evidence to support the client's eligibility for assistance.

g) Any information or verifications requested under this Section must be returned to the Department's or its agent's office in the manner indicated on the information request form. Information mailed or otherwise delivered to an address not indicated on the form will not toll the timeframes for providing information under this Section.

h) Failure to cooperate in the determination of eligibility under this Section, including failure to provide requested information or verifications, is a basis for the denial of an application for benefits. A person has the right to appeal such a denial under 89 Ill. Adm. Code 102.80. The Department shall not deny an application if third party information cannot be timely obtained when the delay is beyond the control of the person and a timely request was made to the third party for the information. The Department shall not deny an application for failure to timely provide information in the applicant's possession if the person has made a good faith attempt to retrieve the information and is unable, due to incapacity, illness, family emergency or other just cause, to do so.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

(Source: Amended at 34 Ill. Reg. _____, effective _____)

Section 120.347 Treatment of Trusts and Annuities

a) This Section applies to trusts established on or after August 11, 1993.

b) A trust is any arrangement in which a grantor transfers property to a trustee or trustees with the intention that it be held, managed or administered by the trustee or trustees for the benefit of the grantor or designated beneficiaries. A trust also includes any legal instrument or device that is similar to a trust, including an annuity.

c) A person shall be considered to have established a trust if resources~~assets~~ of the person were used to form all or part of the principal of the trust and the trust is established (other than by will) by any of the following:

1) the person;

2) the person's spouse; or

3) any other person, including a court or administrative body, with legal authority to act on behalf of or at the direction of the person or the person's spouse.

d) This Section does not apply to the following trusts:

1) an irrevocable trust containing the resources~~assets~~ of a ~~disabled~~ person who is determined disabled (as provided~~described~~ in Section 120.314) and under age 65 that is established by a parent, grandparent, legal guardian or court for the sole benefit (as defined in Section 120.388(m)(2)) of the ~~disabled~~ person, if language contained in the trust stipulates that any amount remaining in the trust (up to the amount expended by the Department on medical assistance) shall be paid to the Department upon the death of the person. This exclusion continues after the person reaches age 65 as long as the person continues to be disabled but any additions made by the person to the trust after age 65 will be treated as a transfer of resources~~assets~~ under Sections~~Section~~ 120.387 and 120.388. If the trust contains proceeds from a personal injury settlement, any Department charge (as described at 89 Ill. Adm. Code 102.260) must be satisfied in

order for the trust to be excluded under this subsection; or

2) an irrevocable trust containing the resources~~assets~~ of a ~~disabled~~ person who is determined disabled (as provided~~described~~ in Section 120.314) that is established and managed by a non-profit association that pools funds but maintains a separate account for each beneficiary that is established by the disabled person, a parent, grandparent, legal guardian or court for the sole benefit of the disabled person, if language contained in the trust stipulates that any amount remaining in the trust (up to the amount expended by the Department on medical assistance) that is not retained by the trust for reasonable administrative costs related to wrapping up the affairs of the subaccount shall be paid to the Department upon the death of the person. This exclusion continues after the person reaches age 65 as long as the person continues to meet the definition of disabled (to the extent permitted under federal law). Any funding of a subaccount in a pooled trust by a person over age 64 will be treated as a transfer for fair market value under Section 120.388 so long as the person meets the definition of disabled. If the trust contains proceeds from a personal injury settlement, any Department charge (as described at 89 Ill. Adm. Code 102.260) must be satisfied in order for the trust to be excluded under this subsection (d). A non-profit association under this subsection (d)(2) shall mean an entity that is:

A) organized and operated exclusively for other than profitmaking purposes and distributes no part of the entity's income to its members; and

B) qualified to receive charitable donations for which a taxpayer may lawfully claim a deduction under the provisions of section 501(a) of the Internal Revenue Code (26 USC 501(a)).

e) Subsections (f) and (g) of this Section apply to the portion of the trust attributable to the person and without regard to:

1) the purpose for establishment of the trust;

2) whether the trustee has or exercises any discretion under the trust; or

3) whether there are any restrictions on distributions or use of distributions

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

from the trust.

f) For revocable trusts, the Department shall:

1) treat the principal as an available resource~~asset~~;

2) treat as income payments from the trust that are made to or for the benefit of the person; and

3) treat any other payments from the trust as transfers of resources~~assets~~ by the person (subject to the provisions of, and depending on the date of the payment, Section 120.387 or 120.388).

g) For irrevocable trusts, the Department shall:

1) treat as an available resource~~asset~~ the amount of the trust from which payment to or for the benefit of the person could be made;

2) treat as income payments from the trust that are made to or for the benefit of the person;

3) treat any other payments from the trust as transfers of resources~~assets~~ by the person (subject to the provisions of Section 120.387 or 120.388, as applicable); and

4) treat as a transfer of resources~~assets~~ by the person the amount of the trust from which no payment could be made to the person under any circumstances (subject to the provisions of Section 120.387 or 120.388, as applicable). The date of the transfer is the date the trust was established or, if later, the date that payment to the person was foreclosed. The amount of the trust is determined by including any payments made from the trust after the date that payment to the person was foreclosed.

h) Trust Income. For married couples, income from trusts shall be attributed to each spouse as provided in the trust, unless:

1) payment of income is made solely to one spouse, in which case the income shall be attributed to that spouse;

2) payment of income is made to both spouses, in which case one-half of the income shall be attributed to each spouse; or

3) payment of income is made to either spouse, or both, and to another person or persons, in which case the income shall be attributed to each spouse in proportion to the spouse's interest, or, if payment is made to both spouses and no such interest is specified, one-half of the joint interest shall be attributed to each spouse.

i) Annuities.

1) Revocable and assignable annuities are considered available resources.

2) Income received from an annuity by an institutionalized person is considered non-exempt income. Income received by the community spouse of an institutionalized person is treated as available to the community spouse for the purpose of determining the community spouse income allowance under Section 120.379(e).

3) An annuity owned by an institutionalized person or the community spouse of an institutionalized person that can be purchased by a willing and arm's length buyer shall be treated as an available resource, subject to the following:

A) Language in an annuity prohibiting transfer, assignment or revocation of the annuity shall not preclude the Department from treating the annuity as an available resource unless an assignment would materially change the duty of the issuer of the annuity (e.g., the financial institution or insurance carrier), or materially increase the burden or risk imposed on it under the annuity contract. A prohibition of assignment of an annuity is construed as barring only the delegation of duties of performance under the contract and not assignment of rights. (See UCC 810 ILCS 5/2-210(3).) Assignment of an annuitant's rights to payment under an annuity shall not be considered a material change to the duty of, or risk to, the issuer. To the extent they cannot be assigned, annuities with retirement tax status (26 USC 401 through 409A), including those described in Section 120.388(o)(1) and (2), are not subject to this subsection (i)(3)(A).

B) The Department presumes that the value of an available annuity shall be based on the present value of its future payments, using a term of years based on life expectancy (as determined under current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration at http://www.ssa.gov/OACT/STATS/table4c6.html) and an interest rate based on IRC section 7520 interest rates (26 USC 7520), published monthly by the IRS. This presumption may be rebutted by documented evidence of quotes of viatical or other structured settlements showing that only a lesser value for an annuity can be obtained. To determine the credibility of a rebutted value, the Department may obtain its own valuations of an annuity based on quotes received from private entities. If the Department determines that an annuity cannot be sold for its present value, then the greatest value that can be obtained in an arm's length transaction on the open marketplace shall be the amount treated as an available resource.

4) The fact that a transaction involving an annuity is determined an allowable transfer under Section 120.388 does not exempt the annuity from the provisions of this subsection (i). An annuity considered an available resource under this subsection (i) shall not also be subject to penalty under Section 120.388. The appropriate treatment of an annuity, whether under this subsection (i) or Section 120.388, shall be based on the terms of the annuity, facts related to any transactions involving the annuity (as described in Section 120.388(e)(2)), and application and choice of law under the particular circumstances.

5) Only annuities purchased on or after the effective date of this rulemaking may be considered available resources under this Section.

j) The principal of a trust fund established under the Self Sufficiency Trust Fund Program (see 20 ILCS 1705/21.1) is an exempt resource.

(Source: Amended at 34 Ill. Reg. _____, effective _____)

Section 120.379 Provisions for the Prevention of Spousal Impoverishment

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

a) The provisions for the prevention of spousal impoverishment apply only to an institutionalized person (as defined in Section 120.388(c)) whose spouse resides in the community. For purposes of this Section, those persons shall be referred to as the institutionalized spouse and the community spouse.~~a resident of a long term care facility whose spouse resides in the community and to a person who but for the provision of home and community based services under Section 4.02 of the Illinois Act on the Aging would require the level of care provided in a long term care facility and whose spouse resides in the community.~~

b) Income. In determining the financial eligibility of an institutionalized spouse, only non-exempt income attributed to the institutionalized spouse shall be considered available. The following rebuttable presumptions shall apply in determining the income attributed to each spouse~~An assessment is completed to determine the total combined amount of nonexempt assets of the individual and his or her community spouse~~:

1) if payment of income is made solely in the name of one spouse, the income will be considered available only to that spouse; ~~when residence begins in a long term care facility or when home and community based services begin; and~~

2) if payment of income is made in the names of both spouses, one-half of the income shall be considered available to each spouse;~~when requested by either spouse or a representative acting on behalf of either spouse, even if an application for assistance has not been filed.~~

3) if payment of income is made in the names of either spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made to both spouses and no other interest is specified, one-half of the joint interest shall be considered available to each spouse);

4) if payment of income is made from a trust, the income shall be considered available to each spouse as provided under Section 120.347(h); and

5) if there is no trust or instrument establishing ownership, one-half of the income shall be considered available to the institutionalized spouse and one-half to the community spouse.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

c) Resources. In determining the financial eligibility of an institutionalized spouse, the following shall apply~~A re-assessment is not required if~~:

1) At the beginning of a continuous period of institutionalization, the total value of resources owned by either or both spouses shall be computed. ~~a resident of a long term care facility is discharged for a period of less than 30 days and then reenters the facility;~~

2) Assessment. Upon the request of an institutionalized spouse, community spouse, or a representative of either, at the beginning of a continuous period of institutionalization, the Department shall conduct an assessment of the couple's resources for the purpose of determining the combined amount of nonexempt resources in which either spouse has an ownership interest. The person requesting the assessment shall be responsible for providing documentation and verification necessary for the Department to complete the assessment. ~~a resident of a long term care facility enters a hospital and then returns to the facility from the hospital;~~

3) For purposes of this subsection (c), a continuous period of institutionalization is defined as at least 30 days of continuous institutional care. An initial assessment remains effective during that period if: ~~an individual discontinues receiving home and community-based services for a period of less than 30 days; or~~

A) a resident of a long term care facility is discharged for a period of less than 30 days and then reenters the facility;

B) a resident of a long term care facility enters a hospital and then returns to the facility from the hospital;

C) a person discontinues receiving home and community-based services for a period of less than 30 days; or

D) a person discontinues receiving home and community-based services due to hospitalization and then is discharged and begins to receive home and community-based services.

4) At the time of an institutionalized spouse's application for medical assistance, all nonexempt resources held by either the institutionalized

person, the community spouse, or both shall be considered available to the institutionalized spouse. From this amount may be deducted and transferred to the community spouse the Community Spouse Resource Allowance (CSRA), as provided under subsection (d) of this Section. The remaining amount shall be the total amount of resources considered available to the institutionalized spouse.~~an individual discontinues receiving home and community-based services due to hospitalization and then is discharged and begins to receive home and community-based services.~~

d) Transfer of Resources to the Community Spouse. From the amount of nonexempt resources considered available to the institutionalized spouse, as described in subsection (c)(4) of this Section, a ~~The~~ transfer of resources~~property~~ is allowed~~, as determined in subsection (b) of this Section,~~ by the institutionalized spouse~~client~~ to the community spouse or to another individual for the sole benefit (as defined in Section 120.388(m)(2)(D)) of the community spouse in an amount that does not exceed the CSRA~~Community Spouse Asset Allowance (CSAA)~~. The CSRA is the difference between the amount of resources otherwise available to the community spouse and the greatest of:~~CSAA, as of October 1, 1989, is an amount up to but not greater than $60,000 that the individual may transfer, without affecting eligibility, to the community spouse or to another individual for the sole benefit of the community spouse. As of October 1, 1989, the amount of assets an individual may transfer to his or her community spouse is $60,000 minus any nonexempt assets of the community spouse. The amount established as the CSAA shall be provided for calendar years after 1989 by the Department of Health and Human Services. The CSAA may exceed the standard annual figure established by the U.S. Department of Health and Human Services only in one of the following circumstances:~~

1) the amount established annually by the US Department of Health and Human Services (DHHS) (as of January 1, 2009, $109,560); ~~in a legal proceeding, a court approves the transfer of income-producing assets to the community spouse in an amount greater than the standard CSAA; or~~

2) the amount established through a fair hearing under subsection (f)(3) of this Section; or~~as the result of an appeal hearing (described in 89 Ill. Adm. Code 104.1), the Department determines that the transfer of income-producing assets to the community spouse in an amount greater than the standard CSAA is necessary to raise the community spouse's income to,~~

~~but not more than, the Community Spouse Maintenance Needs Allowance (described in subsection (f) of this Section).~~

3) the amount transferred under a court order against an institutionalized spouse for the support of the community spouse.

~~A) The Department will measure the amount of an allowable increase in the CSAA by the cost to purchase an actuarially sound single premium life annuity producing monthly payments that, when added to the community spouse's income, will be sufficient to raise the community spouse's income to, but not more than, the Community Spouse Maintenance Needs Allowance. If assets are insufficient to purchase such an annuity, the Department will measure the amount of an allowable increase in the CSAA by the cost to purchase an actuarially sound single premium life annuity producing monthly payments using available assets.~~

~~B) It is the appellant's responsibility to provide the Department with an estimate from a reputable company of the cost to purchase the annuity.~~

~~C) The Department may compare the estimate with available information on the cost of other single premium life annuities.~~

~~D) In calculating the amount of the community spouse's income after approval of an increased CSAA, the Department shall deem the amount of the annuity payments as being available to the community spouse, although it will not require the actual purchase of an annuity.~~

~~e) The appeal hearing, described in subsection (d)(2) of this Section, shall be held within 30 days after the date the appeal is filed.~~

e)~~f)~~ Deductions are allowed from an institutionalized spouse's post-eligibility ~~the MANG client's non-SSI~~ income (pursuant to Section 120.61(d) and (e)) for a community spouse income allowance and a family allowance~~for a Community Spouse Maintenance Needs Allowance and a Family Maintenance Needs Allowance for each dependent family member who is living with the community spouse and who does not have enough income to meet his or her needs. Family~~

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~members include dependent children under age 21, dependent adult children, dependent parents or dependent siblings of either spouse~~. The deductions are~~amount of the deduction is~~ determined as follows:

1) ~~The deduction for the~~ Community Spouse Maintenance Allowance.~~Spouse Maintenance Needs Allowance, as of October 1, 1989, is equal to the community spouse maintenance needs standard ($1,500) less any nonexempt monthly income of the community spouse.~~

A) The amount of monthly income that may be deducted from the institutionalized spouse's post-eligibility income for the benefit of the community spouse is equal to the minimum monthly maintenance needs allowance (MMMNA) less the amount of monthly income otherwise available to the community spouse (as determined under subsection (b) of this Section.The amount established as the MMMNA (as of January 1, 2009, $2,739 per month)~~community spouse maintenance needs standard~~ shall be provided for calendar years after 2009~~1989~~ by DHHS~~the Department of Health and Human Services~~.

B) The deduction is allowed only to the extent the income of the person~~individual~~ is in fact contributed to the community spouse. However, the deduction for the community spouse income allowance~~Community Spouse Maintenance Needs Allowance~~ shall not be less than the amount ordered by a~~the~~ court for support of the community spouse or the amount determined as the result of a~~the~~ fair hearing provided for under subsection (f) of this Section.

C) For purposes of this Section, all income of the institutionalized spouse that can be made available to the community spouse shall be made available before resources may be transferred in excess of the CSRA specified under subsection (d)(1) of this Section that will generate income to make up the difference between the MMMNA and the amount of income available to the community spouse.

2) Family Allowance. The amount of monthly income that may be deducted from the institutionalized spouse's post-eligibility income for the benefit of ~~The deduction for the Family Maintenance Needs Allowance for~~ each

~~dependent~~ family member is equal to one-third of the difference between the family maintenance needs standard (150%~~122%~~ of the annual Federal Poverty Level for two persons ~~as of September 30, 1989, 133% as of July 1, 1991 and 150% as of July 1, 1992~~) and any nonexempt income of the family member. Family members only include dependent children under age 21, dependent adult children, dependent parents or dependent siblings of either spouse who reside with the community spouse.

3) A deduction is also allowed from the institutionalized spouse's post-eligibility income for dependent children under age 21 who do not reside with the community spouse pursuant to Section 120.61(e)(5).

4) The term "dependent" has the meaning ascribed to a "qualified" person under 26 USC 152.

f) Fair Hearings. Either the institutionalized spouse or the community spouse may request a hearing (as described in 89 Ill. Adm. Code 104.1) under this Section for the following reasons:

1) either spouse is dissatisfied with a determination of:

A) the community spouse income allowance under subsection (e)(1) of this Section;

B) the amount of the monthly income treated as otherwise available to the community spouse (as applied under subsection (e)(1) of this Section);

C) the attribution of resources under subsection (c)(4) of this Section; or

D) the determination of the CSRA under subsection (d) of this Section.

2) Either spouse may request an increase in the MMMNA under subsection (e)(1). If either spouse establishes that, due to exceptional circumstances resulting in significant financial duress, the community spouse needs income above the level provided by the MMMNA, an amount adequate to provide that additional income shall be substituted. For purposes of this

subsection (f)(2), significant financial distress means expenses that the community spouse incurs in excess of the income standard, including:

A) recurring or extraordinary medical expenses of the community spouse that are not covered by any third party resource, including insurance or the Medical Assistance Program;

B) amounts necessary to preserve, maintain or make major repairs to homestead property; or

C) amounts necessary to preserve an income producing resource, subject to the limitations on that property under Section 120.381(a)(3) and as long as the expense is reasonable in relation to the income produced by the resource.

3) Either spouse may request that an alternative CSRA be substituted for the standard CSRA calculated under subsection (d) of this Section if it can be established that the standard CSRA (in relation to the amount of income it generates) is inadequate to raise the community spouse's income to the MMMNA.

A) Before a substitute CSRA may be allocated under this subsection (f)(3), the amount of income attributed to the institutionalized spouse that may be transferred to the community spouse under subsection (e) of this Section shall first be considered available to raise the community spouse's income to the MMMNA.

B) If the sum of income otherwise available to the community spouse and income that may be transferred from the institutionalized spouse is insufficient to raise the community spouse's income to the MMMNA, then a substitute CSRA may be allowed. The amount the substitute CSRA may exceed the CSRA provided for under subsection (d) of this Section is limited to the amount of resources necessary to generate income to raise the community spouse's total income to the MMMNA.

C) In determining the amount of income that a substitute CSRA under this subsection (f)(3) may generate, the Department will use, for purposes of comparison, the cost to purchase an actuarially sound

single premium life annuity producing monthly payments that, when added to the community spouse's total income, will be sufficient to raise the community spouse's income to, but not more than, the MMMNA. If resources are insufficient to purchase an annuity that will raise the community spouse's income to the MMMNA, the Department will measure the amount of an allowable increase in the CSRA by the cost to purchase an actuarially sound single premium life annuity producing monthly payments using available resources.

D) It is the requesting person's responsibility to provide the Department with an estimate from a reputable company of the cost to purchase the annuity described in subsection (f)(3)(C).

E) The Department may compare the estimate with available information on the cost of other single premium life annuities.

F) In calculating the amount of the community spouse's income after approval of a substitute CSRA, the Department shall deem the amount of the monthly annuity payments as being available to the community spouse, although it will not require the actual purchase of an annuity.

g) The appeal hearing described in subsection (d)(2) of this Section shall be held within 30 days after the date the appeal is filed.

h) A transfer of resources under subsection (d) of this Section from the institutionalized spouse to the community spouse shall be made as soon as practicable after the date of initial determination of eligibility and before the first regularly scheduled redetermination of eligibility, taking into account such time as may be necessary to obtain a court order under subsection (d)(3) of this Section. If a transfer of resources to a community spouse has not been made by the first scheduled redetermination and no petition for an order of spousal support is pending judicial review, the resources shall be considered available to the institutionalized spouse.

i) If a community spouse refuses or fails to cooperate in providing information about available income or resources, the institutionalized spouse shall be ineligible for medical assistance unless the institutionalized spouse can

demonstrate undue hardship or assigns to the Department any rights to support he or she may have from the community spouse. If the Department grants a hardship waiver under this subsection (i) or the institutionalized spouse has assigned any rights to support to the Department, eligibility for medical assistance may be approved if the institutionalized spouse is otherwise eligible. The transfers of resources or income from the institutionalized spouse to the community spouse provided for under this Section shall not be permitted if the institutionalized spouse is found eligible under this subsection. A hardship waiver may be granted under this subsection if:

1) the community spouse fails or refuses to cooperate in, or, due to illness or mental incapacity, is incapable of cooperating in, providing necessary financial information required under this Section, or the institutionalized spouse is unable, due to illness or incapacity, to execute an assignment of support rights; and

2) the institutionalized spouse is otherwise eligible for medical assistance but for the information withheld by the community spouse; and

3) the institutionalized spouse is unable to obtain appropriate medical care without the provision of medical assistance or the institutionalized spouse needs protection from actual or threatened harm, neglect or hazardous conditions if he or she were discharged from a facility providing long term care services.

j) If an institutionalized person is found eligible as provided in subsection (i) of this Section, the Department may pursue any available legal process to enforce its right of assignment to support against the community spouse or any other responsible person pursuant to Section 120.319. These processes may include, but shall not be limited to, the administrative support procedures provided under 89 Ill. Adm. Code 103.

(Source: Amended at 34 Ill. Reg. _____, effective _____)

Section 120.380 Resources~~Assets~~

a) Unless otherwise specified and for purposes of this Part, the term "resource" (as defined in 42 USC 382b, except subsection (a)(1) of that section, which excludes the home as a resource) means cash or any other personal or real property that a

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

person owns and has the right, authority or power to liquidate. ~~The value of nonexempt assets shall be considered in determining eligibility for AABD MANG. Assets do not affect eligibility for TANF MANG.~~

b) A resource is considered available to pay for a person's own care when at the disposal of that person; when the person has a legal interest in a liquidated sum and has the legal ability to make the sum available for support, maintenance or medical care; or when the person has the lawful power to make the resource available or to cause the resource to be made available~~Jointly held assets for AABD MANG shall be treated in the same manner as described in 89 Ill. Adm. Code 113.140~~.

c) The value of nonexempt resources shall be considered in determining eligibility for any means-tested public benefit program administered by the Department, the Department of Human Services or the Department on Aging if eligibility is determined, in part, on the basis of resources as provided under this Section~~Potential payments from a Medicaid qualifying trust for AABD MANG and MANG(C) shall be treated in the same manner as described in Section 120.346~~.

d) Determination of Resources. ~~Trusts established on or after August 11, 1993, shall be treated in the manner described in Section 120.347.~~

1) In determining initial financial eligibility for medical assistance, the Department considers nonexempt verified resources available to a person as of the date of decision on the application for medical assistance. The date of verification (see Section 120.308(f)) may be prior to the date of decision. Money considered as income for a month is not considered a resource for that same month. If income for a month is added to a bank account that month, the Department will subtract the amount of income from the bank balance to determine the resource level. Any income remaining in the following months is considered a resource.

2) In determining financial eligibility for retroactive months (see Section 120.61(b)), the Department will consider the amount of income and resources available to a person as of the first day of each of the backdated months for which eligibility is sought.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

3) In determining a person's spenddown obligation (see Section 120.384), the Department considers the amount of nonexempt resources available as of the date of decision, in the case of initial eligibility, and the first day of the month, in the case of retroactive eligibility, that are in excess of the applicable resource disregard (see Section 120.382).

e) Subject to subsection (c) of this Section and 89 Ill. Adm. Code 113.140, the entire equity value of jointly held resources shall be considered available in determining a person's eligibility for assistance, unless:

1) The resource is a joint income tax refund, in which case one-half of the refund is considered owned by each person; or

2) The person documents that he or she does not have access to the resource. Appropriate documents may include, but are not limited to, bank documents, signature cards, trust documents, divorce papers, and papers from court proceedings that show the person is legally unable to access the resource; or

3) The resource is held jointly with an individual eligible under any means-tested public health benefit program (other than the Supplemental Nutrition Assistance Program) administered by the Department, the Department of Human Services, or the Department on Aging; or

4) The person can document the amount of his or her legal interest in the resource and that such amount is less than the entire value of the resource, then the documented amount shall be considered. Appropriate documentation may include, but is not limited to, bank documents, trust documents, signature cards, divorce papers, or court orders that show the person's legal interest is less than the entire value of the resource; or

5) The person documents that the resource or a portion of the resource is not owned by the person and the person's accessibility to the resource is changed (see subsections (b)(2) and (4) of this Section for documentation examples).

f) In determining the eligibility of a person for long term care services whose spouse resides in the community, all nonexempt resources owned by the institutionalized spouse, the community spouse, or both shall be considered available to the

institutionalized spouse in determining his or her eligibility for medical assistance. From the total amount of such resources may be deducted a Community Spouse Resource Allowance as provided under Section 120.379.

g) Trusts established prior to August 11, 1993 shall be treated in the manner described in Section 120.346.

h) Trusts established on or after August 11, 1993 shall be treated in the manner described in Section 120.347.

i) The value of a life estate shall be determined at the time the life estate in the property is established and at the time the property (for example, resouces~~assets~~) is liquidated. In determining the value of a life estate and remainder interest based on the value of the property at the time the life estate is established or of the amount received when the property is liquidated, the Department shall apply the values described in Section 120.Table A. The life estate and remainder interest are based on the age of the person at the time the life estate in the property is established and at the time the property is liquidated and the corresponding values described in Section 120.Table A.

j) A person's entrance fee in a continuing care retirement community or life care community (as those entities are described in 42 USC 1396r(c)(5)(B)) shall be considered an available resource to the extent that:

1) the person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used to pay for care should other resources or income of the person be insufficient to pay for the care;

2) the person is eligible for a refund of any remaining entrance fee when the person dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

3) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(Source: Amended at 34 Ill. Reg. _____, effective _____)

Section 120.381 Exempt Resources~~Assets~~

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~AABD MANG assets exempt from consideration for AABD MANG shall be as follows:~~

a) The following resources~~assets~~ are exempt from consideration in determining eligibility for medical assistance ~~and the amount of the assistance payment~~:

1) Homestead Property.~~property~~

A) Homestead property is any property in which a person (and spouse, if any) has an ownership interest and that serves as the person's principal place of residence. This property includes the shelter in which a person resides, the adjoining land on which the shelter is located and related outbuildings.

B) If a person (and spouse, if any) moves out of his or her home without the intent to return, the home is no longer exempt because it is no longer the person's principal place of residence. If a person leaves his or her home to live in a long term care facility, the property is considered exempt, irrespective of the person's intent to return, as long as a spouse or dependent relative of the eligible person continues to live there. The person's equity in the former home is treated as an available resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

2) Personal effects and household goods are exempt to the extent they are excluded under 20 CFR 416.1216.~~Property~~

~~A) Personal effects and household goods of reasonable value (reasonable value means the client's equity value in such property does not exceed $2,000). Wedding and engagement rings and items required due to medical or physical condition.~~

~~B) Regardless of the value, personal effects and household goods are exempt in determining the amount allowed as the Community Spouse Asset Allowance (as described in Section 120.386).~~

3) Resources (for example, land, buildings, equipment and supplies or tools) necessary for self-support up to $6,000 of the person's~~individual's~~ equity in the income producing property provided the property produces a net

annual income of at least six percent of the excluded equity value of the property. The equity value in excess of $6,000 is not excludedapplied toward the asset disregard. If the activity produces income that is less than six percent of the exempt equity due to reasons beyond the person'sindividual's control (for example, the person'sindividual's illness or crop failure) and there is a reasonable expectation that the property will againindividual's activity will increase to produce income equal to six percent of the equity value (for example, a medical prognosis that the personindividual is expected to respond to treatment or that drought resistant corn will be planted), the equity value in the property up to $6,000 is exempt. If the personindividual owns more than one piece of property and each produces income, each is looked at to determine if the six percent rule is met and then the amounts of the person'sindividual's equity in all of those properties are totaled to see if the total equity is $6,000 or less. The total equity value of all properties that is exempt is limited to $6,000.

4) Automobile.

A) Exclude one automobile, regardless of value, used by the client, spouse or other dependent if:

i) it is necessary for employment;

ii) it is necessary for the medical treatment of a specific or regular medical problem;

iii) it is modified for operation by, or transportation of, a handicapped person;

iv) it is necessary because of factors such as climate, terrain or distance to provide necessary transportation to perform essential daily activities; or

v) one vehicle for each spouse is exempt in determining the amount allowed as the Community Spouse Asset Allowance (as described in Section 120.379(d)120.386).

B) If not excluded in subsection (a)(4)(A) of this Section, exclude one

automobile is excluded to the extent its equity value~~the fair market value~~ does not exceed $4500. Any~~Apply the~~ excess equity value is applied~~fair market value~~ toward the applicable resource~~asset~~ disregard (see Section 120.382~~89 Ill. Adm. Code 113.142~~). ~~The Department will determine fair market value in accordance with 89 Ill. Adm. Code 121.57(b)(2)(D)(iv).~~

C) For all other automobiles, apply the equity value ~~(fair market value minus any encumbrance)~~ toward the resource~~asset~~ disregard (see 89 Ill. Adm. Code 113.142).

5) Life insurance policies with a total face value of $1,500 or less and all term life insurance policies. If the total face value exceeds $1,500, the cash surrender value must be counted as a resource.

6) For purposes of this Section, the term "equity value" refers to:

A) in the case of real property, the value described in Section 120.385(c); and

B) in the case of personal property, the price that an item can reasonably be expected to sell for on the open market in the particular geographic area involved, minus any encumbrances (as described in Section 120.385(c)(1)(C)).

b) ~~Burial spaces and funds are exempt as follows: 1)~~Burial spaces that are intended for the use of the person~~individual~~, his or her spouse, or any other member of his or her immediate family are exempt. Immediate family is defined as a person's~~an individual's~~ minor and adult children, including adopted children and stepchildren, a person's~~an individual's~~ brothers, sisters, parents and~~,~~ adoptive parents, and the spouses of these individuals.

~~2)~~ ~~Funds set aside for the burial expenses of the individual and his or her spouse, subject to a limit of $1,500 each. This limit will be reduced by the face value of any excluded life insurance policy and the amount of any funds held in an irrevocable trust or other irrevocable arrangement that is available for burial expenses.~~

~~3)~~ ~~Interest earned on excluded burial funds and appreciation in the value of~~

~~excluded burial arrangements which occurred the earlier of the date of first SSI eligibility or the date of AABD eligibility, but no earlier than November 1, 1982 (see 20 CFR 416.1231(b)(5) (1992)).~~

~~4)~~ ~~Funds specifically and irrevocably set aside for the professional funeral services and burial expenses of the individual and his or her spouse, subject to a limit of $4,000 each, including prepaid funeral and burial plans. This limit will be increased annually by three percent.~~

c) Funds that are set aside for the burial expenses of a person and his or her spouse in a bank account owned by the person that is clearly identified as a burial fund is exempt up to $1500. This amount is reduced by the face value of any excluded life insurance on the person and the amount of any funds held in an irrevocable trust or other irrevocable arrangement that is available for burial expenses.

d) Prepaid Funeral/Burial Contracts. Prepaid funeral/burial contracts that comply with the provisions of the Illinois Funeral or Burial Funds Act [225 ILCS 45] are exempt to the following extent:

1) Funds in a revocable prepaid funeral/burial contract are exempt up to $1500.

2) Effective September 1, 2009, funds in an irrevocable prepaid funeral/burial contract are exempt up to $5,537. This amount shall be increased annually each September 1 by 3%.

3) A prepaid, guaranteed price funeral/burial contract funded by an irrevocable assignment of a person's life insurance policy to the seller of a pre-need contract or the provider of the funeral or the burial services is exempt if the seller's or provider's nominal ownership in the policy is immediately transferred into a trust as provided under 225 ILCS 45/2a(d). The trust is responsible for ensuring that the provider of funeral services under contract receives the proceeds of the policy when it provides the funeral goods and services specified under the contract (see 225 ILCS 45/1a-1(a). The irrevocable assignment of ownership of the insurance policy must be acknowledged by the insurance company.

e)~~e)~~ Resources~~Assets~~ necessary for fulfillment of an approved plan for achieving self-support under 42 CFR 416.1220.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~d)~~ ~~Trust funds are exempt as follows:~~

~~1)~~ ~~The principal of a trust fund only when the instrument establishing the trust specifically states the principal cannot be impaired.~~

~~2)~~ ~~The principal of a trust fund established under the Self Sufficiency Trust Fund Program [20 ILCS 1705/21.1].~~

f)~~e)~~ Resources~~Assets~~ excluded by express provision of 20 CFR 416.1236 (2005~~1997~~).

g)~~f)~~ *Donations or benefits from fund raisers held for a seriously ill client provided the client or a responsible relative of the client does not have control* (for example, not available to the client or the responsible relative) *over the donations or benefits or the disbursement of donations or benefits* [305 ILCS 5/5-2].

h)~~g)~~ Payments made to veterans who receive an annual disability payment or to the survivors of deceased veterans who receive a one-time lump sum payment from the Agent Orange Settlement Fund or any other fund referencing Agent Orange product liability under Public Law 101-201.

i)~~h)~~ Money received from the Social Security Administration under a Plan to Achieve Self-Support (PASS) and held in a separate account.

j)~~i)~~ Disaster relief payments provided by federal, State or local government or a disaster assistance organization.

k)~~j)~~ The amount of earned income tax credit that the client receives as advance payment or as a refund of federal income tax.

l)~~k)~~ For disabled persons who have lost eligibility under Section 120.510 and who are only requesting services other than those described in 89 Ill. Adm. Code 120.61(a), the following additional exemptions shall apply:

1) Retirement accounts that a person with a disability cannot access without penalty before the age of 59½ and medical savings accounts established pursuant to 26 USC 220; and

2) Up to $25,000 if the person owned assets of equal value when his or her

eligibility under Section 120.510 ended.

m)~~l)~~ Certain payments received under the American Recovery and Reinvestment Act of 2009.

1) Payments to World War II veterans who served in the Philippines and spouses of those veterans under Div. A, Title X, Sec. 1002 of P.L. 111-5.

2) Payments or reimbursements for Premium Assistance for COBRA Continuous Coverage under Div. B, Title III, Sec. 3001 of P.L. 111-5.

n)~~m)~~ Certain payments received under the American Recovery and Reinvestment Act of 2009 are exempt as an asset the month of receipt and two months thereafter.

1) Making Work Pay Credit under Div. B, Title I, Sec. 1001 of P.L. 111-5.

2) Tax Credit for Certain Government Retirees under Div. B, Title II, Sec. 2202 of P.L. 111-5.

o)~~n)~~ Economic Recovery Payments under the American Recovery and Reinvestment Act of 2009 under Div B, Title II, Sec. 2201 of P.L. 111-5 are exempt as an asset the month of receipt and nine months thereafter.

(Source: Amended at 34 Ill. Reg. _____, effective _____)

Section 120.382 Resource~~Asset~~ Disregard

In addition to the exempt resources~~assets~~ listed in Section 120.381, the cash value of resources~~assets~~ shall be disregarded for AABD MANG as follows:

a) $2,000 for a person~~client~~ and $3,000 for a person~~client~~ and one dependent residing together. A dependent means a "qualifying" person as that term is described in 26 USC 152.

b) $50 for each additional dependent residing in the same household.

c) Resources equal in amount to the benefits paid on behalf of a person under a qualified long term care insurance policy as provided under 42 USC 1396p(b)(1)(C) and (b)(5). Policies written in Illinois are approved by the

Director of the Illinois Department of Insurance under the Qualified Long Term Care Insurance Partnership (QLTCIP) program (50 Ill. Adm. Code 2012). The dollar value of the amount paid for QLTCIP benefits is disregarded; the extent to which the disregard is applied to a resource will depend and may vary with the underlying equity value (see Section 120.381(a)(6)) the person holds in the resource. ~~The amount equal to the sum of qualifying insurance benefit payments made as a result of coverage under a Long Term Care Partnership Insurance Policy, as described in 50 Ill. Adm. Code 2018, provided that the person has received all of the qualifying insurance benefit payments that are payable under the policy.~~

~~d)~~ ~~All assets of a person who purchases a Long Term Care Partnership Insurance Policy, as described in 50 Ill. Adm. Code 2018, with coverage equal to the average cost of four years of long term care services in a nursing facility, provided that the person has received all of the qualifying insurance benefit payments that are payable under the policy.~~

d)~~e)~~ Eligibility for medical assistance or the benefits described in Sections 120.72 and 120.73~~AABD MANG~~ does not exist when nonexempt resources~~assets~~ exceed allowable disregards~~the above disregard~~.

e~~f~~) For Qualified Medicare Beneficiaries~~Beneficiary~~ (QMB)

1) $4,000 for a single person and $6,000 for a person with one or more dependents.

2) Eligibility for QMB status does not exist when countable assets exceed ~~the above~~ disregard described in this Section.

(Source: Amended at 34 Ill. Reg. _____, effective _____)

Section 120.384 Spenddown of Resources~~Assets (AABD MANG)~~

In determining a person's resource spenddown obligation, the Department compares nonexempt resources available to the person to the appropriate resource disregard. The amount of resources in excess of the disregard determines the amount of the spenddown.

a) If a person presents verification that excess resources are no longer available, the Department will make the appropriate changes the month following the month the

person disposed of the resources.~~Determination of Assets~~

b) Persons enrolled in spenddown are not eligible for payment of covered medical services until spenddown is met. A resource spenddown is met by presenting allowable medical bills or receipts to the Department that equal the amount of the person's nonexempt excess resources. See Sections 120.60(c) and 120.61(c) for specific requirements related to spenddown, including the option to pay in spenddown to the Department by enrolling in the Pay-in Spenddown Program.

c) Once an excess resource has been used to meet spenddown, whether or not the excess amount has actually been reduced, it is no longer considered. However, at reapplication/redetermination, the Department will consider any excess nonexempt resources remaining as currently available. A spenddown cannot be eliminated by a non-allowable transfer made to qualify for or increase the need for medical assistance.

~~1) For individuals residing in the community, the Department determines the amount of non-exempt assets using the verified amount on the date of decision on the application for medical assistance. The date of verification may be prior to the date of decision. Money considered as income for a month is not considered as an asset for that same month. If income for a month is added to a bank account that month, the Department will subtract the amount of income from the bank balance to determine the asset level. Any income remaining the following months is considered as an asset.~~

~~2) The amount of non-exempt assets verified during the application process is used on the date of decision. If medical eligibility includes backdated months, for the backdated months the Department will consider the amount of assets available to apply to the cost of medical care. The Department will not determine the value of assets for backdated months of eligibility. However, the amount of the excess assets verified during the application process is used to determine spenddown status in each backdated month of eligibility.~~

~~3) Once the excess asset has been used to meet spenddown, whether or not the excess amount has actually been reduced, it is no longer considered. However, at reapplication/redetermination, the Department will consider any excess non-exempt assets remaining as currently available.~~

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~b)~~ ~~Community Cases (AABD MANG)~~
~~For AABD MANG, to determine the spenddown obligation for clients in the community, the Department will compare monthly countable income to the appropriate MANG standard and add any non-exempt assets in excess of the appropriate asset disregard to non-exempt monthly income in excess of the appropriate MANG Standard.~~

~~1)~~ ~~Regular AABD MANG – Community Residents~~
~~When an individual residing in the community, has countable monthly income of not more than 99 cents over the appropriate MANG Standard and has non-exempt excess assets of not more than 99 cents over the appropriate asset disregard, the case is referred to as a Regular MANG case. Payment for covered services is made for each month eligibility exists.~~

~~2)~~ ~~Spenddown AABD MANG~~

~~A)~~ ~~When an individual resides in the community and has countable monthly income of at least $1.00 over the MANG Standard and/or non-exempt assets of at least $1.00 in excess of the asset disregard for the appropriate size household, the case is referred to as a community spenddown case. The spenddown amount is the sum of the amount of income in excess of the MANG Standard plus non-exempt assets in excess of the appropriate asset disregard. The Department will disregard any excess income and/or asset amounts that are not at least $1.00 over the appropriate standard or disregard.~~

~~B)~~ ~~If the individual presents verification that the excess amount is no longer available, the Department will make the appropriate changes the month following the month the assets were transferred.~~

~~C)~~ ~~Individuals enrolled in spenddown are not eligible for payment of covered medical services until spenddown is met. Spenddown is met by presenting allowable medical bills or receipts to the Department that equal the amount of the individual's excess countable income and/or non-exempt excess assets. Individuals may also pay-in the amount of the income or asset spenddown to the Department by enrolling in the Pay-in Spenddown Program~~

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~(see Section 120.60). Excess assets do not have to be reduced prior to the authorization of medical assistance.~~

~~e)~~ ~~Group Care Cases~~

~~To determine the spenddown obligation for AABD MANG clients in group care, the Department will compare monthly countable income and non-exempt assets in excess of the appropriate asset disregard to the cost of long term care at the private pay rate or the Department rate, whichever is greater. When an individual has non-exempt excess assets, the excess amount is applied to the monthly long term care charges after the monthly countable income has been applied.~~

~~1)~~ ~~Regular Group Care~~

~~When an individual in group care has countable monthly income plus non-exempt assets in excess of the applicable asset disregard of not more than 99 cents over the private pay rate or the Department rate, whichever is greater, the case is referred to as a Regular Group Care case. If monthly countable income plus excess non-exempt assets are less than the long term care charges at the Department rate, the Department will pay the difference.~~

~~2)~~ ~~Group Care Spenddown~~

~~A)~~ ~~When an individual in group care has countable monthly income plus non-exempt assets in excess of the applicable asset disregard of at least $1.00 over the cost of long term care at the private pay rate or the Department rate, whichever is greater, the case is referred to as a Group Care Spenddown case. The spenddown amount is the sum of the monthly countable income plus non-exempt assets over the applicable asset disregard.~~

~~B)~~ ~~The transfer of asset policy set forth in Section 120.385 still applies. Once the client has been determined to have a resource spenddown because of excess non-exempt assets, the spenddown cannot be eliminated by a non-allowable transfer made to qualify for or increase the need for medical assistance.~~

~~C)~~ ~~If the individual presents verification that the excess amount is no longer available and the transfer of assets is allowable according to Section 120.385, the Department will make the appropriate~~

~~changes the month following the month the assets were transferred. If spenddown has been met, the policy set forth in Section 120.385 regarding transfer of assets does not apply. The client may dispose of the asset as he/she wishes as it has been applied to a met spenddown.~~

~~D)~~ ~~Individuals enrolled in spenddown are not eligible for payment of covered medical services until spenddown is met. Spenddown is met by presenting allowable medical bills or receipts to the Department that equal the amount of the individual's excess countable income and/or non-exempt assets. Excess assets do not have to be reduced prior to the authorization of medical assistance.~~

(Source: Amended at 34 Ill. Reg. _____, effective _____)

Section 120.385 Factors Affecting Eligibility for Long Term Care Services~~Property Transfer for Applications Filed Prior to October 1, 1989 (Repealed)~~

a) For purposes of this Section, the terms "institutionalized persons" and "long term care services" shall have the meanings described in Section 120.388 of this Part. The terms "institutionalized spouse" and "community spouse" shall have the meanings described in Section 120.379(a) of this Part.

b) Disclosure of annuity and naming the State as remainder beneficiary:

1) Effective on the date of this rulemaking, an application (or redetermination related to an application) for long term care services shall include a disclosure by an institutionalized person or his or her community spouse of any interest either or both may have in any annuity or similar financial instrument purchased, regardless of whether the annuity is irrevocable or is treated as an asset. The application or recertification form shall also include a statement that the State of Illinois becomes a remainder beneficiary under such an annuity or similar financial instrument to the extent that the State has provided medical assistance to the institutionalized person.

2) Failure of an institutionalized person, his or her community spouse, or his or her representative to disclose information or to name the State as a remainder beneficiary as provided for in subsection (b)(1) of this Section,

or to disclose sufficient information regarding an annuity in order to establish eligibility for long term care services, shall result in denial or termination of the eligibility. Failure of an institutionalized person, his or her community spouse or his or her representative to disclose the information provided for in subsection (b)(1) of this Section, or to disclose sufficient information regarding an annuity in order to establish eligibility for medical assistance, may also result in denial or termination of eligibility for failure to cooperate under Section 120.308.

c) Home Equity Interest.

1) Effective on the date of this rulemaking, a person shall not be eligible for long term care services if the person's equity interest in his or her homestead exceeds $500,000. This amount shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items: United States city average), rounded to the nearest $1000. A person's equity interest in his or her homestead shall be determined as follows:

A) The current market value (CMV) of the property is the going price for which it can reasonably be expected to sell on the open market in the particular geographic area involved. The CMV of the property may be established by:

i) an appraisal report, no more than six months old at the time of the application for long term care services, completed by an appraiser who is licensed or otherwise meets the requirements under the Real Estate Appraiser Licensing Act [225 ILCS 458]; or

ii) a county real estate assessor's current estimate of the market value or fair cash value of the property used in determining the assessed value of a property; or

iii) any other reliable and verifiable indicia of the price that a property would bring in a sale between a willing buyer and seller under arms-length conditions unaffected by undue pressures;

B) Equity value (EV) is the CMV of the property minus any encumbrance on it;

C) An encumbrance is a legally binding debt against a specific property. Such a debt reduces the value of the encumbered property but does not necessarily prevent the property owner from transferring ownership (selling) to a third party. However, if the owner of encumbered property does sell, the creditor will nearly always require debt satisfaction from the proceeds of sale. Examples of encumbrances include mortgages, reverse mortgages, home equity loans or other debt that is secured by the property;

D) If property is held in any form of shared ownership (e.g., joint tenancy, tenancy in common or other similar arrangement) only the fractional interest in the property shall be considered in determining the person's equity in that property.

2) The eligibility of a person for long term care services shall not be affected under this subsection (c)(2) if any of the following are lawfully residing in the person's home:

A) the person's spouse;

B) the person's child who is under age 21; or

C) the person's adult child who is blind (as described in Section 120.313 of this Part) or disabled (as described in Section 120.314 of this Part).

3) A person whose eligibility for long term care services is affected under this subsection (c) may request a hardship waiver. The process and basis for requesting such a waiver shall be the same as described in Section 120.388(r) of this Part. In determining whether a waiver should be granted, the Department shall also take into account:

A) the amount of time the person has resided in and owned the home;

B) whether a substantial increase in property values in the home's geographic area occurred after the person purchased the home;

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

C) whether the home comprises a substantial portion of the person's assets (as defined in Section 120.388(d)); and

D) whether the person intends to return to the home after a period of institutionalization or, if the person does not intend to return, whether the home can be sold after being listed for sale or, if it cannot be sold, can produce income commensurate with similar income producing properties in the geographic area.

4) For purposes of this Section the words, "homestead" and "home" have the same meaning as the term "homestead" in Section 120.381(a)(1)(A) of this Part.

(Source: Amended at 34 Ill. Reg. _____, effective _____)

Section 120.387 Property Transfers Occurring On or After August 11, 1993 and Before February 8, 2006

a) The provisions for the transfer of property (e.g.,~~for example,~~ assets) listed in subsection (e)~~below~~ only apply to institutionalized persons when the transfer occurs on or after August 11, 1993 and before February 8, 2006. An institutionalized person is defined as a resident of a long term care facility, including a resident who was living in the community at the time of the transfer, and to individuals who but for the provision~~provisions~~ of home and community-based services under Section 4.02 of the Illinois Act on the Aging would require the level of care in a long term care facility. An institutionalized person also includes an individual receiving home and community-based services under Section 4.02 of the Illinois Act on the Aging who was not receiving these services at the time of the transfer.

b) The provisions for the transfer of property (e.g.~~for example~~, assets) listed in subsection (e)~~below~~ apply to the transfer of property by the institutionalized person's spouse in the same manner as if the institutionalized person transferred the property.

c) Transfers of property disregarded as a result of payments made by a Long Term Care Partnership Insurance Policy (as described in 50 Ill. Adm. Code 2018) are not subject to the provisions of this Section.

d) A transfer of assets occurs when an institutionalized person or an institutionalized person's spouse buys, sells or gives away real or personal property or changes (for example, change from joint tenancy to tenancy in common) the way property is held. Changing ownership of property to a life estate interest is an asset transfer (the value of the life estate and remainder interest is determined as described at Section 120.380 and 89 Ill. Adm. Code 113.140). For assets held in joint tenancy, tenancy in common or similar arrangement, a transfer occurs when an action by any person reduces or eliminates the person's ownership or control of the asset. A transfer occurs when an action or actions are taken thatwhich would cause an asset or assets not to be received (e.g.for example, waiving the right to receive an inheritance).

e) A transfer is allowable if:

1) depending on the property transferred, the transfer occurred more than either 60 or 36 months before the date of application, or more than either 60 or 36 months before entry into a long term care facility or more than either 60 or 36 months before receipt of services provided by the Illinois Department on Aging under the In-Home Care Program (as described in 89 Ill. Adm. CodeSection 140.643);

A) the 60 month period applies to payments from a revocable trust that are not treated as income (as described in Section 120.347) and to portions of an irrevocable trust from which no payments could be made (as described in Section 120.347);

B) the 36 month period applies to payments from an irrevocable trust that are not treated as income (as described in Section 120.347) and to any other property transfers not identified in this subsection;

2) a fair market value was received. Fair market value is the price that an article or piece of property might be expected to bring if offered for sale in a fair market. Fair market value is determined by statements obtained from institutions, community members, etc. (e.g.for example, bankers, jewelers, reputable realtors, etc.) recognized as having knowledge of property values;

3) homestead property was transferred to:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

A) a spouse;

B) the person's child who is under age 21;

C) the person's child who is blind (as described in Section 120.313) or disabled (as described in Section 120.314);

D) the person's brother or sister who has an equity interest in the homestead property and who was residing in the home for at least one year immediately prior to the date the person became institutionalized; or

E) the person's child who provided care for the person and who was residing in the homestead property for two years immediately prior to the date the person became institutionalized;

4) the transfer by the institutionalized person was to the community spouse or to another person for the sole benefit of the community spouse ~~and the amount transferred does not exceed the Community Spouse Asset Allowance (as described in Section 120.379)~~;

5) the transfer from the community spouse was to another person for the sole benefit of the community spouse;

6) the transfer was to the person's child or to a trust established solely for the benefit of the person's child who is blind (as described in Section 120.313) or disabled (as described in Section 120.314) or to another person for the sole benefit of the person's child;

7) the transfer was to a trust established solely for the benefit of a person under age 65 who is disabled (as described in Section 120.314);

8) the person intended to transfer the assets for fair market value;

9) it is determined that denial of assistance would create an undue hardship. Examples of undue hardship include, but are not limited to, situations in which:

A) the individual is mentally unable to explain how the assets were transferred;

B) the denial of assistance would force the resident to move from the long term care facility; or

C) the individual would be prohibited from joining a spouse in a facility or would prohibit the individual from entering a facility that is within close proximity to his or her family;

10) the transfer was made exclusively for a reason other than to qualify for assistance. A transfer for less than fair market value is presumed to have been made to qualify for assistance unless a satisfactory showing is made to the Department that the client or spouse transferred the asset exclusively for a reason other than to qualify for assistance;

11) the transfer by the client was to the community spouse and was the result of a court order;

12) the assets transferred for less than fair market value have been returned to the person; or

13) the transfer was to an annuity, the expected return on the annuity is commensurate with the estimated life expectancy of the person, and the annuity pays benefits in approximately equal periodic payments. In determining the estimated life expectancy of the person, the Department shall use the current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration http://www.ssa.gov/OACT/STATS/table4c6.html. ~~life expectancy table described in Section 120.Table B.~~

f) If a transfer or transfers do not meet the provisions of subsection (e), the client is subject to a period of ineligibility for long term care services and for services provided by the Illinois Department on Aging under the In-Home Care Program (as described in Section 140.643). The penalty period is determined in accordance with subsection (g) of this Section. If otherwise eligible, clients remain entitled to other covered medical services.

g) A separate penalty period is determined for each month in which a transfer or

transfers do not meet the provisions of subsection (e) of this Section. Each penalty period is the number of months equal to the total uncompensated amount of assets transferred during a month divided by the monthly cost of long term care at the private rate.

h) The penalty period begins with the month of the transfer or transfers unless the transfer or transfers occurred during a previous penalty period. If so, the penalty period begins with the month following the month the previous penalty period ends.

i) For transfers by the community spouse that result in a penalty period as described in subsection (g) of this Section and the community spouse becomes an institutionalized person and is otherwise eligible for assistance, the Department shall divide any remaining penalty period equally between the spouses.

(Source: Amended at 34 Ill. Reg. _____, effective _____)

Section 120.388 Property Transfers Occurring On or After February 8, 2006

The provisions in this Section are intended to comport with federal requirements related to transfers of assets, in particular, requirements under 42 USC 1396p and guidance from the US Department of Health and Human Services related to those statutory requirements. Interpretation and application of this Section shall be made in light of those requirements.

a) General. A transfer of assets for less than fair market value made on or after February 8, 2006 by an institutionalized person or the spouse of that person 60 months before the later of applying for medical assistance or transferring an asset shall result in a period of ineligibility for long term care services for that person.

b) Long term care services are defined as:

1) services provided in a long term care facility as that institution is defined in Section 120.61(a); and

2) services provided under a home and community based waiver authorized under 42 USC 1396n(c) or (d) and specified in 42 CFR 441 Subpart G or H.

c) Institutionalized individuals or persons are defined as:

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) persons residing in long term care facilities, including those who were residing in the community at the time a transfer of assets was made; or

2) persons who, but for the provision of home and community based waiver services (42 USC 1396a(a)(10)(A)(ii)(VI)), would require the level of care in a long term care facility, including those persons receiving home and community based waiver services who were not receiving the services at the time a transfer of assets was made.

d) Assets.

1) For purposes of this Section, the term "assets" or "property" includes all income (as defined in 42 USC 1382a) and resources (as defined in 42 USC 1382b, except subsection (a)(1) of that section, which excludes the home as a resource) of an institutionalized person and that person's spouse, including, but not limited to: cash; savings certificates; stocks; bonds; interests in real property, including mineral rights; rights to inherited real or personal property or income; and accounts and debts receivable.

2) Assets also include any income or resources that the person or the person's spouse is entitled to but does not receive because of action or inaction by:

A) the person or the person's spouse;

B) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the person or the person's spouse;

C) any person, including any court or administrative body, acting at the direction or upon the request of the person or the person's spouse; or

D) any person who acted (or failed to act) to avoid receiving assets to which the person was entitled.

3) Examples of actions that would cause assets not to be received include:

A) Irrevocably waiving pension income;

B) Waiving the right to receive an inheritance;

C) Not accepting or accessing injury settlements;

D) Arranging for a defendant in a civil action to divert a settlement amount into a trust or similar device for the benefit of the person, who is a plaintiff in the case;

E) Refusing to take legal action to obtain a court-ordered payment that is partially or wholly unpaid, such as alimony; or

F) Receiving an inheritance under a will when renouncing the will and taking a statutory share (see 755 ILCS 5/2-8) is more advantageous. Alternately, renouncing a will and taking a spousal share when taking the inheritance is more advantageous.

4) Failure to take action to receive an asset is not considered a transfer for less than fair market value when evidence is submitted showing the cost of obtaining an asset exceeds the value of the asset.

e) Transfer. A transfer of assets occurs when an institutionalized person or an institutionalized person's spouse buys, sells or gives away real or personal property or changes (e.g., a change from joint tenancy to tenancy in common) the way property is held.

1) Changing ownership of property to a life estate interest is an asset transfer (the value of the life estate and remainder interest is determined as described in Section 120.380 and 89 Ill. Adm. Code 113.140).

2) Transactions involving annuities, including the purchase of an annuity or any action by a person that changes the course of payments to be made by the annuity or the treatment of income or principal of the annuity, are considered transfers under this Section. Such actions include, but are not limited to, additions of principal, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract and any action intended to make an annuity irrevocable or nonassignable.

3) For property held in joint tenancy, tenancy in common or similar arrangement, a transfer occurs when an action by any person reduces or eliminates the person's ownership or control of the property.

4) A transfer of income in the month it is received is considered a transfer of assets if the income would have been considered an asset in the following month as provided under Section 120.380(c)(1). A transfer of the proceeds of a loan in the month received is considered a transfer of assets.

f) Fair market value (FMV) is an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred. Prevailing price is what property would sell for on the open market between a willing buyer and a willing seller, with neither being required to act and both having reasonable knowledge of the relevant facts.

1) In determining if FMV has been received for an asset, the Department shall use all reasonable means available and consider all relevant facts and circumstances relating to the asset and the transaction, including, but not limited to: the cost or price paid for the asset, whether the transaction was at arm's length, comparable sales, replacement cost, and expert opinion. In determining the FMV of farmland in Illinois, the Department may take into account market values determined under tables developed by the University of Illinois Farm Bureau.

2) For an asset to be considered transferred for FMV, the compensation received for the asset must be in a tangible form with intrinsic value that is roughly equivalent to or greater than the value of the transferred asset.

3) Transfers of assets for "love and affection" are not considered transfers for FMV. A transfer to a friend, family member or relative for care provided for free in the past is a transfer of assets for less than FMV. The Department presumes that services, care or accommodations rendered to a person by a friend or family member are gratuitous and without expectation of compensation. This presumption may be rebutted by credible documentary evidence that preexists the delivery of the care, services or accommodations showing the type and terms of compensation and contemporaneous receipts, logs or other credible documentation showing actual delivery of the care or services claimed. Compensation paid in excess of prevailing rates for similar care, services or

accommodations in the community shall be treated as a transfer for less than FMV.

4) "Compensation received" is the amount of money or value of any property or services received in return for the institutionalized person's assets. The compensation received may be in the form of:

A) Cash;

B) Other assets such as promissory notes, stocks, bonds, and both real estate contracts and life estates that are evaluated over an extended time period;

C) Discharge of a debt;

D) Prepayment of a bona fide and irrevocable contract, such as a mortgage, shelter lease, loan or prepayment of taxes;

E) Services; and

F) Any other act, object, service or other benefit that has tangible or intrinsic economic value to the person.

5) The term "uncompensated value" means the difference between the FMV of a transferred asset (less any outstanding loans, mortgages, or other encumbrances on the asset) and the actual compensation received. Only the uncompensated value of a transferred asset is subject to the penalty provisions described in this Section.

g) Look Back Period. The provisions of this Section apply to any asset transfers (occurring on or after February 8, 2006) made 60 months before the date on which the person is both an institutionalized person (as defined in subsection (c) of this Section) and has applied for medical assistance.

h) Penalty. If a person transfers assets for less than fair market value, the person is subject to a period of ineligibility for long term care services. The penalty period is determined in accordance with subsection (j) of this Section. If otherwise eligible, persons subject to a penalty remain eligible for all covered medical services except long term care services.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

i) Penalty Period. A penalty period under this Section:

1) begins with the later of:

A) the first day of a month during which a transfer for less than FMV is made; or

B) the date on which the person is eligible for medical assistance and would otherwise be receiving long term care services (based on an approved application for those services) were it not for the imposition of the penalty period. A person is not considered eligible and services are not considered capable of being received under this subsection (i) until any spenddown is met; and

2) does not occur during any other period of ineligibility under this Section.

j) Penalty Calculation. A penalty period is determined based on the uncompensated value of transfers. The penalty period is calculated by dividing the total uncompensated value of assets transferred by the average monthly cost of long-term care services at the private rate in the community in which the person is institutionalized at the time of application. The result is the penalty period in number of months, days and portion of a day (e.g., $65,000/$4000 = 16.25 = 16 months and 7.5 days). The Department will not round down or otherwise disregard any period of ineligibility calculated under this subsection.

k) Multiple Transfers. Multiple, non-allowable transfers made during the look-back period shall be cumulated and treated as a single transfer. A single period of ineligibility shall be calculated based on the total uncompensated value of the transfers. Once a penalty period is imposed, it continues to run without regard to whether the person continues receiving long term care services.

l) When transfers by a community spouse result in a penalty period for the institutionalized spouse and the community spouse subsequently becomes institutionalized and is otherwise eligible for medical assistance, the Department shall divide any remaining penalty period equally between the spouses. If one spouse predeceases the other before the penalty period has ended, the remaining penalty period will be added to the surviving spouse's penalty.

m) Penalty Exceptions.

1) A person shall not be subject to a penalty period under this Section to the extent that:

A) homestead property was transferred to:

i) the person's spouse;

ii) the person's child who is under age 21;

iii) the person's child who is determined blind (as described in Section 120.313) or determined disabled (as described in Section 120.314);

iv) the person's brother or sister who has an equity interest in the homestead property and who was residing in the home for at least one year immediately prior to the date the person became institutionalized; or

v) the person's son or daughter who provided care for the person and who resided in the homestead property for the two years immediately prior to the date the person became institutionalized, provided:

- the institutionalized person provides a physician's statement that describes the person's physical and mental condition during the two years prior to institutionalization, explains why the person needed personal or home health services during those two years, and specifies the services appropriate to the person's needs;

- the son or daughter provides a statement showing: the specific services and care provided during the two years; the hours per day spent providing the services; if the son or daughter worked outside the home, how the person's needs were taken care of while working; and if the son or daughter paid a third party to provide the

care, the amount of the payment, the specific services provided and the length of time the services were provided; and

- the person provides a statement from an unrelated third party with knowledge of the person's condition and living arrangements during the two years that corroborates the son's or daughter's statement.

B) the transfer by the institutionalized person was to:

i) the person's spouse or to another person for the sole benefit of the person's spouse;

ii) the person's child or to a trust (including a trust described in Section 120.347(d)) established solely for the benefit of the person's child or to another person for the sole benefit of the institutionalized person's child. To qualify under this subsection (m)(1)(B), the child must be determined blind (as described in Section 120.313) or determined disabled (as described in Section 120.314);

iii) a trust (including trusts described in Section 120.347(d)(1) and (2)) established solely for the benefit of a person who is determined disabled (as described in Section 120.314).

C) the person intended to transfer the property for fair market value (FMV). When a transfer is made for less than FMV, a person is presumed to have done so intentionally. This presumption may be rebutted by objective tangible evidence showing:

i) initial and continuing reasonable, good faith efforts to sell the property on the open market were made and that the compensation received was the best value offered;

ii) a legally binding contract was executed that provided for adequate compensation in a specified form (e.g., goods, services, cash) in exchange for the transferred asset;

iii) the person acted in good faith that he or she was receiving FMV or the best price for the item or property, and the item or property was transferred to a person other than a related party (e.g., a person related by blood, marriage or friendship);

iv) the person had other adequate means or plans for support, including medical care, at the time of the transfer; and

v) the transfer was made for reasons exclusive of qualifying or remaining eligible for medical assistance.

D) the transfer was made exclusively for a reason other than to qualify or remain eligible for medical assistance. A transfer for less than FMV is presumed to have been made to qualify for assistance. This presumption may be rebutted by credible tangible evidence that the person or spouse had no reason to believe that Medicaid payment of long-term care services might be needed. The sudden loss of income or assets, the sudden onset of a disabling condition, or a personal injury may provide convincing evidence. A subjective statement of intent or claim of ignorance of the asset transfer provision is not sufficient. The person must provide evidence that other assets were available at the time of transfer to meet current and future expected needs of that person, including the cost of nursing home or other medical institutional care. Other examples of credible evidence showing a reason for transferring assets for reasons exclusively other than qualifying for medical assistance include, but are not limited to:

i) police reports, other related law or regulatory enforcement, documentation from the Department on Aging, or like credible evidence that assets were misappropriated as a result of elder or other abuse and cannot be recovered;

ii) evidence that the transfer was made by a person lacking the mental capacity to make the transfer and who was not represented by a guardian, family member or other legal representative at the time of the transfer.

E) the person transfers property disregarded as a result of payments made by a qualified long term care insurance policy approved by the Director of the Illinois Department of Insurance under the Qualified Long Term Care Insurance Partnership (QLTCIP) program (50 Ill. Adm. Code 2012).

F) all of the assets transferred for less than FMV have been returned to the person. When all transferred assets are returned, the assets are treated as returned on the date the penalty was imposed; the penalty is erased and the returned assets are treated as available as of the date the penalty was imposed. For the time period between imposition of the penalty and return of the assets, the Department will treat the assets as available to meet the spenddown obligation for that time period only (see Section 120.384). At the point in time that assets are in fact returned, they are treated as available assets that may be reduced by a spenddown obligation or otherwise. Returned assets that are transferred for less than fair market value may be subject to penalty.

G) the Department determines that the denial of eligibility would cause an undue hardship as provided in subsection (r) of this Section.

2) For purposes of subsection (m)(1)(B), a transfer is considered to be for the "sole benefit of" a person if:

A) The transfer is arranged in such a way that no individual or entity except the specified beneficiary can benefit from the property transferred in any way, whether at the time of the transfer or at any time in the future.

B) The transfer to a trust benefits no one but the person, whether at the time the trust is established or at any time in the future.

C) The transfer instrument or document provides for the spending of the funds involved for the benefit of the person on a basis that is actuarially sound, based on the life expectancy of the individual involved (as determined under current actuarial tables published by the Office of the Chief Actuary of the Social Security

Administration at http://www.ssa.gov/OACT/STATS/table4c6.html). This subsection (m)(2)(C) does not apply to trusts described in Section 120.347(d) because those trusts provide for a "payback" to the State upon the death of the beneficiary.

D) The transfer was accomplished via a written instrument of transfer (e.g., a trust document) that legally binds the parties to a specified course of action and clearly sets out the conditions under which the transfer was made, as well as who can benefit from the transfer. A transfer without such a document may not be said to have been made for the sole benefit of the person since there is no way to establish, without the document, that only the specified person will benefit from the transfer.

n) The purchase of an annuity by or on behalf of an institutionalized person or the spouse of that person shall be treated as a transfer of assets for less than FMV unless:

1) the annuity names the State of Illinois as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized person; or

2) the annuity names the State of Illinois in the second position after the community spouse or minor child or child with a disability and is named in the first position if the spouse or a representative of the child disposes of any remainder for less than FMV.

o) The purchase of an annuity by or on behalf of an institutionalized person shall be treated as a transfer of assets for less than FMV unless:

1) the annuity is considered either:

A) an individual retirement annuity described in section 408(b) of the Internal Revenue Code (26 USC 408(b)); or

B) a deemed individual retirement account (IRA) under a qualified employer plan described in section 408(q) of the Internal Revenue Code (26 USC 408(q)); or

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

2) the annuity is directly purchased with proceeds from one of the following:

A) a traditional IRA described in section 408(a) of the Internal Revenue Code (26 USC 408(a));

B) certain accounts or trusts treated as traditional IRAs under section 408(p) of the Internal Revenue Code (26 USC 408(p));

C) a simplified employee pension described in section 408(k) of the Internal Revenue Code (26 USC 408(k)); or

D) a Roth IRA described in section 408A of the Internal Revenue Code (26 USC 408A); or

3) the annuity meets all the following requirements:

A) was purchased from a commercial financial institution or insurance company authorized under federal or State law to issue annuities;

B) is actuarially sound and based on the estimated life expectancy of the person (as determined under current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration at http://www.ssa.gov/OACT/STATS/table4c6.html). An annuity that pays out over a period less than a person's estimated life expectancy is considered a transfer for less than FMV;

C) is irrevocable and nonassignable; and

D) pays benefits in approximately equal periodic payments no less than quarterly, with no deferred or balloon payments.

p) The purchase of a life estate interest in another person's home shall be treated as a transfer for less than FMV unless the purchaser resided in the home for at least 12 consecutive months after the date of the transfer. If the purchaser resided in the home for less than 12 consecutive months, the entire purchase amount will be considered a transfer for less than FMV.

q) The purchase of a promissory note, loan or mortgage by a person shall be treated as a transfer of assets for less than FMV unless the following conditions are met (a promissory note, loan, or mortgage that does not satisfy these conditions shall be valued based on the outstanding balance due the person under the instrument as of the later of the date of application for medical assistance or the date of the transfer):

1) a written instrument recording the transaction is executed, signed and dated on the effective date of the transaction;

2) the instrument provides for a repayment term that is actuarially sound (as determined under current actuarial tables published by the Office of the Chief Actuary of the Social Security Administration at http://www.ssa.gov/OACT/STATS/table4c6.html);

3) the instrument provides for payments to be made in equal installments (no less than monthly) during the term of the loan with no deferral and no balloon payments;

4) the instrument prohibits the cancellation of the balance upon the death of a lender; and

5) a tangible, verifiable record of consistent, timely payments in the amounts provided under subsection (q)(2) demonstrates a good faith attempt to repay the instrument. Unpaid installments delinquent three months or more will result in the Department treating the amount remaining unpaid on the instrument as a non-allowable transfer.

r) Hardship Waiver.

1) The Department may waive a penalty period or a portion of a penalty period if it determines that application of a penalty may create an undue hardship. An undue hardship exists when application of a penalty would deprive an institutionalized person:

A) of medical care, endangering the person's health or life; or

B) of food, clothing, shelter, or other necessities of life.

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

2) An undue hardship does not exist when imposition of a penalty would merely cause a person or the person's family members inconvenience or might restrict the person or the person's family members' lifestyles but would not put him or her at risk of serious deprivation. Undue hardship does not exist when a person transfers assets to a community spouse (other than as allowed under Section 120.379(d)) and the community spouse refuses to cooperate in making the resources available to the person. Undue hardship does not exist when a person transfers or gives property away for the primary purpose of qualifying for long term care services (see subsection (m)(1)(D)), notwithstanding legal, financial or other professional advice the person may have received from third parties.

3) The Department shall issue a notice to any person who is subject to a penalty period not less than 10 days prior to imposition of the penalty. The notice shall inform the person of the period of ineligibility for long term care services and that a hardship waiver may be requested. The notice shall state that the person or the facility in which the person resides (pursuant to subsection (p)(4)) may submit in writing evidence that a hardship exists. The evidence may be submitted to the Department, which shall review the information and make a determination whether a hardship waiver should be granted.

4) The person requesting a hardship waiver shall have the burden of proof that actual, not just possible, hardship exists. The person must provide written evidence to substantiate the circumstances of the transfer, attempts to recover the uncompensated value of the transfer, reasons for the transfer and the impact of a period of ineligibility for long term care services. The following criteria shall be considered in determining whether a hardship waiver may be granted:

A) whether credible and convincing evidence is presented that the person has taken all equitable and legal means available to recover an asset or assets that have been transferred for less than fair market value. In cases involving alleged theft, fraud, elder abuse or other misappropriation of assets, evidence of referrals to the police or other law or regulatory enforcement agencies is required. In cases in which assets have been transferred for less than FMV as a result of legal, financial or other professional advice, evidence of

legal attempts to recover the value of the assets from the professional adviser may be required;

B) whether the transfers were to family members, whether the transfers were made at arm's length, whether the transfers were made in close proximity in time to an application for long term care services, and evidence showing transfers were made for reasons other than qualifying for medical assistance;

C) the medical condition, mental capacity, financial ability and other factors that may have affected the person at the time of the decision to transfer the assets for less than FMV and the person's ability to pursue recovery; and

D) whether:

i) the denial of assistance would force the person to move; or

ii) subject to the availability of beds, the person would be prohibited from joining a spouse in a facility or from entering a facility that is in close proximity to his or her family.

5) A notice of a denial of waiver shall include a statement that the person may appeal pursuant to 89 Ill. Adm. Code 102.80.

6) A facility in which an institutionalized person is residing may request a hardship waiver on behalf of that person under this subsection (r) provided written consent has been obtained from the person who is legally competent to do so, or the person's personal representative, who has appropriate legal authority to provide the consent.

s) Records Production. The Department or its agent may request any and all records necessary to determine the existence and extent of any transfers of property under this Section. Persons are required to cooperate in providing requested information and verifications in accordance with Section 120.308. The Department will provide any needed assistance requested by a person and will use reasonable measures requesting records, taking into account the age, significance, relevancy and difficulty of obtaining the records, the medical condition and mental capacity

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

of the person, and other factors that may affect the person's ability to retrieve records.

(Source: Added at 34 Ill. Reg. _____, effective _____)

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Section 120.TABLE B Life Expectancy (Repealed)

MALE		FEMALE	
Age	Life Expectancy	Age	Life Expectancy
0	71.80	0	78.79
1	71.53	1	78.42
2	70.58	2	77.48
3	69.62	3	76.51
4	68.65	4	75.54
5	67.67	5	74.56
6	66.69	6	73.57
7	65.71	7	72.59
8	64.73	8	71.60
9	63.74	9	70.61
10	62.75	10	69.62
11	61.76	11	68.63
12	60.78	12	67.64
13	59.79	13	66.65
14	58.82	14	65.67
15	57.85	15	64.68
16	56.91	16	63.71
17	55.97	17	62.74
18	55.05	18	61.77
19	54.13	18	60.80
20	53.21	20	59.83
21	52.29	21	58.86
22	51.38	22	57.89
23	50.46	23	56.92
24	49.55	24	55.95
25	48.63	25	54.98
26	47.72	26	54.02
27	46.80	27	53.05
28	45.88	28	52.08
29	44.97	29	51.12
30	44.06	30	50.15
31	43.15	31	49.19
32	42.24	32	48.23
33	41.33	33	47.27

34	40.23	34	46.31
35	39.52	35	45.35
36	38.62	36	44.40
37	37.73	37	43.45
38	36.83	38	42.50
39	35.94	39	41.55
40	35.05	40	40.60
41	34.15	41	39.66
42	33.26	42	38.72
43	32.37	43	37.78
44	31.49	44	36.85
45	30.61	45	35.92
46	29.74	46	35.00
47	28.88	47	34.08
48	28.02	48	33.17
49	27.17	49	32.27
50	26.32	50	31.37
51	25.48	51	30.48
52	24.65	52	29.60
53	23.82	53	28.72
54	23.01	54	27.85
55	22.21	55	27.00
56	21.43	56	26.15
57	20.66	57	25.31
58	19.90	58	24.48
59	19.15	59	23.67
60	18.42	60	22.86
61	17.70	61	22.06
62	16.99	62	21.27
63	16.30	63	20.49
64	15.62	64	19.72
65	14.96	65	18.96
66	14.32	66	18.21
67	13.70	67	17.48
68	13.09	68	16.76
69	12.50	69	16.04
70	11.92	70	15.35
71	11.35	71	14.65
72	10.80	72	13.99

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~73~~	~~10.27~~	~~73~~	~~13.33~~
~~74~~	~~9.27~~	~~74~~	~~12.68~~
~~75~~	~~9.24~~	~~75~~	~~12.05~~
~~76~~	~~8.76~~	~~76~~	~~11.43~~
~~77~~	~~8.29~~	~~77~~	~~10.43~~
~~78~~	~~7.83~~	~~78~~	~~10.24~~
~~79~~	~~7.40~~	~~79~~	~~9.67~~
~~80~~	~~6.98~~	~~80~~	~~9.11~~
~~81~~	~~6.59~~	~~81~~	~~8.58~~
~~82~~	~~6.21~~	~~82~~	~~8.06~~
~~83~~	~~5.85~~	~~83~~	~~7.56~~
~~84~~	~~5.51~~	~~84~~	~~7.08~~
~~85~~	~~5.19~~	~~85~~	~~6.63~~
~~86~~	~~4.89~~	~~86~~	~~6.20~~
~~87~~	~~4.61~~	~~87~~	~~5.79~~
~~88~~	~~4.34~~	~~88~~	~~5.41~~
~~89~~	~~4.09~~	~~89~~	~~5.05~~
~~90~~	~~3.86~~	~~90~~	~~4.71~~
~~91~~	~~3.64~~	~~91~~	~~4.40~~
~~92~~	~~3.43~~	~~92~~	~~4.11~~
~~93~~	~~3.24~~	~~93~~	~~3.84~~
~~94~~	~~3.06~~	~~94~~	~~3.59~~
~~95~~	~~2.90~~	~~95~~	~~3.36~~
~~96~~	~~2.74~~	~~96~~	~~3.16~~
~~97~~	~~2.60~~	~~97~~	~~2.97~~
~~98~~	~~2.47~~	~~98~~	~~2.80~~
~~99~~	~~2.34~~	~~99~~	~~2.64~~
~~100~~	~~2.22~~	~~100~~	~~2.48~~
~~101~~	~~2.11~~	~~101~~	~~2.34~~
~~102~~	~~1.99~~	~~102~~	~~2.20~~
~~103~~	~~1.89~~	~~103~~	~~2.06~~
~~104~~	~~1.78~~	~~104~~	~~1.93~~
~~105~~	~~1.68~~	~~105~~	~~1.81~~
~~106~~	~~1.59~~	~~106~~	~~1.69~~
~~107~~	~~1.50~~	~~107~~	~~1.58~~
~~108~~	~~1.41~~	~~108~~	~~1.48~~
~~109~~	~~1.33~~	~~109~~	~~1.38~~
~~110~~	~~1.25~~	~~110~~	~~1.28~~
~~111~~	~~1.17~~	~~111~~	~~1.19~~

DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

~~112~~	~~1.10~~	~~112~~	~~1.10~~
~~113~~	~~1.02~~	~~113~~	~~1.02~~
~~114~~	~~0.96~~	~~114~~	~~0.96~~
~~115~~	~~0.89~~	~~115~~	~~0.89~~
~~116~~	~~0.83~~	~~116~~	~~0.83~~
~~117~~	~~0.77~~	~~117~~	~~0.77~~
~~118~~	~~0.71~~	~~118~~	~~0.71~~
~~119~~	~~0.66~~	~~119~~	~~0.66~~

(Source: Repealed at 34 Ill. Reg. _____, effective _____)