GATEWAY TO GLOBAL AGING DATA

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Gateway Policy Explorer: Long-Term Care Series

Illinois, USA

Long-Term Care In-Kind Benefit Plan Details

1992-2023

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Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

Why are we tracking past policy? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

Illinois, USA

In-Kind Benefits

Plan details 1992-2023 * †

Public long-term care (LTC) benefits in Illinois are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Illinois, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, with separate programs for home-based care, semi-residential care, residential care, and some that cover a variety of care. Programs may vary in eligibility criteria.

Since 1992, Illinois' Medicaid LTC system has been subject to two major policy reforms: an increase in income eligibility limits for aged, blind, and disabled adults in 2000, and the implementation of Medicaid expansion under the Affordable Care Act (ACA) in 2014.

Key Dates

First law: 1965

Major changes since 1992: 2000, 2014

Contents

* If you have questions or suggestions, please contact policy@g2aging.org.

† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Chapter 1: Policy enacted 1992-1999

Overview

Long-term care (LTC) benefits in Illinois are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Illinois is administered at the state level by the Illinois Department of Public Aid (IDPA), and later the Illinois Department of Human Services (IDHS), established in 1997, and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Illinois are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Home and Community-Based Services for Persons who are Elderly - HCBS-PE).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the HCBS-PE program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC).

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and HCBS-PE beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

During this policy period, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023a)

Illinois Law for Medicaid

- Illinois Compiled Statutes: Article V. Medical Assistance (305 ILCS 5)
- Illinois Administrative Code: Title 89, Social Services - Part 120 Medical Assistance Programs (Ill. Admin. Code tit. 89, § 120)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Illinois Medicaid spending on beneficiaries in fiscal year 1992 was 50%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (50% in 1992), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Illinois Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Illinois.

Eligibility for Medicaid in Illinois for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) States

  Illinois is one of a few states that uses more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.
  - Income requirements: There is no single monthly income standard for SSI-related individuals in Illinois, as it depends on the amount of the optional State Supplementary Payment (SSP) received by the individual (this amount varies). Eligibility is determined by adding together individual allowances for needs such as rent, food, clothing, personal essentials, and heat, as specified in the state plan (Bruen, et. al., 2003). See Box 1 for additional 209(b) criteria regarding how income is calculated for this track and Box 2 for more information on how the optional SSP is calculated.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989. See Box 1 for additional 209(b) criteria regarding how resources are calculated for this track.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (89 IAC § 120.388).[1]
  - Citizenship/immigration requirements: The applicant must be an Illinois resident and a U.S. Citizen or non-citizen who meets additional eligibility requirements.[2] After 1996, the applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (89 IAC § 120.310) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[3]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to be equal to or less than the medically needy income limit. As a 209(b) state, Illinois must allow aged, blind, and disabled applicants to spend down their income to become eligible for Medicaid. In 1992, this was $283 for an individual, and $375 for a couple (KFF, 2003). Valid expenses include medical care and other types of remedial care. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[4]
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[5]
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[5]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Refugee Program: Refugees receiving state cash assistance under this program are automatically eligible for medical assistance in Illinois.
- Breast and Cervical Cancer Prevention and Treatment Program (as of 1995): Covers uninsured women at any income level who need treatment for breast or cervical cancer.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Home Health Services, Nursing Facility Care
There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Home and Community-Based Services for Persons who are Elderly Program (HCBS-PE)
Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 60-64 and physically disabled (IDoA, 1990).

Other community-based programs
There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Community Care Program (CCP): State program providing HCBS to individuals at least age 60. It incorporates the HCBS-PE population as well as Medicaid-ineligible individuals that meet other eligibility requirements and are covered through state-only funds. However, the majority of CCP participants are Medicaid beneficiaries (75 percent).
- Persons with HIV or AIDS Program
- Persons with Brain Injury (BI) Program —began in 1999
- Supportive Living Program —began in 1999

Benefit

Home care benefit

Home Health Services
Home Health provides (IDPA, 1990; IDHFS, 2016a):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Nursing Facility Care
Nursing Facility Care does not provide home care during this policy period.

HCBS-PE
HCBS-PE provides personal care services in addition to those under the state plan, which include (IDoA, 1990; Medicaid.gov, 2014):[6]

- Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Semi-residential care

Home Health Services, Nursing Facility Care
These programs do not provide semi-residential care during this policy period.

HCBS-PE
HCBS-PE provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (IDoA, 1990; IDRS, 1982-1998).

Residential care

Home Health Services, HCBS-PE

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in two types of nursing facilities (DPA, 1990; 305 ILCS 5, 2023):

- Intermediate care facility (ICF): Provides health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of mental or physical condition require care and services above the level of room and board. Services include health-related and programmatic care, supervised personal care, and room and board.
- Skilled nursing facility (SNF): Provides nursing care, routine physical therapy, occupational therapy, and speech pathology, room and board, and use of required equipment.

Other benefits

Illinois Medicaid provides additional benefits related to LTC (DPA, 1990; DHFS, 2015; IDHFS, 2023c):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

HCBS-PE

HCBS-PE provides the following services in addition to those offered under the state plan, unless otherwise noted (IDoA, 1990):

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Transportation to and from ADHC, and sometimes for essential errands/shopping, or for essential customer business

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Illinois Department of Public Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Home Health Services

Skilled nursing services must be provided by a registered nurse. Home health aide services, such as personal care, assistance with medications, or ambulation, are provided by home health aides, but must be under the supervision of a registered nurse (42 CFR 484.30-36, 1992; 77 IAC § 245.40, 2010a).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (42 CFR 483.30, 1992).

HCBS-PE

The provision of care for program services will vary by authorized service.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician (HCFR, 1992).

Author's Note: Additional information on the minimum level of dependence is pending requested materials.[7]

Nursing Facility Care
Applicants must be evaluated using the Illinois Determination of Need assessment and receive at least a total of 29 points (IDRS, 2000; Medicaid.gov, 2014).

HCBS-PE
The applicant must be evaluated using the DON assessment and receive at least 15 points in the functional impairment section and a total of 29 points (IDRS, 2000; IDoA, 2009; Medicaid.gov, 2014).[8]

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid
Federal law requires states to renew Medicaid eligibility at least every 12 months (89 IAC § 120.399).

Home Health Services
The total plan of care must be reviewed by the attending physician and Home Health Agency personnel as often as the severity of the patient's condition requires, but at least once every 60 days (42 CFR 484.16, 1992; IDPA, 2004).

Nursing Facility Care
Residents must be reassessed at least every 12 months (42 CFR 483.20, 1992).

HCBS-PE
Program participants must be reassessed every 12 months (IDRS, 2000; Medicaid.gov, 2014).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care
There is no age requirement.

HCBS-PE
The individual must be at least age 65, or age 60-64 and physically disabled (IDoA, 1990, p. 54).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the three largest programs.

Home Health Services
Unknown

Author's Note: Information on the definition of dependence is pending requested materials.[7]

Nursing Facility Care
The applicant must meet a nursing facility level of care (NFLOC), meaning they require the amount and type of care one would receive in a nursing home. To meet this threshold, they must score a minimum of 29 on the DON (IDRS, 2000; Medicaid.gov, 2014).

HCBS-PE
The applicant must meet an NFLOC, which is scoring at least 15 points in the functional impairment section and a total of 29 points on the DON (IDoA, 1990).

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician must order home health services in accordance with a developed plan of care (77 IAC § 245, 1991; 77 IAC § 245, 2010a). Upon acceptance of a new patient, a registered nurse conducts an initial assessment and describes the patient's current needs. The assessment records diagnoses, functional limitations, medications, treatments, activity, diet, procedures, mental status, and equipment required.

Nursing Facility Care, HCBS-PE

Nursing facility care and HCBS-PE use the Determination of Need (DON) assessment to evaluate applicants for medical eligibility. This assessment includes a Mini-Mental State Exam (MMSE) and a functional level of needs and unmet needs section. The functional status section assesses both ADLs, such as eating, bathing, and grooming, and Instrumental ADLs (IADLs, such as managing money, housework, and laundry. Each area is scored 0 - 3 for level of need, and 0 - 3 depending on the level of natural supports available to meet the need. The score of 0 indicates "no need," increasing up to "total dependence" with a score of 3. The MMSE measures cognitive functioning of the applicant. The final score is calculated by adding the results of the MMSE, the level of impairment, and the unmet need. See Box 3 for more information on the MMSE, and 89 IAC § 679.30 (2019) for full descriptions of DON scoring criteria.[9]

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 4 for more information on the PASRR, and Box 5 for the MDS.

Evaluators

Evaluators vary by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician must order home health services in accordance with a developed plan of care. The home health services team periodically reviews and updates the plan of care, which is subsequently reviewed and signed by the patient's physician. Upon acceptance of a new patient, a registered nurse conducts an initial assessment and describes the patient's current needs (77 IAC § 245, 1991; 77 IAC § 245, 2010a).

Nursing Facility Care

Evaluators depend on the applicant's point of entry. All nursing facility applicants are evaluated for level of care using the Determination of Need (DON) assessment. DON assessments are conducted in hospitals by Care Coordination Units (CCUs) contracted by the Illinois Department of Aging (IDoA), and in the community by both CCUs and the Illinois Department of Human Services (DHS) Division of Rehabilitation Services (IDRS) staff (IDRS, 1982-1998; IDoA, 1990; IDHFS, 2017).

HCBS-PE

Care Coordinators from CCUs administer DON assessments (IDoA, 1990).[10]

Benefit limitations

Can you mix LTC benefits?

All Illinois Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Illinois enforces Estate Recovery. The acceptance of Medicaid in Illinois creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (Zieger, 1997, p.369; Tilly, et. al., 2002; IHFS, 2023a).

Home Health Services

Unknown

Author's Note: Information on Home Health user charges is pending requested materials.[7]

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 1992, the federal minimum PNA was $30 per month. As of 2000, Illinois' PNA was equal to the federal minimum, and it is likely that this is the same PNA for the 1992 policy period.

HCBS-PE

There are no copayments or similar charges imposed on program participants (Medicaid.gov, 2009; Medicaid.gov, 2014).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 2: Policy enacted 2000-2013

Policy change in 2000
In 2000, Illinois raised the income limits for aged, blind, and disabled Medicaid applicants to standards set to the federal poverty level (FPL) under a new eligibility track, referred to here as eligibility track 2b (aged and disabled adults).

Illinois implemented the income increase on a timeline that would set the income standard at 70% of the FPL in the year 2000, 85% of the FPL in 2001, and 100% of the FPL in 2003 where it would remain (P.A. 91-0699, 2000). This also became the new spend down amount under the medically needy track (3a) for aged, blind, and disabled applicants.

Other reforms during this period:

- (2012) Illinois implemented a home equity limit that made individuals with home equity above $525,000.00 ineligible for LTC. This standard increases annually with inflation (89 IAC § 120.385).
- (2012) Illinois increased the look back period for transfers of assets from 36 months to 60 months for all transfers that occurred on or after January 1, 2007 (IDHFS, 2012).

Overview

Long-term care (LTC) benefits in Illinois are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Illinois is administered at the state level by the Illinois Department of Human Services (IDHS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Illinois are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Home and Community-Based Services for Persons who are Elderly - HCBS-PE).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the HCBS-PE program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC).

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and HCBS-PE beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023a)

Illinois Law for Medicaid

- Illinois Compiled Statutes: Article V. Medical Assistance (305 ILCS 5)
- Illinois Administrative Code: Title 89, Social Services - Part 120 Medical Assistance Programs (Ill. Admin. Code tit. 89, § 120)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Illinois Medicaid spending on beneficiaries in fiscal year 2000 was 50%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (50% in 2000), though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Illinois Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Illinois.

Eligibility for Medicaid in Illinois for people needing LTC services is primarily attained by satisfying at least one of 3 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) States

  Illinois is one of a few states that uses more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.
  - Income requirements: There is no single monthly income standard for SSI-related individuals in Illinois, as it depends on the amount of the optional State Supplementary Payment (SSP) received by the individual (this amount varies). Eligibility is determined by adding together individual allowances for needs such as rent, food, clothing, personal essentials, and heat, as specified in the state plan (Bruen, et. al., 2003). See Box 1 for additional 209(b) criteria regarding how income is calculated for this track and Box 2 for more information on how the optional SSP is calculated.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989. See Box 1 for additional 209(b) criteria regarding how resources are calculated for this track.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (89 IAC § 120.388).[11]
    - Home equity limit: From 2011, the equity interest in the individual's home may not exceed $525,000, or else they will be ineligible for LTC services.[12] This figure increases annually with inflation.
  - Citizenship/immigration requirements: The applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (89 IAC § 120.310) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[3]

Eligibility Track 2: Optional Categorically Needy

- 2b. Federal Poverty Level (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 70% of the FPL (P.A. 91-0699, 2000). In 2000, this was $487 for an individual, and $657 for a couple (ASPE, 2023). In 2001, this standard was raised to 85% of the FPL, or $608 for an individual, and $822 for a couple. Finally, in 2003, the standard was raised to 100% of the FPL, which was $748

for an individual, and $1,010 for a couple (IDPA, 2001). See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[13]
  - Asset requirements: Applicants must spend down their assets to be equal to or less than $2,000 for an individual and $3,000 for a couple. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[14]
    - Asset transfer & Home equity limit: Same as eligibility track 1b.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[3]

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to be equal to or less than the medically needy income limit. As a 209(b) state, Illinois must allow aged, blind, and disabled applicants to spend down their income to become eligible for Medicaid. In 2000, the effective maximum for these individuals was 70% of the FPL, following eligibility track 2b. Valid expenses include medical care and other types of remedial care. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[13]
  - Asset requirements: Applicants must spend down their assets to be equal to or less than $2,000 for an individual and $3,000 for a couple. Additional asset disregards exist if a person is institutionalized and has a spouse residing in the community.[14]
    - Asset transfer & Home equity limit: Same as eligibility track 1b.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
    - The applicant must be at least age 65, blind, or disabled.[3]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervical Cancer Prevention and Treatment Program: Covers uninsured women at any income level who need treatment for breast or cervical cancer.
- Refugee and Repatriate Assistance (RRA): Individuals receiving the RRA cash assistance benefit may be eligible for Medicaid coverage.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Home and Community-Based Services for Persons who are Elderly Program (HCBS-PE)

Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 60-64 and physically disabled (IDoA, 1990).

Other community-based programs

There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Community Care Program (CCP): State program providing HCBS to individuals at least age 60. It incorporates the HCBS-PE population as well as Medicaid-ineligible individuals that meet other eligibility requirements and are covered through state-only funds. However, the majority of CCP participants are Medicaid beneficiaries (75 percent).
- Persons with HIV or AIDS Program
- Persons with Brain Injury (BI) Program
- Supportive Living Program

Benefit

Home care benefit

Home Health Services

Home Health provides (IDPA, 1990; IDHFS, 2016a):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Nursing Facility Care

Nursing Facility Care does not provide home care during this policy period.

HCBS-PE

HCBS-PE provides personal care services in addition to those under the state plan, which include (IDoA, 1990; Medicaid.gov, 2014):[6]

- Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Semi-residential care

Home Health Services, Nursing Facility Care

These programs do not provide semi-residential care during this policy period.

HCBS-PE

HCBS-PE provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (IDoA, 1990; IDRS, 1982-1998).

Residential care

Home Health Services, HCBS-PE

These programs do not provide residential care during this policy period.

Nursing Facility Care

Medicaid provides care in two types of nursing facilities (DPA, 1990; 305 ILCS 5, 2023):

- Intermediate care facility (ICF): Provides health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of mental or physical condition require care and services above the level of room and board. Services include health-related and programmatic care, supervised personal care, and room and board.
- Skilled nursing facility (SNF): Provides nursing care, routine physical therapy, occupational therapy, and speech pathology, room and board, and use of required equipment.

Other benefits

Illinois Medicaid provides additional benefits related to LTC (DPA, 1990; DHFS, 2015; IDHFS, 2023c):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

HCBS-PE

HCBS-PE provides the following services in addition to those offered under the state plan, unless otherwise noted (IDoA, 1990):

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Transportation to and from ADHC, and sometimes for essential errands/shopping, or for essential customer business

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Illinois Department of Public Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Home Health Services

Skilled nursing services must be provided by a registered nurse. Home health aide services, such as personal care, assistance with medications, or ambulation, are provided by home health aides, but must be under the supervision of a registered nurse (42 CFR 484.30-36, 1992; 77 IAC § 245.40, 2010a).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (42 CFR 483.30, 1992).

HCBS-PE

The provision of care for program services will vary by authorized service.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician (HCFR, 1992).

Author's Note: Additional information on the minimum level of dependence is pending requested materials.[7]

Nursing Facility Care

Applicants must be evaluated using the Illinois Determination of Need assessment and receive at least a total of 29 points (IDRS, 2000; Medicaid.gov, 2014).

HCBS-PE

The applicant must be evaluated using the DON assessment and receive at least 15 points in the functional impairment section and a total of 29 points (IDRS, 2000; IDoA, 2009; Medicaid.gov, 2014).[8]

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (89 IAC § 120.399).

Home Health Services

The total plan of care must be reviewed by the attending physician and Home Health Agency personnel as often as the severity of the patient's condition requires, but at least once every 60 days (42 CFR 484.16, 1992; IDPA, 2004).

Nursing Facility Care

Residents must be reassessed at least every 12 months (42 CFR 483.20, 1992).

HCBS-PE

Program participants must be reassessed every 12 months (IDRS, 2000; Medicaid.gov, 2014).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

HCBS-PE

The individual must be at least age 65, or age 60-64 and physically disabled (IDoA, 1990, p. 54).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the three largest programs.

Home Health Services

Unknown

Author's Note: Information on the definition of dependence is pending requested materials.[7]

Nursing Facility Care

The applicant must meet a nursing facility level of care (NFLOC), meaning they require the amount and type of care one would receive in a nursing home. To meet this threshold, they must score a minimum of 29 on the DON (IDRS, 2000; Medicaid.gov, 2014).

HCBS-PE

The applicant must meet an NFLOC, which is scoring at least 15 points in the functional impairment section and a total of 29 points on the DON (IDoA, 1990).

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician must order home health services in accordance with a developed plan of care (77 IAC § 245, 1991; 77 IAC § 245, 2010a). Upon acceptance of a new patient, a registered nurse conducts an initial assessment and describes the patient's current needs. The assessment records diagnoses, functional limitations, medications, treatments, activity, diet, procedures, mental status, and equipment required.

Nursing Facility Care, HCBS-PE

Nursing facility care and HCBS-PE use the Determination of Need (DON) assessment to evaluate applicants for medical eligibility. This assessment includes a Mini-Mental State Exam (MMSE) and a functional level of needs and unmet needs section. The functional status section assesses both ADLs, such as eating, bathing, and grooming, and Instrumental ADLs (IADLs, such as managing money, housework, and laundry. Each area is scored 0 - 3 for level of need, and 0 - 3 depending on the level of natural supports available to meet the need. The score of 0 indicates "no need," increasing up to "total dependence" with a score of 3. The MMSE measures cognitive functioning of the applicant. The final score is calculated by adding the results of the MMSE, the level of impairment, and the unmet need. See Box 3 for more information on the MMSE, and 89 IAC § 679.30 (2019) for full descriptions of DON scoring criteria.[9]

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 4 for more information on the PASRR, and Box 5 for the MDS.

Evaluators

Evaluators vary by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician must order home health services in accordance with a developed plan of care. The home health services team periodically reviews and updates the plan of care, which is subsequently reviewed and signed by the patient's physician. Upon acceptance of a new patient, a registered nurse conducts an initial assessment and describes the patient's current needs (77 IAC § 245, 1991; 77 IAC § 245, 2010a).

Nursing Facility Care

Evaluators depend on the applicant's point of entry. All nursing facility applicants are evaluated for level of care using the Determination of Need (DON) assessment. DON assessments are conducted in hospitals by Care Coordination Units (CCUs) contracted by the Illinois Department of Aging (IDoA), and in the community by both CCUs and the Illinois Department of Human Services (DHS) Division of Rehabilitation Services (IDRS) staff (IDRS, 1982-1998; IDoA, 1990; IDHFS, 2017).

HCBS-PE

CCUs or Managed Care Organizations (MCOs, if the individual is enrolled in managed care) conduct initial assessments and reassessments. Care Coordinators conducting assessments must meet one of the following qualifications (Medicaid.gov, 2009; Medicaid.gov, 2014):

- Be a registered nurse, or have a B.S.N, or have a B.A./B.S. degree in social science, social work or related field. One year of program experience, which is defined as assessment, provision, and/or authorization of formal services for the elderly, may replace one year of college education up to and including four years of experience replacing a baccalaureate degree.
- Be a licensed practical nurse with one year of program experience which is defined as assessment of a provision of formal services for the elderly and /or authorizing service provision.
- Be waived for persons hired/serving in this capacity prior to December 31, 1991 Provision of a waiver for care coordinators hired prior to December 31, 1991 was based on their years of experience. These care coordinators must maintain certification for a case manager and must also follow in-service requirements.

Care Coordinators must also complete specified training before conducting assessments.

Benefit limitations

Can you mix LTC benefits?

All Illinois Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Illinois enforces Estate Recovery. The acceptance of Medicaid in Illinois creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (Zieger, 1997, p.369; Tilly, et. al., 2002; IHFS, 2023a).

Home Health Services

Unknown

Author's Note: Information on Home Health user charges is pending requested materials.[7]

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 2000, the PNA was $30 per month (CRS, 2002).

HCBS-PE

There are no copayments or similar charges imposed on program participants (Medicaid.gov, 2009; Medicaid.gov, 2014).

Taxation of benefits

In-kind benefits are not subject to taxation.

Chapter 3: Policy enacted 2014-2023

Policy change in 2014

In 2014, Illinois implemented eligibility track 2c, Medicaid expansion under the Affordable Care Act (ACA). The expansion extended Medicaid coverage to a new population of adults that were previously ineligible for Medicaid. This new population may receive long-term care (LTC), including nursing facility care and home and community-based services (HCBS) programs (HFS, 2014).

Medicaid expansion covers adults between the ages of 19 and 64 with incomes up to 138% of the Federal Poverty Level (FPL). States that have adopted the expansion receive an enhanced federal matching rate (FMAP) for the new population (KFF, 2023).

The ACA also required states to extend spousal impoverishment rules to individuals receiving LTC through HCBS programs, including HCBS-PE. From 2014, additional income and asset disregards applied to the community spouse of an individual enrolled in HCBS-PE (Medicaid.gov, 2014).

Other reforms during this period:

- (2020) In March of 2020, the Medicaid resource test was suspended due to the COVID-19 public health emergency (PHE). With the ending of the PHE on May 11, 2023, the resource test resumed on May 12, 2023 (IDHFS, 2023b).
- (2023) Illinois increased the asset limit to $17,500 for both individuals and couples for aged, blind, and disabled Medicaid cases (IDHFS, 2023). The $17,500 resource limit amount applies to each household, regardless of the number of persons in the household.
- (2023) Illinois increased the Monthly Maintenance Needs Allowance (MMNA) to $3,715.50, and the Community Spouse Resource Allowance (CSRA) to $120,780.00. Previously, these were frozen at the state's 2012 standards (NLR, 2023).

Overview

Long-term care (LTC) benefits in Illinois are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Illinois is administered at the state level by the Illinois Department of Human Services (IDHS), and enrollment is voluntary.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Illinois are mostly provided through state plan benefit programs (Home Health Services, Nursing Facility Care), or through federally approved home-and community-based services (HCBS) LTC programs (Home and Community-Based Services for Persons who are Elderly - HCBS-PE).

Beneficiaries receiving state plan benefits must establish medical necessity for each service prescribed by a physician. Home Health services provide home care for beneficiaries that have established medical necessity, while Nursing Facility Care only provides care in a nursing home. State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. People covered by the HCBS-PE program are able to receive a variety of LTC benefits if deemed medically eligible, such as case management and adult day health care (ADHC).

Benefit programs vary in dependence requirements. Home Health requires the individual to have a medical necessity for services, while Nursing Facility and HCBS-PE beneficiaries must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

Statutory basis

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2023a)

Illinois Law for Medicaid

- Illinois Compiled Statutes: Article V. Medical Assistance (305 ILCS 5)
- Illinois Administrative Code: Title 89, Social Services - Part 120 Medical Assistance Programs (Ill. Admin. Code tit. 89, § 120)

Financing

Source of financing

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Illinois Medicaid spending on beneficiaries in fiscal year 2014 was 50%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending (50% in 2014), though there are exceptions for certain administrative functions and populations that may receive a higher federal matching rate.[15]

Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

Risk covered definition

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary is eligible, Medicaid will also pay for 24-hour care in a nursing facility.

Eligible population

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Illinois Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Illinois.

Eligibility for Medicaid in Illinois for people needing LTC services is primarily attained by satisfying at least one of 4 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1b. 209(b) States
  Illinois is one of a few states that uses more restrictive methodologies to determine Medicaid eligibility than those of the Supplemental Security Income (SSI) program.
  - Income requirements: There is no single monthly income standard for SSI-related individuals in Illinois, as it depends on the amount of the optional State Supplementary Payment (SSP) received by the individual (this amount varies). Eligibility is determined by adding together individual allowances for needs such as rent, food, clothing, personal essentials, and heat, as specified in the state plan (Bruen, et. al., 2003). See Box 1 for additional 209(b) criteria regarding how income is calculated for this track and Box 2 for more information on how the optional SSP is calculated.
  - Asset requirements: Until 2023, resources may not exceed $2,000 for an individual and $3,000 for a couple. From 2023, the resource limit was raised to $17,500 for both individuals and couples (IDHFS, 2023a). See Box 1 for additional 209(b) criteria regarding how resources are calculated for this track.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services (89 IAC § 120.388).[16]
    - Home equity limit: The equity interest in the individual's home may not exceed $543,000, or else they will be ineligible for LTC services (89 IAC § 120.385).[12] This figure increases annually with inflation.
  - Citizenship/immigration requirements: The applicant must be a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August

22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (89 IAC § 120.310) for additional information.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled.[3]

Eligibility Track 2: Optional Categorically Needy

- 2b. Federal Poverty Level (FPL) aged and disabled
  - Income requirements: Monthly income may not exceed 100% of the federal poverty level (FPL). In 2014, this was $972.50 for an individual and $1,310.83 for a couple. See Table 2 for historical income limits. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[17]
  - Asset requirements: Until 2023, resources may not exceed $2,000 for an individual and $3,000 for a couple. From 2023, the resource limit was raised to $17,500 for both individuals and couples (IDHFS, 2023a). Additional asset disregards exist if a person is institutionalized or enrolled in HCBS-PE and has a spouse residing in the community.[18]
    * Asset transfer & Home equity limit: Same as eligibility track 1b.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - Other requirements
    * The applicant must be at least age 65, blind, or disabled.[3]
- 2c. Affordable Care Act (ACA) expansion adults
  - Income requirements: Monthly income may not exceed 138% of the FPL. In 2014, this was $1,320 for an individual and $1,780 for a household of two. See Table 2 for historical income limits. Spousal income disregards are not applied when determining eligibility for this group (HFS, 2014).
  - Asset requirements: There is no asset test for this population.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
  - Other requirements
    * Applicants must be age 19-64, ineligible for Medicare, and ineligible for other Medicaid eligibility tracks.

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income to be equal to or less than the medically needy income limit. As a 209(b) state, Illinois must allow aged, blind, and disabled applicants to spend down their income to become eligible for Medicaid. In 2014, the effective maximum for these individuals was 100% of the FPL, following eligibility track 2b. Valid expenses include medical care and other types of remedial care. Additional income disregards exist if a person is institutionalized and has a spouse residing in the community.[17]
  - Asset requirements: Until 2023, applicants must spend down their assets to be equal to or less than $2,000 for an individual and $3,000 for a couple. From 2023, the resource limit was raised to $17,500 for both individuals and couples (IDHFS, 2023a). Additional asset disregards exist if a person is institutionalized or enrolled in HCBS-PE and has a spouse residing in the community.[18]
    * Asset transfer & Home equity limit: Same as eligibility track 1b.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1b.
    * The applicant must be at least age 65, blind, or disabled.[3]

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include:

- Breast and Cervical Cancer Prevention and Treatment Program: Covers uninsured women at any income level who need treatment for breast or cervical cancer.
- Coverage for Immigrant Seniors (from 2020): For seniors 65 years and older who are not eligible for Medicaid due to their immigration status. This program offers a benefit package with $0 premiums and $0 co-payments. Covered services include doctor and hospital care, lab tests, rehabilitative services such as physical and occupational therapy, home health, mental health and substance use disorder services, dental and vision services, and prescription drugs.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

Home Health Services, Nursing Facility Care

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence.

Home and Community-Based Services for Persons who are Elderly Program (HCBS-PE)
Beyond meeting minimum level of dependence requirements, applicants must be at least age 65, or age 60-64 and physically disabled (Medicaid.gov, 2022).

Other community-based programs
There exist several home and community-based services (HCBS) programs targeted at older adults that are omitted due to limited enrollment. Some of these programs include:

- Community Care Program (CCP): State program providing HCBS to individuals at least age 60. It incorporates the HCBS-PE population as well as Medicaid-ineligible individuals that meet other eligibility requirements and are covered through state-only funds. However, the majority of CCP participants are Medicaid beneficiaries (75 percent).
- Persons with HIV or AIDS Program
- Persons with Brain Injury (BI) Program
- Supportive Living Program

Benefit

Home care benefit

Home Health Services
Home Health provides (IDPA, 1990; IDHFS, 2016a):

- Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, Levin tube care, provided by a registered nurse or licensed practical nurse
- Home health aide services: Semi-skilled care, such as simple wound care, vital monitoring, and personal care

Nursing Facility Care
Nursing Facility Care does not provide home care during this policy period.

HCBS-PE
HCBS-PE provides personal care services in addition to those under the state plan, which include (IDoA, 1990; Medicaid.gov, 2014):[6]

- Assistance with ADLs, such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
- Assistance with IADLs, such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration

Semi-residential care

Home Health Services, Nursing Facility Care
These programs do not provide semi-residential care during this policy period.

HCBS-PE
HCBS-PE provides adult day health care (ADHC). ADHC centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (IDoA, 1990; IDRS, 1982-1998).

Residential care

Home Health Services, HCBS-PE
These programs do not provide residential care during this policy period.

Nursing Facility Care
Medicaid provides care in two types of nursing facilities (DPA, 1990; 305 ILCS 5, 2023):

- Intermediate care facility (ICF): Provides health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who because of mental or physical condition require care and services above the level of room and board. Services include health-related and programmatic care, supervised personal care, and room and board.
- Skilled nursing facility (SNF): Provides nursing care, routine physical therapy, occupational therapy, and speech pathology, room and board, and use of required equipment.

Other benefits

Illinois Medicaid provides additional benefits related to LTC (DPA, 1990; DHFS, 2015; IDHFS, 2023c):

- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy

HCBS-PE

HCBS-PE provides the following services in addition to those offered under the state plan, unless otherwise noted (IDoA, 1990):

- Case Management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Transportation to and from ADHC, and sometimes for essential errands/shopping, or for essential customer business

Provision of care

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Illinois Department of Public Health. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Managed care plans will have limited provider networks.

Home Health Services

Skilled nursing services must be provided by a registered nurse. Home health aide services, such as personal care, assistance with medications, or ambulation, are provided by home health aides, but must be under the supervision of a registered nurse (42 CFR 484.30-36, 1992; 77 IAC § 245.40, 2010a).

Nursing Facility Care

Nursing facility services are provided and supervised by registered nurses and other nursing personnel (42 CFR 483.30, 1992).

HCBS-PE

The provision of care for program services will vary by authorized service.

Benefit eligibility

Qualifying period

Potential users may apply at any time.

Minimum level of dependence

The minimum level of dependence varies by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

As required by federal law, home health services must be medically necessary and ordered by a physician (HCFR, 1992). The applicant must require intermittent skilled nursing services or therapy services to be eligible (IDHFS, 2016a).

Nursing Facility Care

Applicants must be evaluated using the Illinois Determination of Need assessment and receive at least a total of 29 points (IDRS, 2000; Medicaid.gov, 2013).

HCBS-PE

The applicant must be evaluated using the DON assessment and receive at least 15 points in the functional impairment section and a total of 29 points (IDRS, 2000; IDoA, 2009; Medicaid.gov, 2014).[8]

Duration of benefit

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the three largest programs.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months (89 IAC § 120.399).

Home Health Services

The total plan of care must be reviewed by the attending physician and Home Health Agency personnel as often as the severity of the patient's condition requires, but at least once every 60 days (42 CFR 484.16, 1992; IDPA, 2004).

Nursing Facility Care

Residents must be reassessed at least every 12 months (42 CFR 483.20, 1992).

HCBS-PE

Program participants must be reassessed every 12 months (IDRS, 2000; Medicaid.gov, 2014).

Means testing

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ.

Age requirement

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

Home Health Services, Nursing Facility Care

There is no age requirement.

HCBS-PE

The individual must be at least age 65, or age 60-64 and physically disabled (IDoA, 1990, p. 54).

Care needs assessment

Definition of dependence

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the three largest programs.

Home Health Services

The applicant must require intermittent skilled nursing services or therapy services (IDHFS, 2016a). Services can include initiation and implementation of curative or rehabilitative nursing procedures performed by licensed nursing personnel.

Nursing Facility Care

The applicant must meet a nursing facility level of care (NFLOC), meaning they require the amount and type of care one would receive in a nursing home. To meet this threshold, they must score a minimum of 29 on the DON (IDRS, 2000; Medicaid.gov, 2014).

HCBS-PE

The applicant must meet an NFLOC, which is scoring at least 15 points in the functional impairment section and a total of 29 points on the DON (IDoA, 1990).

Evaluation of dependence

Evaluations of dependence vary depending on the health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician must order home health services in accordance with a developed plan of care (77 IAC § 245, 1991; 77 IAC § 245, 2010a). The order must include an explanation of clinical findings that support the patient's need of either intermittent skilled nursing services or therapy services (IDHFS, 2016a). Upon acceptance of a new patient, a registered nurse conducts an initial assessment and describes the patient's current needs. The assessment records diagnoses, functional limitations, medications, treatments, activity, diet, procedures, mental status, and equipment required.

Nursing Facility Care, HCBS-PE

Nursing facility care and HCBS-PE use the Determination of Need (DON) assessment to evaluate applicants for medical eligibility. This assessment includes a Mini-Mental State Exam (MMSE) and a functional level of needs and unmet needs section. The functional status section assesses both ADLs, such as eating, bathing, and grooming, and Instrumental ADLs (IADLs, such as managing money, housework, and laundry. Each area is scored 0 - 3 for level of need, and 0 - 3 depending on the level of natural supports available to meet the need. The score of 0 indicates "no need," increasing up to "total dependence" with a score of 3. The MMSE measures cognitive functioning of the applicant. The final score is calculated by adding the results of the MMSE, the level of impairment, and the unmet need. See Box 3 for more information on the MMSE, and 89 IAC § 679.30 (2019) for full descriptions of DON scoring criteria.[9]

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR) and periodic assessments using the Minimum Data Set (MDS). See Box 4 for more information on the PASRR, and Box 5 for the MDS.

Evaluators

Evaluators vary by health benefit program. The details of the three largest programs are summarized below.

Home Health Services

A licensed physician must order home health services in accordance with a developed plan of care. The home health services team periodically reviews and updates the plan of care, which is subsequently reviewed and signed by the patient's physician. Upon acceptance of a new patient, a registered nurse conducts an initial assessment and describes the patient's current needs (77 IAC § 245, 1991; 77 IAC § 245, 2010a).

Nursing Facility Care

Evaluators depend on the applicant's point of entry. All nursing facility applicants are evaluated for level of care using the Determination of Need (DON) assessment. DON assessments are conducted in hospitals by Care Coordination Units (CCUs) contracted by the Illinois Department of Aging (IDoA), and in the community by both CCUs and the Illinois Department of Human Services (DHS) Division of Rehabilitation Services (IDRS) staff (IDRS, 1982-1998; IDoA, 1990; IDHFS, 2017).

HCBS-PE

CCUs or Managed Care Organizations (MCOs, if the individual is enrolled in managed care) conduct initial assessments and reassessments. Care Coordinators conducting assessments must meet one of the following qualifications (Medicaid.gov, 2009; Medicaid.gov, 2014):

- Be a registered nurse, or have a B.S.N, or have a B.A./B.S. degree in social science, social work or related field. One year of program experience, which is defined as assessment, provision, and/or authorization of formal services for the elderly, may replace one year of college education up to and including four years of experience replacing a baccalaureate degree.
- Be a licensed practical nurse with one year of program experience which is defined as assessment of a provision of formal services for the elderly and /or authorizing service provision.
- Be waived for persons hired/serving in this capacity prior to December 31, 1991 Provision of a waiver for care coordinators hired prior to December 31, 1991 was based on their years of experience. These care coordinators must maintain certification for a case manager and must also follow in-service requirements.

Care Coordinators must also complete specified training before conducting assessments.

Benefit limitations

Can you mix LTC benefits?

All Illinois Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in a federally approved HCBS program. Beneficiaries may not duplicate services across programs.

Is there free choice between cash and benefits in-kind?

The LTC system does not offer a cash benefit.

Can you receive LTC benefits with other social security benefits?

It is possible to receive LTC benefits along with other welfare benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

User costs

User charges

Medicaid

As required by federal law, Illinois enforces Estate Recovery. The acceptance of Medicaid in Illinois creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (Zieger, 1997, p.369; Tilly, et. al., 2002; IHFS, 2023a).

Home Health Services, HCBS-PE

There are no copayments or similar charges imposed on program participants (Medicaid.gov, 2009; Medicaid.gov, 2014); KFF, 2020).

Nursing Facility Care

Beneficiaries are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance (PNA). In 2014, the PNA was $30 per month.

Taxation of benefits

In-kind benefits are not subject to taxation.

Tables and Formulas

Table 1: Illinois Federal Medical Assistance Percentage (FMAP) for Medicaid

Fiscal Year	FMAP
1992	50.00%
1993	50.00
1994	50.00
1995	50.00
1996	50.00
1997	50.00
1998	50.00
1999	50.00
2000	50.00
2001	50.00
2002	50.00
2003	51.48
2004	52.21
2005	50.00
2006	50.00
2007	50.00
2008	50.00
2009	61.18
2010	61.88
2011	57.07
2012	50.00
2013	50.00
2014	50.00
2015	50.76
2016	50.89
2017	51.30
2018	50.74
2019	50.31
2020	54.79
2021	57.16
2022	57.29
2023 [1]	54.98

Source: U.S. DHHS (2022)

Notes: FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period. [1] The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

Box 1: 209(b) More Restrictive Criteria - Income and Resource Methodology

The following more restrictive income methodologies are applied to the aged, blind, and disabled under eligibility track 1b:

- Irregular or infrequent earnings of up to $10 monthly are not disregarded
- Earnings of a blind or disabled child who is a student are not disregarded up to $400 per month or $1,620 per calendar year
- $65 plus half of the remainder of earnings is not disregarded for the aged and disabled —Illinois disregards $20 plus half of the next $60 for a maximum of $50
- One-third of the support payments made by an absent parent to a blind or disabled child are not disregarded
- Up to $20 of irregular income per month is not disregarded
- Income from the Disaster Relief Act of 1974 and other assistance provided as a result of a presidentially declared disaster is not disregarded
- Self-employment income is prorated monthly by SSI on an annual basis —Illinois accounts for self-employment income as received each month and does not prorate over a year

For resources, there is only one policy more restrictive than that of the SSI program. In Illinois, benefits retained from a presidentially declared disaster are not exempted for nine months.

Source: Illinois Medicaid State Plan (1991)

Box 2: State Supplementary Payment (SSP) Calculations

The SSP cash payment amount is determined by adding allowances for individual need items that apply to the applicant's situation and then deducting income as appropriate. The allowance amount may differ by year. The individual need items are listed below:

- Personal allowance for food, clothing, household supplies, and personal essentials.
- Shelter for rent or for property expenses paid on a home the applicant owns or is purchasing.
- Utilities including water, sewer charges, electricity, cooking fuel, heating fuels, and garbage disposal or trash removal.
- Laundry when neither the applicant nor any family member, relative, or housekeeping service is physically able/available to do the laundry, orwhen there are no washing or drying facilities in the home, or when the applicant is in their home and is incontinent or bedfast.
- Telephone allowance, land line or cellular.
- Transportation, lunches, and special fees for children regularly attending elementary or high school, college, or unpaid vocational training.
- Grant adjustment that assures that the total amount of all SSI benefit increases since July 1977 remain available to supplement recipients. The grant adjustment is the sum of all SSI benefit increases since July 1977, and is adjusted whenever there is an SSI benefit increase.
- Shopping service when the client is unable to shop and there is no one available to do it free of charge.
- Services for the blind allowance, including a guide for recreation or reading services, or additional clothing and personal essentials for any months that the client is attending the Illinois Visually Handicapped Institute.
- Special payments authorized for specific situations, such as correction of an underpayment.
- Service animals when the animal is needed to assist with activities of daily living or to maintain independent functioning in the community.

Allowance amounts vary by year. See IDHS (2023) for the current cash assistance manual and individual need item allowance amounts.

Source: IDHCFS (2023c), supp. 6 to attachment 2.6-A; IDHS (2023)

Box 3: Determination of Need (DON) Assessment: Mini-Mental State Exam (MMSE)

The Mini-Mental State Exam (MMSE) is a cognitive screening tool within the Determination of Need (DON) assessment that provides a brief, objective measure of cognitive function. It can be used to screen for cognitive impairment, to estimate the severity of the impairment, and to document cognitive change over time.

The MMSE is made up of 11 questions with corresponding numerical scores depending on how the applicant answers:

1. What is the (year) (season) (day) (date) (month)?
    - Score 1 point for each each correct answer
2. Where are we —(state) (county) (town) (nursing facility/hospital) (floor)?
    - Score 1 point for each each correct answer
3. Name 3 objects. Allow 1 second to say each. Ask the applicant all 3 after you have said them.
    - Score 1 point for each correct answer in the first trial only. Then repeat the 3 objects until the client learns all 3. Count trials and repeat the 3 objects until the client learns all 3. Count trials and record.
4. Spell "WORLD" backwards.
    - Score 1 point for each letter in the correct order
5. Ask for the 3 objects repeated in question 3
    - Score 1 point for each correct answer
6. Identify a pencil and a watch
    - Score 1 point for each correct identification
7. Repeat the following —"no ifs, ands or buts."
    - Score 1 point for correct repetition
8. Follow a 3-stage command —"take a paper in your right hand, fold it in half, and put it in your lap."
    - Score 1 point for each command correctly followed for a total of 3 possible points
9. Read and obey the following—"close your eyes."
    - Score 1 point for correctly following the command
10. Write a sentence.
    - Score 1 point for a written sentence
11. Copy a design.
    - Score 1 point for copying a design

The maximum score is 30 points. The assessor will enter the total correct answers for the MMSE score.

Source: ILDA (2009)

Box 4: Preadmission Screening and Resident Review (PASRR)

Nursing facilities are required by federal law to conduct a Preadmission Screening and Resident Review (PASRR). The purpose of PASRR is to prevent individuals with mental illness, intellectual disability, developmental disability, or a related condition from inappropriate admission to a nursing facility. The process consists of a Level I screen, Level II evaluation (depending on the outcome of the Level 1 screening), and a final determination. All applicants of Medicaid certified nursing facilities receive a Level I screen to identify possible conditions. These screens generally consist of forms completed by hospital discharge planners, community health nurses, or others as defined by the state. Individuals who do or may have a mental condition as described above are referred for a Level II PASRR evaluation.

PASRRs were required on an annual basis until 1996, when the annual requirement was removed. Some states continue to conduct PASRRs on an annual basis.

Source: 42 CFR 483.100-138

Box 5: Minimum Data Set (MDS)

Nursing facilities are required by federal law to periodically assess each resident. The Minimum Data Set (MDS) is the uniform instrument used nationally to assess resident condition. The MDS collects resident data for a variety of purposes, such as to inform care plans or assess a resident's ongoing need for nursing home care. Assessments are performed every 3 months or more often depending on the resident's health condition.

The first MDS was implemented nationally in 1991. There have been two new versions of the MDS since then —one in 1995 (MDS 2.0), and another in 2010 (MDS 3.0). However, all versions generally assess the following domains: functional and cognitive status, behavioral symptoms, diagnoses and medications, geriatric syndromes, and psychosocial functioning.

Source: UCSF (2023)

Table 2: Historical Illinois Medicaid Income Limits & Spousal Impoverishment Standards

Year	100% FPL (Individual)	100% FPL (Couple)	138% FPL (Individual)	138% FPL (Couple)	Monthly Maintenance Needs Allowance (MMNA)	Community Spouse Resource Allowance (CSRA)
1992	$568.00	$766.00			$1,718.00	$68,700.00
1993	581.00	786.00			1,769.00	70,740.00
1994	614.00	820.00			1,817.00	72,660.00
1995	623.00	836.00			1,871.00	74,820.00
1996	645.00	864.00			1,919.00	76,740.00
1997	658.00	885.00			1,976.00	79,020.00
1998	671.00	905.00			2,019.00	80,760.00
1999	687.00	922.00			2,049.00	81,960.00
2000	696.00	938.00			2,103.00	84,120.00
2001	716.00	968.00			2,175.00	87,000.00
2002	739.00	995.00			2,232.00	89,280.00
2003	749.00	1,010.00			2,267.00	90,660.00
2004	776.00	1,041.00			2,319.00	92,760.00
2005	798.00	1,070.00			2,377.00	95,100.00
2006	817.00	1,100.00			2,489.00	99,540.00
2007	851.00	1,141.00			2,541.00	101,640.00
2008	867.00	1,167.00			2,610.00	104,400.00
2009	903.00	1,215.00			2,739.00	109,560.00
2010	903.00	1,215.00			2,739.00	109,560.00
2011	908.00	1,226.00			2,739.00	109,560.00
2012[1]	931.00	1,261.00			2,841.00	113,640.00
2013	958.00	1,293.00			2,739.00	109,560.00
2014	973.00	1,311.00	1,343.00	1,809.00	2,739.00	109,560.00
2015	981.00	1,328.00	1,354.00	1,832.00	2,739.00	109,560.00
2016	990.00	1,335.00	1,367.00	1,843.00	2,739.00	109,560.00
2017	1,005.00	1,354.00	1,387.00	1,868.00	2,739.00	109,560.00
2018	1,012.00	1,372.00	1,397.00	1,893.00	2,739.00	109,560.00
2019	1,041.00	1,410.00	1,437.00	1,945.00	2,739.00	109,560.00
2020	1,064.00	1,437.00	1,468.00	1,983.00	2,739.00	109,560.00
2021	1,074.00	1,452.00	1,482.00	2,004.00	2,739.00	109,560.00
2022	1,133.00	1,526.00	1,564.00	2,106.00	2,739.00	109,560.00
2023	1,215.00	1,643.00	1,677.00	2,268.00	2,739.00	109,560.00
					3,715.50	120,780.00

Source: IDHFS (2004-2023); CRS (2002); Torch (1996)

Notes: Federal poverty level (FPL) amounts for individuals and couples are monthly. Income limits at 138% of the FPL begin in 2014, corresponding to the implementation of the new eligibility track under the Affordable Care Act. MMNA and CSRA amounts shown for years 1992, 1994-1999, and 2001-2002 are estimations. Sources from subsequent years indicate that Illinois increased their MMNA and CSRA annually based on a percentage increase in the Consumer Price Index (CPI). We have estimated the values for these years using the CPI increase for each year.

[1] MMNA and CSRA amounts were increased in 2012 effective January 1, 2012, but were later decreased back to 2009 standards, effective July 1, 2012.

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Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

Activities of Daily Living (ADLs): Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

Adult Day Health Care (ADHC): A community-based long-term care benefit that provides comprehensive health care services in a congregate day setting. Services include nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. Services are provided according to the assessed needs of the beneficiary. This benefit is often referred to as Adult Day Services in Illinois.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably is the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

Aid to the Aged, Blind, or Disabled - Medical Assistance Grant (AABD MAG): Individuals who qualify for the AABD state cash assistance program that provides benefits to aged, blind, or disabled individuals of limited means. AABD MAG individuals automatically qualify for Medicaid due to their receipt of the cash grant. This program is tied to Medicaid coverage through the 209(b) eligibility track.

Aid to the Aged, Blind, or Disabled - Medical Assistance No Grant (AABD MANG): Individuals who do not qualify for the AABD state cash assistance program but are aged, blind, or disabled and meet other state-defined eligibility requirements for Medicaid.

Aid to the Aged, Blind, or Disabled (AABD): Medicaid coverage group in Illinois for the aged, blind, and disabled. This group includes both AABD MAG (individuals that receive medical assistance and state cash assistance) and AABD MANG (individuals that only receive medical assistance). State documents generally refer to all aged, blind, and disabled Medicaid recipients as AABD, and distinguish further through MAG or MANG when necessary.

Care Coordination Units (CCUs): Units within the Illinois Department of Aging that perform pre-admission screenings of all persons age 60 and older seeking admission to a nursing facility. This includes all dependence evaluations for the Community Care Program (CCP) as well.

Community Care Program (CCP): State program that provides home and community-based services to Illinoisans that are under at least age 60. This program is state and federally-funded, and Medicaid-eligible program participants are covered under the Home and

Community-Based Services for Persons who are Elderly (HCBS-PE) program. Medicaid-ineligible individuals that meet other eligibility requirements may still be eligible for CCP through state-only funds, and they may transition in and out of Medicaid eligibility. However, the majority of CCP participants are Medicaid beneficiaries (75 percent). For non-Medicaid CCP participants, cost-sharing is required, and fees are determined by the participant's ability to pay, usually on a sliding scale based on one's income.

Community Spouse Resource Allowance (CSRA): Upper limit on countable assets for a spouse residing in the community if their spouse is institutionalized. From 2014, this extended to community spouses of individuals enrolled in HCBS-PE.

Determination of Need (DON): Assessment used to determine dependence eligibility for Nursing Facility Care, Home and Community-Based Services for Persons who are Elderly (HCBS-PE), and the Persons with Disabilities (PwD) program. This assessment includes a Mini-Mental State Exam (MMSE) and a functional level of needs and unmet needs section. The functional status section assesses activities of daily living, such as eating, bathing, and grooming, and instrumental activities of daily living, such as managing money, housework, and laundry.

Eligibility Track 1b. 209(b) States: The Social Security Act provides states the authority to apply more restrictive eligibility criteria than are used by the Supplemental Security Income (SSI) program. States that elect this option are called 209(b) states. Because eligibility for SSI does not guarantee Medicaid eligibility in a 209(b) state, these states do not cover the mandatory SSI Beneficiaries group. Instead, 209(b) states impose more restrictive criteria through the mandatory 209(b) group. A person receiving SSI can still be eligible for Medicaid in the mandatory 209(b) group, but that person must also meet the more restrictive eligibility requirements imposed by the state.

Eligibility Track 2b. Federal Poverty Level (FPL) Aged and Disabled: Optional coverage group under Medicaid that allows for expanded income limits up to 100 percent of the federal poverty level for individuals that are at least age 65, blind, or disabled.

Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population.

Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled: Optional coverage group under Medicaid for aged, blind, or disabled individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage.

Eligibility Tracks: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual must satisfy only one eligibility track to qualify for Medicaid.

Estate Recovery: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age. Illinois does not limit recovery to the federally required minimum services and seeks recovery of payments for all medical assistance received.

Federal Medical Assistance Percentage (FMAP): The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent.

Federal Poverty Level (FPL): Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

Fee-for-service (FFS): A health care delivery system where providers are paid for each service performed.

Home and Community-Based Services for Persons who are Elderly (HCBS-PE) program: Program that provides services and individualized support to persons at least age 65. These services are provided to those who would otherwise require care in a nursing facility. The HCBS-PE program is the Medicaid component of the larger, state-managed Community Care Program (CCP).

Home Health Aide Services: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

Home Health Services: Medicaid health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

Home Services Program (HSP): State program that provides home and community-based services to physically disabled Illinoisans that are under age 59. This program is state and federally-funded, and Medicaid-eligible program participants are covered under the Persons with Disabilities (PwD) program. Medicaid-ineligible individuals that meet other eligibility requirements may still be eligible for HSP through state-only funds.

Home-and Community-Based Services (HCBS): Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

Illinois Department of Aging (IDoA): Department of the Illinois state government that exercises, administers, and enforces all rights, powers, and duties vested in it by the Illinois Act on the Aging. The IDoA oversees the Community Care Program (CCP), which includes the HCBS-PE program.

Illinois Department of Human Services (IDHS): Department of the Illinois state government responsible for providing a wide variety of safety net services to Illinois residents in poverty, who are facing other economic challenges, or who have any of a variety of disabilities. This includes Medicaid and HCBS programs.

Illinois Department of Public Aid (IDPA): The single-state agency administering and overseeing the Medicaid program in Illinois. In 1997, the Department closed and all Medicaid responsibilities transferred to the newly-established Illinois Department of Human Services (IDHS).

Illinois Division of Rehabilitation Services (IDRS): Illinois' lead agency serving individuals with disabilities. The IDRS administers the Home Services Program (HSP), which includes the PwD program.

Instrumental Activities of Daily Living (IADLs): Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

Intermediate Care Facility (ICF): A long term care facility that provides nursing and supportive care to residents on a non-continuous skilled nursing care basis, under a physician's direction. An ICF is typically regarded as a lower-level nursing care facility when compared to a skilled nursing facility (SNF), but its residents require more care and attention than those in a residential care facility for elderly or an adult residential care facility.

Managed Care: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Managed Long-Term Services and Supports (MLTSS): Illinois' transition to mandatory managed care enrollment. Implemented in 2016, dual eligible (eligible for Medicare and Medicaid) beneficiaries who receive institutional (except those receiving developmental disability institutional services) or community-based long-term care are required to enroll in managed care, unless they meet another exclusion.

Mandatory Categorically Needy: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

Medicaid State Plan: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available.

Medically necessary: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

Medically Needy: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is generally an optional pathway. As a 209(b) state, Illinois must allow aged, blind, and disabled applicants to spend down their income to become eligible for Medicaid.

Mini-Mental State Exam (MMSE): A cognitive screening tool that provides a brief, objective measure of cognitive function. It can be used to screen for cognitive impairment, to estimate the severity of the impairment, and to document cognitive change over time.

Minimum Data Set (MDS): A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

Monthly Maintenance Needs Allowance (MMNA): Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized. From 2014, this extended to community spouses of individuals enrolled in HCBS-PE.

Nursing facility care: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

Nursing facility level of care (NFLOC): Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

Optional Categorically Needy: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care, and more.

Other populations: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

Personal Care Services: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

Personal Needs Allowance: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

Persons with Disabilities (PwD) program: Illinois Medicaid LTC program that provides services and individualized support to persons with a disability who live in the home. These services are provided to those who would otherwise require care in a nursing facility. The PwD program is the Medicaid component of the larger, state-managed Home Services Program (HSP).

Preadmission Screening and Resident Review (PASRR): A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

PRUCOL: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

Skilled Nursing Facility (SNF): A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.

Skilled Nursing Services: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

Social Security Administration (SSA): United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

State Supplemental Payment (SSP): Small supplement to recipients of federal Supplemental Security Income (SSI) and some non-SSI recipients who are low-income persons with disabilities and older adults with limited resources to pay their living expenses.

Supplemental Nutritional Assistance Program (SNAP): Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

Supplemental Security Income (SSI)-related: Illinois Medicaid applicants that are either receiving SSI payments or who are deemed SSI recipients. Deemed recipiants are those that meet the categoical and financial requirements of the SSI program, regardless of whether they receive a payment.

Supplemental Security Income (SSI): The U.S. old-age cash assistance program for aged, blind, and disabled persons of limited means.

Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application.
2. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).
3. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2023b) for more information on these requirements.
4. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the MMNA in Illinois was $1,718 per month. This standard increases annually with inflation.
5. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the Community Spouse Resource Allowance (CSRA), which was $68,700 in 1992. This standard increases annually with inflation. Countable assets/property are real and personal property that are counted to determine eligibility.
6. Personal care services under HCBS-PE are divided into two separate benefits: homemaker services and chore/housekeeping services. Benefit definitions match the general definition of personal care services and have been combined under personal care services for harmonization across states.
7. Our team has submitted a Freedom of Information Act (FOIA) request to the Illinois Department of Healthcare and Family Services (IDHFS). The requested documents will provide historical information on Illinois' Home and Community-Based long-term care programs. Until then, these sections have missing information.
8. Individuals that received a DON score of 28 prior to 1989 DON revisions that raised eligibility to a minimum of 29 may remain eligible for the programs.
9. While the Illinois Administrative Code detailing DON score descriptions has been amended since 1992, there have been no substantive changes to the DON itself. Amendments have consisted of minor changes to language within the code, with no substantive change to the score descriptions.
10. The authors have not yet verified additional details on evaluators for HCBS-PE in this policy period. were not able to verify that the information from the later period was applicable to this period. Additional verified details are available in the next policy period.
11. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. As of 2012, for transfers made on or after January 1, 2007, the look back period is 60 months prior to the date of application for all assets (IDHFS, 2012).

12. The equity value is derived by subtracting any legal encumbrances (e.g., liens, mortgages) from the fair market value of the home. Exceptions exist if the person's spouse, child, or adult child with a disability is living in the home.

13. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2000, the MMNA in Illinois was $2,103 per month. This standard increased annually with inflation until 2009, where it remained at that level for several years.

14. The community spouse is also able to keep countable assets up to the Community Spouse Resource Allowance (CSRA), which was $84,120 in 2000. This standard increased annually with inflation until 2009, where it remained at that level for several years. Countable assets/property are real and personal property that are counted to determine eligibility.

15. The Affordable Care Act (ACA) provides 100% matching funds for newly eligible adults with incomes up to 138% of the Federal Poverty Level between 2014-2016, gradually declining to 90% in 2020 where it remains indefinitely (ASPE, 2014).

16. The look back period is 60 months prior to the date of application for all assets (ILSOS, 2010b).

17. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) or enrolled in HCBS-PE and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep up to a maximum Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 2014, the MMNA in Illinois was $2,739 per month (IDHS, 2022a). This did not increase until January 1, 2023, when the amount was raised to $3,715.50 per month (NLR, 2023).

18. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the Community Spouse Resource Allowance (CSRA), which was $109,560 in 2014 (IDHS, 2022b). This did not increase until January 1, 2023, when the amount was raised to $120,780.00 (NLR, 2023). Countable assets/property are real and personal property that are counted to determine eligibility.

Version information

Current Version: 1.0 (November 2023)

Version History

- 1.0 (November 2023): First version.