HB3479

LRB10010189KTG20371b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB3479

by Rep. Sara Feigenholtz

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-11 from Ch. 23, par. 5-11

Amends the Medical Assistance Article of the Illinois Public Aid Code. In addition to other specified actions required under the Code, requires a managed care community network that contracts with the Department of Healthcare and Family Services to establish, maintain, and provide a fair and reasonable reimbursement rate to pharmacy providers for pharmaceutical services, prescription drugs and drug products, and pharmacy or pharmacist-provided services. Provides that the reimbursement methodology shall not be less than the current reimbursement rate utilized by the Department for prescription and pharmacy or pharmacist-provided services and shall not be below the actual acquisition cost of the pharmacy provider. Requires a managed care community network to ensure that the pharmacy formulary used by the managed care community network and its contract providers is no more restrictive than the Department's pharmaceutical program. Effective July 1, 2018.

LRB100 10189 KTG 20371 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Illinois Public Aid Code is amended by changing Section 5-11 as follows:

(305 ILCS 5/5-11) (from Ch. 23, par. 5-11)

Sec. 5-11. Co-operative arrangements; contracts with other State agencies, health care and rehabilitation organizations, and fiscal intermediaries.

(a) The Illinois Department may enter into co-operative arrangements with State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services to the end that there may be maximum utilization of such services in the provision of medical assistance.

The Illinois Department shall, not later than June 30, 1993, enter into one or more co-operative arrangements with the Department of Mental Health and Developmental Disabilities providing that the Department of Mental Health and Developmental Disabilities will be responsible for administering or supervising all programs for services to persons in community care facilities for persons with developmental disabilities, including but not limited to

intermediate care facilities, that are supported by State funds or by funding under Title XIX of the federal Social Security Act. The responsibilities of the Department of Mental Health and Developmental Disabilities under these agreements are transferred to the Department of Human Services as provided in the Department of Human Services Act.

The Department may also contract with such State health and rehabilitation agencies and other public or private health care and rehabilitation organizations to act for it in supplying designated medical services to persons eligible therefor under this Article. Any contracts with health services or health maintenance organizations shall be restricted to organizations which have been certified as being in compliance with standards promulgated pursuant to the laws of this State governing the establishment and operation of health services or health maintenance organizations. The Department shall renegotiate the contracts with health maintenance organizations and managed care community networks that took effect August 1, 2003, so as to produce $70,000,000 savings to the Department net of resulting increases to the fee-for-service program for State fiscal year 2006. The Department may also contract with insurance companies or other corporate entities serving as fiscal intermediaries in this State for the Federal Government in respect to Medicare payments under Title XVIII of the Federal Social Security Act to act for the Department in paying medical care suppliers. The provisions of Section 9 of "An Act

in relation to State finance", approved June 10, 1919, as amended, notwithstanding, such contracts with State agencies, other health care and rehabilitation organizations, or fiscal intermediaries may provide for advance payments.

(b) For purposes of this subsection (b), "managed care community network" means an entity, other than a health maintenance organization, that is owned, operated, or governed by providers of health care services within this State and that provides or arranges primary, secondary, and tertiary managed health care services under contract with the Illinois Department exclusively to persons participating in programs administered by the Illinois Department.

The Illinois Department may certify managed care community networks, including managed care community networks owned, operated, managed, or governed by State-funded medical schools, as risk-bearing entities eligible to contract with the Illinois Department as Medicaid managed care organizations. The Illinois Department may contract with those managed care community networks to furnish health care services to or arrange those services for individuals participating in programs administered by the Illinois Department. The rates for those provider-sponsored organizations may be determined on a prepaid, capitated basis. A managed care community network may choose to contract with the Illinois Department to provide only pediatric health care services. The Illinois Department shall by rule adopt the criteria, standards, and procedures by which

a managed care community network may be permitted to contract with the Illinois Department and shall consult with the Department of Insurance in adopting these rules.

A county provider as defined in Section 15-1 of this Code may contract with the Illinois Department to provide primary, secondary, or tertiary managed health care services as a managed care community network without the need to establish a separate entity and shall be deemed a managed care community network for purposes of this Code only to the extent it provides services to participating individuals. A county provider is entitled to contract with the Illinois Department with respect to any contracting region located in whole or in part within the county. A county provider is not required to accept enrollees who do not reside within the county.

In order to (i) accelerate and facilitate the development of integrated health care in contracting areas outside counties with populations in excess of 3,000,000 and counties adjacent to those counties and (ii) maintain and sustain the high quality of education and residency programs coordinated and associated with local area hospitals, the Illinois Department may develop and implement a demonstration program from managed care community networks owned, operated, managed, or governed by State-funded medical schools. The Illinois Department shall prescribe by rule the criteria, standards, and procedures for effecting this demonstration program.

A managed care community network that contracts with the

Illinois Department to furnish health care services to or arrange those services for enrollees participating in programs administered by the Illinois Department shall do all of the following:

(1) Provide that any provider affiliated with the managed care community network may also provide services on a fee-for-service basis to Illinois Department clients not enrolled in such managed care entities.

(2) Provide client education services as determined and approved by the Illinois Department, including but not limited to (i) education regarding appropriate utilization of health care services in a managed care system, (ii) written disclosure of treatment policies and restrictions or limitations on health services, including, but not limited to, physical services, clinical laboratory tests, hospital and surgical procedures, prescription drugs and biologics, and radiological examinations, and (iii) written notice that the enrollee may receive from another provider those covered services that are not provided by the managed care community network.

(3) Provide that enrollees within the system may choose the site for provision of services and the panel of health care providers.

(4) Not discriminate in enrollment or disenrollment practices among recipients of medical services or enrollees based on health status.

(5) Provide a quality assurance and utilization review program that meets the requirements established by the Illinois Department in rules that incorporate those standards set forth in the Health Maintenance Organization Act.

(6) Issue a managed care community network identification card to each enrollee upon enrollment. The card must contain all of the following:

(A) The enrollee's health plan.

(B) The name and telephone number of the enrollee's primary care physician or the site for receiving primary care services.

(C) A telephone number to be used to confirm eligibility for benefits and authorization for services that is available 24 hours per day, 7 days per week.

(7) Ensure that every primary care physician and pharmacy in the managed care community network meets the standards established by the Illinois Department for accessibility and quality of care. The Illinois Department shall arrange for and oversee an evaluation of the standards established under this paragraph (7) and may recommend any necessary changes to these standards.

(8) Provide a procedure for handling complaints that meets the requirements established by the Illinois Department in rules that incorporate those standards set

forth in the Health Maintenance Organization Act.

(9) Maintain, retain, and make available to the Illinois Department records, data, and information, in a uniform manner determined by the Illinois Department, sufficient for the Illinois Department to monitor utilization, accessibility, and quality of care.

(10) (Blank).

(11) Establish, maintain, and provide a fair and reasonable reimbursement rate to pharmacy providers for pharmaceutical services, prescription drugs and drug products, and pharmacy or pharmacist-provided services. The reimbursement methodology shall include a fair and reasonable professional dispensing fee for pharmaceutical services, prescription drugs, and drug products and a fair and reasonable professional fee for pharmacy or pharmacist-provided services. The reimbursement methodology shall not be less than the current reimbursement rate utilized by the Illinois Department for prescription and pharmacy or pharmacist-provided services as described in Section 5-5.12 and shall not be below the actual acquisition cost of the pharmacy provider.

(12) Ensure that the pharmacy formulary used by the managed care community network and its contract providers is no more restrictive than the Illinois Department's pharmaceutical program.

The Illinois Department shall contract with an entity or

entities to provide external peer-based quality assurance review for the managed health care programs administered by the Illinois Department. The entity shall meet all federal requirements for an external quality review organization.

Each managed care community network must demonstrate its ability to bear the financial risk of serving individuals under this program. The Illinois Department shall by rule adopt standards for assessing the solvency and financial soundness of each managed care community network. Any solvency and financial standards adopted for managed care community networks shall be no more restrictive than the solvency and financial standards adopted under Section 1856(a) of the Social Security Act for provider-sponsored organizations under Part C of Title XVIII of the Social Security Act.

The Illinois Department may implement the amendatory changes to this Code made by this amendatory Act of 1998 through the use of emergency rules in accordance with Section 5-45 of the Illinois Administrative Procedure Act. For purposes of that Act, the adoption of rules to implement these changes is deemed an emergency and necessary for the public interest, safety, and welfare.

(c) Not later than June 30, 1996, the Illinois Department shall enter into one or more cooperative arrangements with the Department of Public Health for the purpose of developing a single survey for nursing facilities, including but not limited to facilities funded under Title XVIII or Title XIX of the

federal Social Security Act or both, which shall be administered and conducted solely by the Department of Public Health. The Departments shall test the single survey process on a pilot basis, with both the Departments of Public Aid and Public Health represented on the consolidated survey team. The pilot will sunset June 30, 1997. After June 30, 1997, unless otherwise determined by the Governor, a single survey shall be implemented by the Department of Public Health which would not preclude staff from the Department of Healthcare and Family Services (formerly Department of Public Aid) from going on-site to nursing facilities to perform necessary audits and reviews which shall not replicate the single State agency survey required by this Act. This Section shall not apply to community or intermediate care facilities for persons with developmental disabilities.

(d) Nothing in this Code in any way limits or otherwise impairs the authority or power of the Illinois Department to enter into a negotiated contract pursuant to this Section with a managed care community network or a health maintenance organization, as defined in the Health Maintenance Organization Act, that provides for termination or nonrenewal of the contract without cause, upon notice as provided in the contract, and without a hearing.

(Source: P.A. 95-331, eff. 8-21-07; 96-1501, eff. 1-25-11.)

Section 99. Effective date. This Act takes effect January 1, 2018.