



## 101ST GENERAL ASSEMBLY

### State of Illinois

2019 and 2020

HB2715

by Rep. Robyn Gabel

#### SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.1  
305 ILCS 5/5-30.11 new

Amends the Medical Assistance Article of the Illinois Public Aid Code. Require managed care organizations (MCOs) to ensure (i) that contracted providers shall be paid for any medically necessary service rendered to any of the MCO's enrollees, regardless of inclusion on the MCO's published and publicly available roster of available providers; and (ii) that all contracted providers are contained on an updated roster within 7 days of entering into a contract with the MCO and that such roster be readily accessible by all medical assistance enrollees for purposes of selecting an approved healthcare provider. Requires the Department of Healthcare and Family Services to develop a single standard list of all additional clinical information that shall be considered essential information and may be requested from a hospital to adjudicate a claim. Provides that a provider shall not be required to submit additional information, justifying medical necessity, for a service which has previously received a service authorization by the MCO or its agent. Contains provisions concerning a timely payment interest penalty; an expedited provider payment schedule; a single list of standard codes to identify the reason for nonpayment on a claim; payments under the Department's fee-for-service system; a 90-day correction period for providers to correct errors or omissions in a payment claim; service authorization requests; discharge notification and facility placement; and other matters. Defines terms. Effective immediately.

LRB101 09319 KTG 54414 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

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

4 Section 5. The Illinois Public Aid Code is amended by  
5 changing Section 5-30.1 and by adding Section 5-30.11 as  
6 follows:

7 (305 ILCS 5/5-30.1)

8 Sec. 5-30.1. Managed care protections.

9 (a) As used in this Section:

10 "Managed care organization" or "MCO" means any entity which  
11 contracts with the Department to provide services where payment  
12 for medical services is made on a capitated basis.

13 "Emergency services" include:

14 (1) emergency services, as defined by Section 10 of the  
15 Managed Care Reform and Patient Rights Act;

16 (2) emergency medical screening examinations, as  
17 defined by Section 10 of the Managed Care Reform and  
18 Patient Rights Act;

19 (3) post-stabilization medical services, as defined by  
20 Section 10 of the Managed Care Reform and Patient Rights  
21 Act; and

22 (4) emergency medical conditions, as defined by  
23 Section 10 of the Managed Care Reform and Patient Rights

1 Act.

2 "Claim Rejection" means a claim which is not correctly  
3 formatted and therefore cannot be processed when submitted for  
4 payment due to errors that cannot be corrected by the MCO.

5 "Claim payment rate adjustment" means any retroactive  
6 change to the rate or rates of payment from an MCO to a  
7 provider that results in a change in the total payment to the  
8 provider from the amount originally paid to the provider for  
9 the service. Such rate adjustments shall include, but not be  
10 limited to, either positive or negative rate adjustments,  
11 incentive payments, bonuses, or settlement adjustments.

12 "Claim recoupment adjustment" means any reduction to the  
13 initial final claim payment amount that is applied as an  
14 off-set for the purpose of recouping amounts due from the  
15 provider and owed to the MCO or the Department. All recoupment  
16 adjustments must be clearly and separately noted on any  
17 remittance advice when paying the provider. The rate-based  
18 total payment amount must be clearly and separately delineated  
19 from any applied recoupment adjustment.

20 "Claim denial" means a determination of nonpayment by the  
21 MCO of a properly formatted claim for services rendered by the  
22 provider. "Denial" means the MCO has determined that it has no  
23 liability under the Medical Assistance Program, the MCO  
24 contract with the Department, an existing contract with the  
25 provider, or other applicable provisions of law. Examples of an  
26 acceptable denial include, but are not limited to: (i) the

1 determination that the service rendered is not covered under  
2 the Medical Assistance Program, the MCO contract with the  
3 Department, an existing contract with the provider, or other  
4 applicable provisions of law; (ii) the beneficiary listed on  
5 the claim is not enrolled in the MCO; or (iii) a contractually  
6 required service authorization was not requested by the  
7 provider.

8 "Service authorization" means any service for which an MCO  
9 requires a provider, as specified in its service agreement,  
10 contract, or handbook, to submit a request for medical review  
11 authorizing the service, either prior to, concurrent with, or  
12 following the delivery of the service. Service authorization  
13 includes, but is not limited to, the following terms:  
14 precertification, preadmission review, pre-service review,  
15 prior authorization, prior approval, notification, concurrent  
16 review, retrospective review, prepayment review, and post  
17 payment review.

18 (b) As provided by Section 5-16.12, managed care  
19 organizations are subject to the provisions of the Managed Care  
20 Reform and Patient Rights Act.

21 (c) An MCO shall pay any provider of emergency services  
22 that does not have in effect a contract with the contracted  
23 Medicaid MCO. The default rate of reimbursement shall be the  
24 rate paid under Illinois Medicaid fee-for-service program  
25 methodology, including all policy adjusters, including but not  
26 limited to Medicaid High Volume Adjustments, Medicaid

1 Percentage Adjustments, Outpatient High Volume Adjustments,  
2 and all outlier add-on adjustments to the extent such  
3 adjustments are incorporated in the development of the  
4 applicable MCO capitated rates.

5 (d) An MCO shall pay for all post-stabilization services as  
6 a covered service in any of the following situations:

7 (1) the MCO authorized such services;

8 (2) such services were administered to maintain the  
9 enrollee's stabilized condition within one hour after a  
10 request to the MCO for authorization of further  
11 post-stabilization services;

12 (3) the MCO did not respond to a request to authorize  
13 such services within one hour;

14 (4) the MCO could not be contacted; or

15 (5) the MCO and the treating provider, if the treating  
16 provider is a non-affiliated provider, could not reach an  
17 agreement concerning the enrollee's care and an affiliated  
18 provider was unavailable for a consultation, in which case  
19 the MCO must pay for such services rendered by the treating  
20 non-affiliated provider until an affiliated provider was  
21 reached and either concurred with the treating  
22 non-affiliated provider's plan of care or assumed  
23 responsibility for the enrollee's care. Such payment shall  
24 be made at the default rate of reimbursement paid under  
25 Illinois Medicaid fee-for-service program methodology,  
26 including all policy adjusters, including but not limited

1 to Medicaid High Volume Adjustments, Medicaid Percentage  
2 Adjustments, Outpatient High Volume Adjustments and all  
3 outlier add-on adjustments to the extent that such  
4 adjustments are incorporated in the development of the  
5 applicable MCO capitated rates.

6 (e) The following requirements apply to MCOs in determining  
7 payment for all emergency services:

8 (1) MCOs shall not impose any requirements for prior  
9 approval of emergency services.

10 (2) The MCO shall cover emergency services provided to  
11 enrollees who are temporarily away from their residence and  
12 outside the contracting area to the extent that the  
13 enrollees would be entitled to the emergency services if  
14 they still were within the contracting area.

15 (3) The MCO shall have no obligation to cover medical  
16 services provided on an emergency basis that are not  
17 covered services under the contract.

18 (4) The MCO shall not condition coverage for emergency  
19 services on the treating provider notifying the MCO of the  
20 enrollee's screening and treatment within 10 days after  
21 presentation for emergency services.

22 (5) The determination of the attending emergency  
23 physician, or the provider actually treating the enrollee,  
24 of whether an enrollee is sufficiently stabilized for  
25 discharge or transfer to another facility, shall be binding  
26 on the MCO. The MCO shall cover emergency services for all

1 enrollees whether the emergency services are provided by an  
2 affiliated or non-affiliated provider.

3 (6) The MCO's financial responsibility for  
4 post-stabilization care services it has not pre-approved  
5 ends when:

6 (A) a plan physician with privileges at the  
7 treating hospital assumes responsibility for the  
8 enrollee's care;

9 (B) a plan physician assumes responsibility for  
10 the enrollee's care through transfer;

11 (C) a contracting entity representative and the  
12 treating physician reach an agreement concerning the  
13 enrollee's care; or

14 (D) the enrollee is discharged.

15 (f) Network adequacy and transparency.

16 (1) The Department shall:

17 (A) ensure that an adequate provider network is in  
18 place, taking into consideration health professional  
19 shortage areas and medically underserved areas;

20 (B) publicly release an explanation of its process  
21 for analyzing network adequacy;

22 (C) periodically ensure that an MCO continues to  
23 have an adequate network in place; ~~and~~

24 (D) require MCOs, including Medicaid Managed Care  
25 Entities as defined in Section 5-30.2, to meet provider  
26 directory requirements under Section 5-30.3; and ~~and~~

1           (E) require MCOs to: (i) ensure that any provider  
2           under contract with an MCO on the date of service is  
3           paid for any medically necessary service rendered to  
4           any of the MCO's enrollees, regardless of inclusion on  
5           the MCO's published and publicly available roster of  
6           available providers; and (ii) ensure that all  
7           contracted providers are listed on an updated roster  
8           within 7 days of entering into a contract with the MCO  
9           and that such roster is readily accessible to all  
10           medical assistance enrollees for purposes of selecting  
11           an approved healthcare provider.

12           (2) Each MCO shall confirm its receipt of information  
13           submitted specific to physician or dentist additions or  
14           physician or dentist deletions from the MCO's provider  
15           network within 3 days after receiving all required  
16           information from contracted physicians or dentists, and  
17           electronic physician and dental directories must be  
18           updated consistent with current rules as published by the  
19           Centers for Medicare and Medicaid Services or its successor  
20           agency.

21           (g) Timely payment of claims.

22           (1) The MCO shall pay a claim within 30 days of  
23           receiving a claim that contains all the essential  
24           information needed to adjudicate the claim.

25           (A) The Department shall develop a single standard  
26           list of all additional clinical information, beyond



1 the standard uniform national billing requirements,  
2 which shall be considered essential information that  
3 may be requested from a hospital to adjudicate a claim.  
4 An MCO shall not require a hospital to provide  
5 information to adjudicate a claim, other than  
6 information stated on the standard list developed by  
7 the Department.

8 (B) The Department shall include the standard list  
9 of essential information in the agreement between each  
10 MCO and the Department and the Department shall publish  
11 the standard list of essential information on its  
12 website.

13 (C) The standard list of essential information  
14 shall be developed by the Department, in consultation  
15 with MCOs and the statewide association representing a  
16 majority of hospitals in the State. The Department may  
17 update the standard list of all essential information  
18 to adjudicate a claim no more frequently than annually.

19 (2) If an MCO requires information from the standard  
20 list of essential information to adjudicate a claim, it  
21 must request this additional information within 5 business  
22 days of receipt of the claim. ~~The MCO shall notify the~~  
23 ~~billing party of its inability to adjudicate a claim within~~  
24 ~~30 days of receiving that claim.~~

25 (A) Under no circumstance shall a provider be  
26 required to submit additional information, justifying

1 medical necessity, for a service which has previously  
2 received a service authorization by the MCO or its  
3 agent. All services rendered in good faith by a  
4 provider based on a service authorization from an MCO  
5 or its agent shall be timely paid by the MCO at a rate  
6 associated with the service authorized and consistent  
7 with the contractual agreement between the MCO and the  
8 provider or, if there is no contractual agreement, at a  
9 rate otherwise required by law.

10 (B) Any request for additional information,  
11 necessary for the final adjudication of payment, may  
12 only temporarily suspend the 30-day timely payment  
13 requirement from the date additional information is  
14 requested from the provider until the date it is  
15 received from the provider.

16 (3) The MCO shall pay a penalty that is at least equal  
17 to the timely payment interest penalty imposed under the  
18 Illinois Insurance Code for any claims not timely paid.

19 (A) When an MCO is required to pay a timely payment  
20 interest penalty to a provider, the MCO must  
21 automatically calculate and pay the timely payment  
22 interest penalty that is due to the provider within 30  
23 days after the payment of the claim. In no event shall  
24 a provider be required to request or apply for payment  
25 of any owed timely payment interest penalties.

26 (B) A MCO shall report at the time of payment to

1 each provider all timely payment interest penalty  
2 payments made to that provider, with such payments  
3 being reported separately from the claim payment for  
4 services rendered to the MCO's enrollee. Timely  
5 interest penalty payments shall not be considered a  
6 claim payment rate adjustment, as defined in this  
7 Section, and shall be considered separately due and  
8 payable by the MCO to the provider.

9 (4) The Department shall require MCOs to expedite  
10 payments to providers based on criteria that include, but  
11 are not limited to: ~~The Department may establish a process~~  
12 ~~for MCOs to expedite payments to providers based on~~  
13 ~~criteria established by the Department.~~

14 (A) At a minimum, each MCO shall ensure that  
15 providers identified on the Department's expedited  
16 provider list, determined in accordance with 89 Ill.  
17 Adm. Code 140.71(b), are paid by the MCO on a schedule  
18 at least as frequently as the providers are paid under  
19 the Department's fee-for-service expedited provider  
20 schedule.

21 (B) Compliance with the expedited provider  
22 requirement may be satisfied by an MCO through the use  
23 of a Periodic Interim Payment (PIP) program that has  
24 been mutually agreed to and documented between the MCO  
25 and the provider, if the PIP program ensures that any  
26 expedited provider receives regular and periodic

1 payments based on prior period payment experience from  
2 that MCO. Total payments under the PIP program may be  
3 reconciled against future PIP payments on a schedule  
4 mutually agreed to between the MCO and the provider.

5 (5) The Department shall establish a single list of  
6 standard codes, by provider industry, to identify the  
7 reason or reasons a claim is not to be paid. The list must  
8 include an explanation of each code and the action or  
9 actions required by the provider to correct all errors, if  
10 any.

11 (A) The Department and each MCO shall use the  
12 standard code set and descriptions published by the  
13 Department on the Explanation of Payment, and make  
14 available a system which maps the standard codes and  
15 descriptions to the applicable American National  
16 Standard Institute codes and includes all necessary  
17 corrective actions, if possible to move the claim,  
18 whether submitted in electronic format or  
19 non-electronic, to a payable status.

20 (B) The requirement under this Section is meant to  
21 provide a more descriptive supplement to any required  
22 notifications subject to the ASC X12 electronic  
23 transaction standards adopted under the federal Health  
24 Insurance Portability and Accountability Act.

25 (C) The single list of standard codes shall be  
26 developed in consultation with industry

1 representatives of the Medicaid managed care health  
2 plans and representatives of provider associations  
3 representing the majority of providers within the  
4 identified provider industry.

5 (g-5) Recognizing that the rapid transformation of the  
6 Illinois Medicaid program may have unintended operational  
7 challenges for both payers and providers:

8 (1) in no instance shall a medically necessary covered  
9 service rendered in good faith, based upon eligibility  
10 information documented by the provider, be denied coverage  
11 or diminished in payment amount if the eligibility or  
12 coverage information available at the time the service was  
13 rendered is later found to be inaccurate; and

14 (2) the Department shall, by December 31, 2016, adopt  
15 rules establishing policies that shall be included in the  
16 Medicaid managed care policy and procedures manual  
17 addressing payment resolutions in situations in which a  
18 provider renders services based upon information obtained  
19 after verifying a patient's eligibility and coverage plan  
20 through either the Department's current enrollment system  
21 or a system operated by the coverage plan identified by the  
22 patient presenting for services:

23 (A) such medically necessary covered services  
24 shall be considered rendered in good faith;

25 (B) such policies and procedures shall be  
26 developed in consultation with industry

1 representatives of the Medicaid managed care health  
2 plans and representatives of provider associations  
3 representing the majority of providers within the  
4 identified provider industry; and

5 (C) such rules shall be published for a review and  
6 comment period of no less than 30 days on the  
7 Department's website with final rules remaining  
8 available on the Department's website.

9 (3) The rules on payment resolutions shall include, but  
10 not be limited to:

11 (A) the extension of the timely filing period;

12 (B) retroactive prior authorizations; and

13 (C) guaranteed minimum payment rate of no less than  
14 the current, as of the date of service, fee-for-service  
15 rate, plus all applicable add-ons, when the resulting  
16 service relationship is out of network.

17 (4) The rules shall be applicable for both MCO coverage  
18 and fee-for-service coverage.

19 (g-6) MCO Performance Metrics Report.

20 (1) The Department shall publish, on at least a  
21 quarterly basis, each MCO's operational performance,  
22 including, but not limited to, the following categories of  
23 metrics:

24 (A) claims payment, including timeliness and  
25 accuracy;

26 (B) prior authorizations;

- 1 (C) grievance and appeals;  
2 (D) utilization statistics;  
3 (E) provider disputes;  
4 (F) provider credentialing; and  
5 (G) member and provider customer service.

6 (2) The Department shall ensure that the metrics report  
7 is accessible to providers online by January 1, 2017.

8 (3) The metrics shall be developed in consultation with  
9 industry representatives of the Medicaid managed care  
10 health plans and representatives of associations  
11 representing the majority of providers within the  
12 identified industry.

13 (4) Metrics shall be defined and incorporated into the  
14 applicable Managed Care Policy Manual issued by the  
15 Department.

16 (g-7) MCO claims processing and performance analysis. In  
17 order to monitor MCO payments to hospital providers, pursuant  
18 to this amendatory Act of the 100th General Assembly, the  
19 Department shall post an analysis of MCO claims processing and  
20 payment performance on its website every 6 months. Such  
21 analysis shall include a review and evaluation of a  
22 representative sample of hospital claims that are rejected and  
23 denied for clean and unclean claims and the top 5 reasons for  
24 such actions and timeliness of claims adjudication, which  
25 identifies the percentage of claims adjudicated within 30, 60,  
26 90, and over 90 days, and the dollar amounts associated with

1 those claims. The Department shall post the contracted claims  
2 report required by HealthChoice Illinois on its website every 3  
3 months.

4 (g-8) Notwithstanding any other law, whenever the  
5 resolution of a dispute between an MCO and a provider related  
6 to the MCO's obligation to pay a claim results in the  
7 determination that the recipient's coverage on the date of  
8 service was under the Department's fee-for-service system, the  
9 provider shall be afforded an additional 120 days from the date  
10 of notice of such determination to submit the claim to the  
11 Department for payment under the fee-for-service system. The  
12 Department shall expedite the processing and adjudication of  
13 such claims.

14 (A) In such instances, there shall be no dispute as  
15 to the Department's liability under the  
16 fee-for-service system for a validly rendered service.

17 (B) Any requirement of prior service authorization  
18 by the State shall be waived in such circumstances.

19 (C) In such instances, if a claim for payment  
20 derives from a transfer from one hospital to another,  
21 resulting in continuous care by both hospitals, there  
22 shall be no dispute in the assignment of coverage for  
23 the service, such that if the initiating hospital  
24 service was covered under the Department's  
25 fee-for-service system, then the liability for the  
26 entire claim shall remain under the Department's



1           fee-for-service system.

2           (9-9) Notwithstanding any other provisions of law, if the  
3 Department or an MCO requires submission of a claim for payment  
4 in a non-electronic format, a provider shall always be afforded  
5 a period of no less than 90 business days, as a correction  
6 period, following any notification of rejection by either the  
7 Department or the MCO to correct errors or omissions in the  
8 original submission.

9           Under no circumstances, either by an MCO or under the  
10 Department's fee-for-service system, shall a provider be  
11 denied payment for failure to comply with any timely claims  
12 submission requirements of this Code or under any existing  
13 contract, unless the non-electronic format claim submission  
14 occurs after the initial 180 days following the latest date of  
15 service on the claim, or after the 90 business days correction  
16 period following notification to the provider of rejection or  
17 denial of payment.

18           (g-10) Medical necessity determination.

19           (1) Any MCO under contract with the Department that  
20 requires service authorization for any service, in order  
21 for payment to be made, must have an electronic system that  
22 accepts and preserves electronically for both parties all  
23 service authorization requests, related clinical  
24 documentation, and service authorization determinations. A  
25 transaction tracking number must be issued to the provider  
26 at the time of the request, noting the level of care

1 requested for the service authorization, and must be  
2 transmitted to the requesting provider either  
3 electronically or provided telephonically.

4 (2) A MCO must authorize or reject a request for  
5 service authorization, submitted prior to the delivery of  
6 the service, within 4 calendar days of the day when all  
7 information requested by the MCO, in order to rule on the  
8 request, has been provided. Such service authorization or  
9 rejection must contain the transaction tracking number and  
10 level of care being authorized or rejected. If the  
11 enrollee's medical condition is such that a time frame of 4  
12 days could seriously jeopardize the enrollee's life or  
13 health, the MCO must authorize or reject a request within  
14 48 hours. Time frames for authorization of  
15 post-stabilization services are governed by subsection (d)  
16 of this Section. If no authorization or denial is provided  
17 within the appropriate time frame outlined in this  
18 subsection, the request for service authorization shall be  
19 considered approved, and the service associated with the  
20 authorization shall be deemed payable by the MCO at the  
21 standard contractual rate of reimbursement for the service  
22 or as required by law.

23 (3) If a service authorization is given, the MCO cannot  
24 request further clinical data for the purpose of a medical  
25 necessity review prior to payment when a claim for the  
26 service is received by the MCO, unless the service on the

1 claim differs significantly from the service which was  
2 approved. Unless the service is deemed to significantly  
3 differ from the service authorized when the service  
4 authorization was given by the MCO, the service shall be  
5 deemed medically necessary and authorized for payment at  
6 the rate consistent with the service initially authorized  
7 by the MCO and shall be paid.

8 (4) If the service on a claim differs significantly  
9 from the service previously approved, the provider must  
10 have at least 30 days from receiving a request from the MCO  
11 to submit clinical information to show medical necessity of  
12 the service that was billed. If the clinical information  
13 demonstrates that the billed service was medically  
14 necessary, the claim shall be paid.

15 (5) If a service did not require a service  
16 authorization under the MCO's policies, and the MCO  
17 undertakes a medical necessity review prior to paying the  
18 claim, the MCO must request all necessary information for  
19 the review from the provider within 5 business days of the  
20 receipt of the claim and the provider shall have at least  
21 30 business days from the receipt of the request to provide  
22 the information requested by the MCO.

23 (6) Before an MCO can recover payments made based on a  
24 post-payment audit, the MCO must give the provider a 60 day  
25 written notice of each claim for which recovery is sought  
26 and the reasons for the recovery using a standard code from

1 the list established under paragraph (5) of subsection (g).  
2 Record requests in a post payment audit may not exceed the  
3 standards set forth in the Medicare Fee for Service  
4 Recovery Audit Program for the provider type being audited,  
5 adjusted for the provider's Medicaid volumes. Post-payment  
6 recovery based on lack of medical necessity for claims that  
7 were previously approved based on a medical necessity  
8 review can only occur if it is demonstrated by the MCO that  
9 the information provided at the time of the previous review  
10 was knowingly materially inaccurate or incomplete at the  
11 time the information was provided by the provider.

12 (7) If an MCO denies payment of or reduces the rate of  
13 payment of a claim for a service which was:

14 (A) provided in good faith following the receipt of  
15 a service authorization by the MCO and the denial is  
16 for lack of service authorization, the MCO shall be  
17 required to pay the provider double the amount due the  
18 provider as a penalty add-on, in addition to the  
19 standard contractual rate of reimbursement, or as  
20 required by law, that would have been due for the  
21 service if no denial had occurred; or

22 (B) provided in good faith and denied for  
23 insufficient documentation and subsequently determined  
24 that the claim contained all information necessary to  
25 process and approve payment of the claim, the MCO shall  
26 be required to pay the provider a penalty add-on, in

1           addition to the standard contractual rate of  
2           reimbursement or as required by law, equal to the value  
3           of the amount owed the provider pursuant to the  
4           standard contractual rate of reimbursement or as  
5           required by law. Such penalty add-on shall be due and  
6           payable to the provider within 30 days of payment of  
7           the original claim payment.

8           The penalties imposed under this paragraph shall be due  
9           in addition to any interest owed pursuant to the timely  
10          payment provisions of subsection (g).

11          (h) The Department shall not expand mandatory MCO  
12 enrollment into new counties beyond those counties already  
13 designated by the Department as of June 1, 2014 for the  
14 individuals whose eligibility for medical assistance is not the  
15 seniors or people with disabilities population until the  
16 Department provides an opportunity for accountable care  
17 entities and MCOs to participate in such newly designated  
18 counties.

19          (i) The requirements of this Section apply to contracts  
20 with accountable care entities and MCOs entered into, amended,  
21 or renewed after June 16, 2014 (the effective date of Public  
22 Act 98-651).

23          (j) The requirements of this Section added by this  
24          amendatory Act of the 101st General Assembly shall apply to  
25          services provided on or after the first day of the month that  
26          begins 60 days after the effective date of this amendatory Act

1 of the 101st General Assembly.

2 (Source: P.A. 99-725, eff. 8-5-16; 99-751, eff. 8-5-16;  
3 100-201, eff. 8-18-17; 100-580, eff. 3-12-18; 100-587, eff.  
4 6-4-18.)

5 (305 ILCS 5/5-30.11 new)

6 Sec. 5-30.11. Discharge notification and facility  
7 placement of individuals; managed care. Whenever a hospital  
8 provides notice to a managed care organization (MCO) that an  
9 individual covered under the State's medical assistance  
10 program has received a discharge order from the attending  
11 physician and is ready for discharge from an inpatient hospital  
12 stay to another level of care, the MCO shall secure the  
13 individual's placement in or transfer to another facility  
14 within 24 hours of receiving the hospital's notification, or  
15 shall pay the hospital a daily rate equal to the hospital's  
16 daily rate associated with the stay ending, including all  
17 applicable add-on adjustment payments.

18 Section 99. Effective date. This Act takes effect upon  
19 becoming law.