HB1202

LRB10324930KTG51264b

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

HB1202

Introduced 1/31/2023, by Rep. Mary E. Flowers

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-47 new

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that it is the intent of the General Assembly to ensure that all youth in the care of the Department of Children and Family Services have increased access to health care under the YouthCare Program. Provides that in order to maximize the accessibility of health care services for youth in care and former youth in care enrolled in the YouthCare Program, the Department of Healthcare and Family Services shall amend its managed care contracts such that a managed care organization (MCO) that manages health care for youth in care and former youth in care must pay for services rendered by a non-affiliated provider, for which the health plan would pay if rendered by an affiliated provider, at the rate paid under the Illinois Medicaid fee-for-service program methodology for such services, including all policy adjusters, including, but not limited to, Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO capitated rates, unless a different rate was agreed upon by the health plan and the non-affiliated provider. Provides that the payment requirement under the amendatory Act shall not apply if: (i) the services provided by the non-affiliated provider were not emergency services; (ii) the non-affiliated provider has, within the 12 months preceding the date of service, rejected a contract that was offered in good faith by the health plan as determined by the Department; and (iii) the health plan has terminated a contract with the non-affiliated provider for cause, and the Department has not deemed the termination to have been without merit. Effective immediately.

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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 adding Section 5-47 as follows:

(305 ILCS 5/5-47 new)

Sec. 5-47. Managed care services for youth in care; payments to non-affiliated providers.

(a) Statement of purpose. It is the intent of the General Assembly to ensure that all youth in the care of the Department of Children and Family Services have increased access to health care under the YouthCare Program.

(b) Definitions. As used in this Section, "youth in care" has the meaning ascribed to that term in Section 4d of the Children and Family Services Act.

(c) In order to maximize the accessibility of health care services for youth in care and former youth in care enrolled in the YouthCare Program, the Department of Healthcare and Family Services shall amend its managed care contracts such that a managed care organization (MCO) that manages health care for youth in care and former youth in care must pay for services rendered by a non-affiliated provider, for which the health plan would pay if rendered by an affiliated provider, at the

rate paid under the Illinois Medicaid fee-for-service program methodology for such services, including all policy adjusters, including, but not limited to, Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments, and all outlier add-on adjustments to the extent such adjustments are incorporated in the development of the applicable MCO capitated rates, unless a different rate was agreed upon by the health plan and the non-affiliated provider.

(d) In cases where a MCO must pay for services rendered by a non-affiliated provider, the requirements under subsection (c) shall not apply if the services were not emergency services, as defined in Section 5-30.1, and:

(1) the non-affiliated provider has, within the 12 months preceding the date of service, rejected a contract that was offered in good faith by the health plan as determined by the Department; or

(2) the health plan has terminated a contract with the non-affiliated provider for cause, and the Department has not deemed the termination to have been without merit. The Department may deem that a determination for cause has merit if:

(A) an institutional provider has repeatedly failed to conduct discharge planning; or

(B) the provider's conduct adversely and substantially impacts the health of Medicaid patients;

or

(C) the provider's conduct constitutes fraud, waste, or abuse; or

(D) the provider's conduct violates the code of ethics governing his or her profession.

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