Rep. Camille Y. Lilly

Filed: 4/12/2024

AMENDMENT TO HOUSE BILL 4076

AMENDMENT NO. _____. Amend House Bill 4076 by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Public Aid Code is amended by adding Section 11-5.3a as follows:

(305 ILCS 5/11-5.3a new)

Sec. 11-5.3a. Vendor assistance with redeterminations.

(a) Each managed care organization, as defined in Section 5-30.1, may enter into one or more contracts with eligible vendors to assist in the redetermination of eligibility of medical assistance enrollees, other than enrollees for whom an ex parte renewal is determined by the Department in accordance with a federal waiver provided under Section 1902(e)(14)(A) of the Social Security Act. Eligible vendors must be certified by the Business Enterprise Program and have no less than 60% of its owners with established residency in Illinois as of the

effective date of this amendatory Act of the 103rd General Assembly.

(b) Selected vendors shall assist in the redetermination of eligibility for medical assistance by utilizing a system that meets the following requirements:

(1) The system must be hosted on a platform that is secure and compliant with standards under the federal Health Insurance Portability and Accountability Act of 1996. Such platform must be scalable and may be cloud-based or on premises.

(2) The system must use a communication platform to programmatically perform calls, text messages, and other communication functions using web services or application programming interface services.

(3) The system must be able to make contact with a medical assistance enrollee in an automated fashion, continuing until contact is made and confirmed and contact information is updated.

(4) The system must allow medical assistance enrollees to enter, update, and transmit their required information through use of a voice virtual agent or text virtual agent to an online web form and back to a human assistant without losing any data input.

(5) The system must allow a medical assistance enrollee to switch between the voice virtual agent, the text virtual agent, and an online web form.

(6) The system must be designed to be compliant with the Americans with Disabilities Act (ADA). ADA compliance must be found regardless of which of the different ways a medical assistance enrollee enters the data, and then, any of the other means to which the medical assistance enrollee can switch, must continue to be ADA compliant regardless of the stage of the redetermination process that the enrollee is in and regardless of the number of transitions from one data entry means to another.

(7) The system must provide an analytics dashboard that is tethered to the communication platform with no additional software installation on the user's computer or mobile devices.

(8) The system must include a data processing platform to accumulate enrollee data to begin the process in an automated fashion. This includes data validation, rejection, and preparation for communication such as call or text.

(9) The system must be capable of contacting each medical assistance enrollee not less than 3 times per year utilizing skip tracing and bi-directional texting processes to locate up-to-date contact information for members.

(10) The system must include a data processing platform to provide data submitted by medical assistance enrollees to managed care organizations at a predefined

frequency, such as daily, weekly, or monthly and for measures identified within the Healthcare Effectiveness Data and Information Set guidelines.

(c) The Department shall establish a process to accept information provided by managed care organizations or their contracted vendors under this Section no later than 60 days after the effective date of this amendatory Act of the 103rd General Assembly. Nothing in this amendatory Act of the 103rd General Assembly shall be construed to contravene any federal regulation, policy, or requirement of the Centers for Medicare and Medicaid Services. If any provision of this Section or its application is found to be in violation of any federal regulation, policy, or requirement of the Centers for Medicare and Medicaid Services, that provision is declared invalid.

(d) Beginning no later than the 30th day of each fiscal year, the Department shall issue monthly payments to each managed care organization, which shall be used to issue payments to its contracted vendors in accordance with this Section. Each managed care organization shall receive a payment in an amount equal to $10 per medical assistance enrollee scheduled for a redetermination of eligibility during the monthly payment period, other than enrollees for whom an ex parte renewal is determined by the Department in accordance with a federal waiver provided under Section 1902(e)(14)(A) of the Social Security Act.

(e) Each managed care organization shall report, in a

format prescribed by the Department, on at least a quarterly basis the status of its activity or that of its vendors regarding assistance with redeterminations. The Department shall, in turn, report quarterly on its utilization of the information provided by the managed care organizations or their contracted vendors in accordance with this Section.

Section 99. Effective date. This Act takes effect July 1, 2024.".