HB6213

LRB09919222KTG45140b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB6213

Introduced 2/11/2016, by Rep. Carol Ammons

SYNOPSIS AS INTRODUCED:

See Index

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires each Medicaid Managed Care Entity (MMCE) contracted by the Department of Healthcare and Family Services to: (i) make available on the entity's website a provider directory in a machine readable file and format; (ii) make provider directories publicly accessible without the necessity of providing a password, a username, or personally identifiable information; (iii) make available through an electronic provider directory, for each Medicaid Managed Care Entity Plan offered by the entity, certain information in an easily understandable and searchable format, including the contact information and website URLs, if applicable, of all health care professionals, hospitals, pharmacies, and facilities that provide services to Medicaid recipients under the Medicaid Managed Care Entity Plan. Requires each MMCE to ensure that all information included in a print version of the provider directory is updated at least monthly and that the electronic provider directory is updated no later than 3 business days after the MMCE receives updated provider information. Provides that non-compliance with these and other specified requirements may subject the MMCE to certain sanctions. Requires the Department's client enrollment services broker to post certain information on the broker's website, including, information explaining the circumstances under which a Medicaid enrollee can file a grievance or request a hearing to appeal an adverse action by the Department or the MMCE; information on the Medicaid eligibility redetermination process; and information on Medicaid care coordination. Requires the Department to create a consumer quality comparison tool to assist enrollees with Medicaid Managed Care Entity Plan selection. Effective immediately.

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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 5-30.1 and by adding Section 5-30.3 as follows:

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

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

"Emergency services" include:

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

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

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

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

Act.

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

(c) An MCO shall pay any provider of emergency services that does not have in effect a contract with the contracted Medicaid MCO. The default rate of reimbursement shall be the rate paid under Illinois Medicaid fee-for-service program methodology, 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.

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

(1) the MCO authorized such services;

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

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

(4) the MCO could not be contacted; or

(5) the MCO and the treating provider, if the treating provider is a non-affiliated provider, could not reach an

agreement concerning the enrollee's care and an affiliated provider was unavailable for a consultation, in which case the MCO must pay for such services rendered by the treating non-affiliated provider until an affiliated provider was reached and either concurred with the treating non-affiliated provider's plan of care or assumed responsibility for the enrollee's care. Such payment shall be made at the default rate of reimbursement paid under Illinois Medicaid fee-for-service program methodology, 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 that such adjustments are incorporated in the development of the applicable MCO capitated rates.

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

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

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

(3) The MCO shall have no obligation to cover medical services provided on an emergency basis that are not

covered services under the contract.

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

(5) The determination of the attending emergency physician, or the provider actually treating the enrollee, of whether an enrollee is sufficiently stabilized for discharge or transfer to another facility, shall be binding on the MCO. The MCO shall cover emergency services for all enrollees whether the emergency services are provided by an affiliated or non-affiliated provider.

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

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

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

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

(D) the enrollee is discharged.

(f) Network adequacy.

(1) The Department shall:

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

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

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

(D) require MCOs, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet provider directory requirements under Section 5-30.3. ~~require MCOs to maintain an updated and public list of network providers.~~

(g) Timely payment of claims.

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

(2) The MCO shall notify the billing party of its inability to adjudicate a claim within 30 days of receiving that claim.

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

(4) The Department may establish a process for MCOs to expedite payments to providers based on criteria established by the Department.

(h) The Department shall not expand mandatory MCO

enrollment into new counties beyond those counties already designated by the Department as of June 1, 2014 for the individuals whose eligibility for medical assistance is not the seniors or people with disabilities population until the Department provides an opportunity for accountable care entities and MCOs to participate in such newly designated counties.

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended, or renewed after the effective date of this amendatory Act of the 98th General Assembly.

(Source: P.A. 98-651, eff. 6-16-14.)

(305 ILCS 5/5-30.3 new)

Sec. 5-30.3. Empowering meaningful patient choice in Medicaid Managed Care.

(a) Definitions. As used in this Section:

"Client enrollment services broker" means a vendor the Department contracts with to carry out activities related to Medicaid recipients' enrollment, disenrollment, and renewal with Medicaid Managed Care Entities.

"Clinical interest" includes, but is not limited to, experience working with specific patient populations such as people living with HIV/AIDS, people experiencing homelessness, people who identify as LGBTQ, and adolescents.

"Composite domains" means the synthesized categories

reflecting the standardized quality performance measures included in the print and online version of the consumer quality comparison tool. At a minimum, these composite domains shall display Medicaid Managed Care Entities' individual Plan performance on standardized quality, timeliness, and access measures.

"Consumer quality comparison tool" means an online and paper tool developed by the Department with input from interested stakeholders reflecting the performance of Medicaid Managed Care Entity Plans on standardized quality performance measures. This tool shall be designed in a consumer-friendly and easily understandable format.

"Covered services" means those health care services to which a covered person is entitled to under the terms of the Medicaid Managed Care Entity Plan.

"Electronic composite provider directory" means the searchable provider directory tool that displays provider directory information from each Medicaid Managed Care Entity and is available through the client enrollment services broker.

"Facility type" includes, but is not limited to, federally qualified health centers, skilled nursing facilities, and rehabilitation centers.

"Hospital type" includes, but is not limited to, acute care, rehabilitation, children's, and cancer hospitals.

"Medicaid eligibility redetermination" means the process by which the eligibility of a Medicaid recipient is reviewed by

the Department to determine if the recipient's medical benefits will continue, be modified, or terminated.

"Medicaid Managed Care Entity" has the same meaning as defined in Section 5-30.2 of this Code.

(b) Provider directory transparency.

(1) Each Medicaid Managed Care Entity shall:

(A) Make available on the entity's website a provider directory in a machine readable file and format.

(B) Make provider directories publicly accessible without the necessity of providing a password, a username, or personally identifiable information.

(C) Make available through an electronic provider directory, for each Medicaid Managed Care Entity Plan, the following information in an easily understandable and searchable format:

(i) For health care professionals, including dental and vision care providers:

(I) the provider's name;

(II) the street address for each office the provider operates, including each offices' zip code and county location;

(III) the telephone number for each office the provider operates;

(IV) whether the provider serves as a primary care provider;

(V) the provider's specialty and clinical interest if applicable;

(VI) the provider's medical group affiliation, if applicable;

(VII) the provider's facility affiliations, if applicable;

(VIII) languages spoken, other than English, by the clinical staff, if applicable;

(IX) whether the provider is accepting new patients;

(X) the hours of operation for each office the provider operates;

(XI) whether each office or facility the provider operates is accessible for people with physical disabilities, including offices, exam rooms, and equipment; and

(XII) the provider's gender.

(ii) For hospitals:

(I) the hospital's name and the name of each hospital affiliate, if applicable;

(II) the street address of the hospital and all hospital affiliates, including zip codes and county locations;

(III) the hospital type;

(IV) the hours of operation for the hospital and each hospital affiliate;

(V) the types of services performed by the hospital and each hospital affiliate; and

(VI) the accreditation status of the hospital and each hospital affiliate.

(iii) For facilities other than hospitals:

(I) the facility's name;

(II) the street address for the facility and for each affiliate of the facility, including zip codes and county locations;

(III) the facility type;

(IV) the hours of operation for the facility and for each affiliate of the facility; and

(V) the types of services performed by the facility and each affiliate of the facility.

(iv) For pharmacies other than hospitals:

(I) the pharmacy's name;

(II) the pharmacy's street address and the street address of each store the pharmacy operates, including zip codes and county locations; and

(III) the pharmacy's hours of operation.

(v) For durable medical equipment suppliers other than hospitals:

(I) the durable medical equipment supplier's name;

(II) the supplier's street address or street addresses if the supplier operates more than one business, including zip codes and county locations;

(III) categories of supplies offered; and

(IV) the supplier's hours of operation.

(D) Make available, for the electronic provider directory of each Medicaid Managed Care Entity Plan, the following information in addition to all of the information under subparagraph (C):

(i) For health care professionals: types of services performed; whether the provider is accepting children, adults, or both; board certification, if applicable; and website URL, if applicable.

(ii) For hospitals: telephone number and website URL.

(iii) For facilities other than hospitals: telephone number and website URL.

(iv) For pharmacies: telephone number and, if applicable, website URL.

(v) For durable medical equipment suppliers, other than hospitals: telephone number and, if applicable, website URL.

(vi) For non-emergency medical transportation: provider contact information, including telephone

number, hours of operation, areas served, and, if applicable, website URL.

(E) Make the following provider directory information for the applicable Medicaid Managed Care Entity Plan available in print upon request in an easily understandable format:

(i) For health care professionals:

(I) the health care professional's name;

(II) the street address for each office the health care professional operates, including each offices' zip code and county location;

(III) the telephone number for each office the health care professional operates;

(IV) whether the health care professional serves as a primary care provider;

(V) the health care professional's specialty and clinical interest if applicable;

(VI) the health care professional's board certification, if applicable;

(VII) the health care professional's medical group affiliation, if applicable;

(VII) the health care professional's facility affiliations, if applicable;

(VIII) languages spoken, other than English, by the clinical staff, if applicable;

(IX) whether the health care professional is accepting new patients;

(X) the health care professional's office hours;

(XI) the health care professional's website URL;

(XII) whether the health care professional's office or facility is accessible for people with physical disabilities, including offices, exam rooms, and equipment; and

(XIII) the health care professional's gender.

(ii) For hospitals:

(I) the hospital's name and the name of each hospital affiliate, if applicable;

(II) the hospital's street address and the street address of each hospital affiliate, including zip codes and county locations;

(III) the hospital's telephone number and website URL;

(IV) the hospital type;

(V) the hospital's hours of operation and the hours of operation of each hospital affiliate;

(VI) the types of services offered at the

hospital and at each hospital affiliate; and

(VII) the accreditation status of the hospital and each hospital affiliate.

(iii) For facilities other than hospitals:

(I) the facility's name;

(II) the street address for the facility and for each affiliate of the facility, including zip codes and county locations;

(III) the facility's telephone number and website URL;

(IV) the facility type;

(V) the facility's hours of operation; and

(VI) the types of services performed by the facility and each affiliate of the facility, if applicable.

(iv) For pharmacies other than hospitals:

(I) the pharmacy's name;

(II) the pharmacy's street address and the address of each store the pharmacy operates, including zip codes and county locations;

(III) the pharmacy's telephone number and, if applicable, website URL; and

(IV) the pharmacy's hours of operation.

(v) For durable medical equipment suppliers other than hospitals:

(I) the durable medical equipment

supplier's name;

(II) the supplier's street address or street addresses if the supplier operates more than one business, including zip codes and county locations;

(III) the supplier's telephone numbers and, if applicable, website URL;

(IV) categories of supplies offered; and

(V) the supplier's hours of operation.

(vii) For non-emergency medical transportation providers:

(I) the provider's name;

(II) the provider's street address or street addresses if the provider operates more than one office, including zip codes and county locations;

(III) the provider's telephone number and, if applicable, website URL;

(IV) areas where services are available; and

(V) the provider's hours of operation.

(F) Include a disclosure in any print version of the provider directory that all information required under subparagraph (E) of paragraph (1) of subsection (b) is accurate as of the date of the directory publication and that up-to-date information can be

obtained by consulting the Medicaid Managed Care Entity's online directory or by telephone. The Medicaid Managed Care Entity shall include the appropriate website URL and telephone number as part of the disclosure.

(G) Ensure that all information included in a print version of the provider directory is updated at least monthly and that the electronic provider directory is updated no later than 3 business days after the Medicaid Managed Care Entity receives updated provider information.

(H) Confirm with the Medicaid Managed Care Entity's contracted providers who have not submitted claims within the past 6 months that the contracted providers intend to remain in the network and correct any incorrect provider directory information as necessary.

(I) Ensure that in situations in which a Medicaid Managed Care Entity Plan enrollee receives covered services from a non-participating provider due to a material misrepresentation in a Medicaid Managed Care Entity's provider directory, the Medicaid Managed Care Entity Plan enrollee shall not be held responsible for any costs resulting from that material misrepresentation.

(J) Conspicuously display an e-mail address and a

toll-free telephone number to which any individual may report any inaccuracy in the respective print and electronic versions of the provider directory. If the Medicaid Managed Care Entity receives a report from any person who specifically identifies provider directory information as inaccurate, the Medicaid Managed Care Entity shall investigate the report and correct any inaccurate information displayed in the electronic directory, as necessary, no later than the third business day after the date the report is received.

(K) Make electronic and print provider directories available in English, Spanish, and other prevalent languages spoken by a significant number or percentage of Medicaid enrollees within each Medicaid Managed Care Entity's service areas.

(2) The Department shall:

(A) Regularly monitor Medicaid Managed Care Entities to ensure that they are compliant with the requirements under paragraph (1) of subsection (b). Medicaid Managed Care Entities found materially non-compliant with the requirements under paragraph (1) of subsection (b) may be subject to sanctions imposed by the Department, including, but not limited to: (i) a suspension of the enrollment of potential enrollees with the Medicaid Managed Care Entity; (ii) a financial withhold of pay-for-performance funds; (iii)

a withhold of some or all of the monthly capitation payments; or (iv) any other penalties or sanctions allowed by State or federal law.

(B) Require that the information specified in subparagraphs (B) through (D) of paragraph (1) of subsection (b) for each Medicaid Managed Care Entity shall also be made available and searchable through the electronic composite provider directory tool on the client enrollment services broker's website.

(C) Require the client enrollment services broker to conspicuously display near the electronic composite provider directory tool an e-mail address and a toll-free telephone number to which any individual may report inaccuracies in the directory tool. If the client enrollment services broker receives a report that identifies an inaccuracy in the electronic composite provider directory tool, the client enrollment services broker shall report the complaint about the inaccuracy to the appropriate Medicaid Managed Care Entity within 3 business days after the report is received. The Medicaid Managed Care Entity shall investigate the information and, within 3 business days, provide the client enrollment services broker updated information in order for the client enrollment services broker to correct the electronic composite provider directory. The Medicaid Managed

Care Entity Plan shall, within 3 business days, also update its provider directory tool based on this corrected information.

(c) Formulary transparency.

(1) Medicaid Managed Care Entities shall publish on their respective websites a formulary for each Medicaid Managed Care Entity Plan offered and make the formularies easily understandable and publicly accessible without the necessity of providing a password, a username, or personally identifiable information.

(2) Medicaid Managed Care Entities shall provide printed formularies upon request.

(3) Electronic and print formularies shall display:

(A) the medications covered (both generic and name brand);

(B) if the medication is preferred or not preferred, and what each term means;

(C) what tier each medication is in and the meaning of each tier;

(D) any utilization controls including, but not limited to, step therapy, prior approval, dosage limits, gender or age restrictions, quantity limits, or other policies that affect access to medications;

(E) any required cost-sharing;

(F) a glossary of key terms and explanation of utilization controls and cost-sharing requirements;

(G) a key or legend for all utilization controls visible on every page in which specific medication coverage information is displayed; and

(H) directions explaining the process or processes a consumer may follow to obtain more information if a medication the consumer requires is not covered or listed in the formulary.

(4) Each Medicaid Managed Care Entity shall display conspicuously with each electronic and printed medication formulary an e-mail address and a toll-free telephone number to which any individual may report any inaccuracy in the formulary. If the Medicaid Managed Care Entity receives a report that the formulary information is inaccurate, the Medicaid Managed Care Entity shall investigate the report and correct any incorrect information, as necessary, no later than the third business day after the date the report is received.

(5) Each Medicaid Managed Care Entity shall update electronic formularies within 3 business days of any formulary change and update, at least monthly, printed formularies. The Medicaid Managed Care Entity shall include a disclosure in the electronic and print formularies that provides the date of publication, a statement that the formulary is up to date as of publication, and contact information for questions and requests to receive updated information.

(6) Medicaid Managed Care Entities shall make their electronic and print formularies available in English, Spanish, and other prevalent languages spoken by a significant number or percentage of Medicaid enrollees within each Medicaid Managed Care Entity's service areas.

(7) Medicaid Managed Care Entities found materially non-complaint with the requirements under paragraphs (1) through (6) may be subject to sanctions imposed by the Department, including, but not limited to: (i) a suspension of the enrollment of potential enrollees with the Medicaid Managed Care Entity; (ii) a financial withhold of pay-for-performance funds; (iii) a withhold of some or all of the monthly capitation payments; or (iv) any other penalties or sanctions allowed by State or federal law.

(8) The client enrollment services broker's website shall display prominently a website URL link to each Medicaid Managed Care Entity's Plan formulary.

(d) Grievances and appeals.

(1) The Department shall require the client enrollment services broker to display prominently on the client enrollment services broker's website an explanation of the circumstances and processes for a Medicaid enrollee to file a complaint or grievance and of the enrollee's right to appeal and request a fair hearing for any adverse action by the Department or the Medicaid Managed Care Entity. This information shall also be made available to Medicaid

enrollees whenever an enrollee uses the client enrollment services broker's toll-free telephone number regarding an adverse action taken by the Department or the Medicaid Managed Care Entity or regarding another complaint or concern. This information shall include, but shall not be limited to, explanations about procedures and timeframes describing how an enrollee may pursue his or her rights under the law and how he or she can access free legal assistance or other assistance made available by the State for Medicaid enrollees to pursue an action. The information required under this subsection shall also be made available to Medicaid enrollees upon request through the client enrollment services broker's toll-free telephone number.

(2) The Department shall require the client enrollment services broker to display prominently on the client enrollment services broker's website the information required under paragraph (1) in English, Spanish, and other prevalent languages spoken by a significant number or percentage of Medicaid enrollees in Illinois.

(e) Medicaid redetermination information.

(1) The client enrollment services broker shall display prominently on its website, in an easily understandable format, consumer-oriented information regarding the Medicaid eligibility redetermination process. Such information shall include, but shall not be limited to:

(A) the role of the Medicaid eligibility redetermination process and how it differs from the Medicaid Managed Care enrollment and renewal process;

(B) how the Department will inform Medicaid enrollees when their Medicaid eligibility is under redetermination review;

(C) a basic description of Medicaid enrollee obligations under the Medicaid eligibility redetermination process, including examples of documentation that may be required by the Medicaid enrollee to submit during the Medicaid eligibility redetermination process; and

(D) appropriate resources to find additional information on the Medicaid eligibility redetermination process.

(2) The Department shall require the client enrollment services broker to display prominently on the client enrollment services broker's website the information required under paragraph (1) in English, Spanish, and other prevalent languages spoken by a significant number or percentage of Medicaid enrollees in Illinois.

(f) Medicaid care coordination information.

(1) The client enrollment services broker shall display prominently on its website, in an easily understandable format, consumer-oriented information regarding the role of care coordination services within

Medicaid Managed Care. Such information shall include, but shall not be limited to:

(A) a basic description of the role of care coordination services and examples of specific care coordination activities; and

(B) how a Medicaid enrollee may request care coordination services from a Medicaid Managed Care Entity.

(2) The Department shall require the client enrollment services broker to display prominently on the client enrollment services broker's website the information required under paragraph (1) in English, Spanish, and other prevalent languages spoken by a significant number or percentage of Medicaid enrollees in Illinois.

(q) Consumer quality comparison tool.

(1) The Department shall create a consumer quality comparison tool to assist Medicaid enrollees with Medicaid Managed Care Entity Plan selection. This tool shall provide Medicaid Managed Care Entities' individual Plan performance on a set of standardized quality performance measures. The Department shall ensure that this tool shall be accessible in both a print and online format, with the online format allowing for individuals to access additional detailed Plan performance information.

(2) At a minimum, the print version of the consumer quality comparison tool shall be provided by the Department

on an annual basis to Medicaid enrollees who are required by the Department to enroll in a Medicaid Managed Care Entity Plan during an enrollee's open enrollment period. The print version of the consumer quality comparison tool shall also meet all of the following criteria:

(A) Display Medicaid Managed Care Entities' individual Plan performance on at least 4 composite domains that reflect Plan quality, timeliness, and access. The composite domains shall draw from the most current available performance data sets including, but not limited to:

(i) Healthcare Effectiveness Data and Information Set (HEDIS) measures.

(ii) Core Set of Children's Health Care Quality measures as required under the Children's Health Insurance Program Reauthorization Act (CHIPRA).

(iii) Adult Core Set measures.

(iv) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results.

(v) Additional performance measures the Department deems appropriate to populate the composite domains.

(B) Use a 5-star rating system developed by the Department to reflect Medicaid Managed Care Entities' individual Plan performance. The quantity of stars for

each composite domain shall reflect the Medicaid Managed Care Entities' individual Plan performance compared to national benchmark performance averages when national benchmarks are available.

(C) Be customized to reflect the specific Medicaid Managed Care Entities' Plans available to the Medicaid enrollee based on his or her geographic location and Medicaid eligibility category.

(D) Include contact information for the client enrollment services broker and contact information for Medicaid Managed Care Entities available to the Medicaid enrollee based on his or her geographic location and Medicaid eligibility category.

(E) Include guiding questions designed to assist individuals selecting a Medicaid Managed Care Entity Plan.

(F) Be made available in English, Spanish, and other prevalent languages spoken by a significant number or percentage of Medicaid enrollees within each Medicaid Managed Care Entity's service areas.

(3) At a minimum, the online version of the consumer quality comparison tool shall meet all of the following criteria:

(A) Display Medicaid Managed Care Entities' individual Plan performance for the same composite domains selected by the Department for the print

version of the consumer quality comparison tool. The Department may display additional composite domains in the online version of the consumer quality comparison tool as appropriate.

(B) Display Medicaid Managed Care Entities' individual Plan performance on each of the standardized performance measures that contribute to each composite domain displayed on the online version of the consumer quality comparison tool.

(C) Use a 5-star rating system developed by the Department to reflect Medicaid Managed Care Entities' individual Plan performance. The quantity of stars for each composite domain shall reflect the Medicaid Managed Care Entities' individual Plan performance compared to national benchmark performance averages when national benchmarks are available.

(D) Include a sort function to reflect the specific Medicaid Managed Care Entity Plans available to the Medicaid enrollee based on his or her geographic location and Medicaid eligibility category.

(E) Include a sort function to view Medicaid Managed Care Entities' individual Plan performance by star rating and by standardized quality performance measures.

(F) Include contact information for the client enrollment services broker and for each Medicaid

Managed Care Entity.

(G) Include guiding questions designed to assist individuals in selecting a Medicaid Managed Care Entity Plan.

(H) Prominently display current notice of sanctions against Medicaid Managed Care Entities. Notice of the sanctions shall remain present on the online version of the consumer quality comparison tool until the sanctions are lifted.

(I) Be made available in English, Spanish, and other prevalent languages spoken by a significant number or percentage of Medicaid enrollees within each of the Medicaid Managed Care Entity's service areas.

(4) The online version of the consumer quality comparison tool shall be displayed prominently on the client enrollment services broker's website.

(5) In the development of the consumer quality comparison tool, the Department shall establish and publicize a formal process to collect and consider written and oral feedback from consumers, advocates, and stakeholders on aspects of the consumer quality comparison tool, including, but not limited to, the following:

(A) The standardized data sets and surveys, specific performance measures, and composite domains represented in the print and online versions of the consumer quality comparison tool.

(B) The format and presentation of the consumer quality comparison tool.

(C) The methods undertaken by the Department to notify Medicaid enrollees of the availability of the print and online versions of the consumer quality comparison tool.

(6) The Department shall review and update as appropriate the composite domains and performance measures represented in the print and online versions of the consumer quality comparison tool at least once every 3 years. During the Department's review process, the Department shall solicit engagement in the public feedback process described in paragraph (5).

(7) The Department shall ensure that the consumer quality comparison tool shall be available for consumer use no later than 12 months following the effective date of this amendatory Act of the 99th General Assembly.

(h) The Department may adopt rules and take any other appropriate action necessary to implement its responsibilities under this Section.

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

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Statutes amended in order of appearance