Sen. Daniel Biss

Filed: 5/6/2016

AMENDMENT TO HOUSE BILL 6213

AMENDMENT NO. _____. Amend House Bill 6213 by replacing everything after the enacting clause with the following:

"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.

"Composite domains" means the synthesized categories reflecting the standardized quality performance measures included in 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.

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

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

"Integrated provider directory" means a searchable database bringing together network data from multiple Medicaid Managed Care Entities that is available through client enrollment services.

"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) Comply with all federal and State statutes and regulations, including 42 CFR 438.10, pertaining to provider directories within Medicaid Managed Care.

(D) Request, at least annually, provider office hours for each of the following provider types:

(i) Health care professionals, including dental and vision providers.

(ii) Hospitals.

(iii) Facilities, other than hospitals.

(iv) Pharmacies, other than hospitals.

(v) Durable medical equipment suppliers, other than hospitals.

Medicaid Managed Care Entities shall publish the provider office hours in the provider directory upon receipt.

(E) 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.

(F) 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 online electronic provider directory, the Medicaid Managed Care Entity Plan enrollee shall not be held responsible for any costs resulting from that material misrepresentation.

(G) Conspicuously display an e-mail address and a toll-free telephone number to which any individual may report any inaccuracy in 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.

(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).

(B) Require that the client enrollment services broker use the Medicaid provider number to populate the provider information in the integrated provider directory.

(C) Ensure that each Medicaid Managed Care Entity shall, at minimum, make the information in subparagraph (D) of paragraph (1) of subsection (b) available to the client enrollment services broker.

(D) Ensure that the client enrollment services broker shall, at minimum, have the information in subparagraph (D) of paragraph (1) of subsection (b) available and searchable through the integrated provider directory on its website as soon as possible but no later than January 1, 2017.

(E) Require the client enrollment services broker to conspicuously display near the integrated provider directory an email address and a toll-free telephone number provided by the Department to which any individual may report inaccuracies in the integrated provider directory. If the Department receives a report that identifies an inaccuracy in the integrated provider directory, the Department shall provide the

information about the reported inaccuracy to the appropriate Medicaid Managed Care Entity within 3 business days after the reported inaccuracy is received.

(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 inaccurate information displayed in the electronic formulary.

(5) Each Medicaid Managed Care Entity shall include a disclosure in the electronic and requested 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) The client enrollment services broker's website shall display prominently a website URL link to each Medicaid Managed Care Entity's Plan formulary. If a

Medicaid enrollee calls the client enrollment services broker with questions regarding formularies, the client enrollment services broker shall offer a brief description of what a formulary is and shall refer the Medicaid enrollee to the appropriate Medicaid Managed Care Entity regarding his or her questions about a specific entity's formulary.

(d) Grievances and appeals. The Department shall require the client enrollment services broker to display prominently on the client enrollment services broker's website a description of where a Medicaid enrollee can access information on how to file a complaint or grievance or request a fair hearing for any adverse action taken by the Department or the Medicaid Managed Care Entity.

(e) Medicaid redetermination information. The Department shall require the client enrollment services broker to display prominently on the client enrollment services broker's website a description of where a Medicaid enrollee can access information regarding the Medicaid redetermination process.

(f) Medicaid care coordination information. 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:

(1) a basic description of the role of care

coordination services and examples of specific care coordination activities; and

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

(g) 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, a printed 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 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 quality rating system developed by the Department to reflect Medicaid Managed Care Entities' individual Plan performance. The quality rating system for each composite domain shall reflect the Medicaid Managed Care Entities' individual Plan performance and, when possible, plan performance relative to national Medicaid percentiles.

(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.

(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 in the printed 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 quality rating system developed by the Department to reflect Medicaid Managed Care Entities' individual Plan performance. The quality rating system for each composite domain shall reflect the Medicaid Managed Care Entities' individual Plan performance

and, when possible, plan performance relative to national Medicaid percentiles.

(D) Include 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 quality 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 quality performance 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.

(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 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 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 is available for consumer use as soon as possible but no later than January 1, 2018.

(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.".