Rep. Gregory Harris

Filed: 2/26/2018

AMENDMENT TO SENATE BILL 1573

AMENDMENT NO. _____. Amend Senate Bill 1573, AS AMENDED, by replacing everything after the enacting clause with the following:

"Section 5. The Illinois Procurement Code is amended by changing Section 1-10 as follows:

(30 ILCS 500/1-10)

Sec. 1-10. Application.

(a) This Code applies only to procurements for which bidders, offerors, potential contractors, or contractors were first solicited on or after July 1, 1998. This Code shall not be construed to affect or impair any contract, or any provision of a contract, entered into based on a solicitation prior to the implementation date of this Code as described in Article 99, including but not limited to any covenant entered into with respect to any revenue bonds or similar instruments. All

procurements for which contracts are solicited between the effective date of Articles 50 and 99 and July 1, 1998 shall be substantially in accordance with this Code and its intent.

(b) This Code shall apply regardless of the source of the funds with which the contracts are paid, including federal assistance moneys. This ~~Except as specifically provided in this Code, this~~ Code shall not apply to:

(1) Contracts between the State and its political subdivisions or other governments, or between State governmental bodies, except as specifically provided in this Code.

(2) Grants, except for the filing requirements of Section 20-80.

(3) Purchase of care, except as provided in Section 5-30.6 of the Illinois Public Aid Code and this Section.

(4) Hiring of an individual as employee and not as an independent contractor, whether pursuant to an employment code or policy or by contract directly with that individual.

(5) Collective bargaining contracts.

(6) Purchase of real estate, except that notice of this type of contract with a value of more than $25,000 must be published in the Procurement Bulletin within 10 calendar days after the deed is recorded in the county of jurisdiction. The notice shall identify the real estate purchased, the names of all parties to the contract, the

value of the contract, and the effective date of the contract.

(7) Contracts necessary to prepare for anticipated litigation, enforcement actions, or investigations, provided that the chief legal counsel to the Governor shall give his or her prior approval when the procuring agency is one subject to the jurisdiction of the Governor, and provided that the chief legal counsel of any other procuring entity subject to this Code shall give his or her prior approval when the procuring entity is not one subject to the jurisdiction of the Governor.

(8) (Blank).

(9) Procurement expenditures by the Illinois Conservation Foundation when only private funds are used.

(10) (Blank).

(11) Public-private agreements entered into according to the procurement requirements of Section 20 of the Public-Private Partnerships for Transportation Act and design-build agreements entered into according to the procurement requirements of Section 25 of the Public-Private Partnerships for Transportation Act.

(12) Contracts for legal, financial, and other professional and artistic services entered into on or before December 31, 2018 by the Illinois Finance Authority in which the State of Illinois is not obligated. Such contracts shall be awarded through a competitive process

authorized by the Board of the Illinois Finance Authority and are subject to Sections 5-30, 20-160, 50-13, 50-20, 50-35, and 50-37 of this Code, as well as the final approval by the Board of the Illinois Finance Authority of the terms of the contract.

(13) Contracts for services, commodities, and equipment to support the delivery of timely forensic science services in consultation with and subject to the approval of the Chief Procurement Officer as provided in subsection (d) of Section 5-4-3a of the Unified Code of Corrections, except for the requirements of Sections 20-60, 20-65, 20-70, and 20-160 and Article 50 of this Code; however, the Chief Procurement Officer may, in writing with justification, waive any certification required under Article 50 of this Code. For any contracts for services which are currently provided by members of a collective bargaining agreement, the applicable terms of the collective bargaining agreement concerning subcontracting shall be followed.

On and after January 1, 2019, this paragraph (13), except for this sentence, is inoperative.

(14) Contracts for participation expenditures required by a domestic or international trade show or exhibition of an exhibitor, member, or sponsor.

(15) Contracts with a railroad or utility that requires the State to reimburse the railroad or utilities for the

relocation of utilities for construction or other public purpose. Contracts included within this paragraph (15) shall include, but not be limited to, those associated with: relocations, crossings, installations, and maintenance. For the purposes of this paragraph (15), "railroad" means any form of non-highway ground transportation that runs on rails or electromagnetic guideways and "utility" means: (1) public utilities as defined in Section 3-105 of the Public Utilities Act, (2) telecommunications carriers as defined in Section 13-202 of the Public Utilities Act, (3) electric cooperatives as defined in Section 3.4 of the Electric Supplier Act, (4) telephone or telecommunications cooperatives as defined in Section 13-212 of the Public Utilities Act, (5) rural water or waste water systems with 10,000 connections or less, (6) a holder as defined in Section 21-201 of the Public Utilities Act, and (7) municipalities owning or operating utility systems consisting of public utilities as that term is defined in Section 11-117-2 of the Illinois Municipal Code.

Notwithstanding any other provision of law, for contracts entered into on or after October 1, 2017 under an exemption provided in any paragraph of this subsection (b), except paragraph (1), (2), or (5), each State agency shall post to the appropriate procurement bulletin the name of the contractor, a description of the supply or service provided, the total amount

of the contract, the term of the contract, and the exception to the Code utilized. The chief procurement officer shall submit a report to the Governor and General Assembly no later than November 1 of each year that shall include, at a minimum, an annual summary of the monthly information reported to the chief procurement officer.

(c) This Code does not apply to the electric power procurement process provided for under Section 1-75 of the Illinois Power Agency Act and Section 16-111.5 of the Public Utilities Act.

(d) Except for Section 20-160 and Article 50 of this Code, and as expressly required by Section 9.1 of the Illinois Lottery Law, the provisions of this Code do not apply to the procurement process provided for under Section 9.1 of the Illinois Lottery Law.

(e) This Code does not apply to the process used by the Capital Development Board to retain a person or entity to assist the Capital Development Board with its duties related to the determination of costs of a clean coal SNG brownfield facility, as defined by Section 1-10 of the Illinois Power Agency Act, as required in subsection (h-3) of Section 9-220 of the Public Utilities Act, including calculating the range of capital costs, the range of operating and maintenance costs, or the sequestration costs or monitoring the construction of clean coal SNG brownfield facility for the full duration of construction.

(f) (Blank).

(g) (Blank).

(h) This Code does not apply to the process to procure or contracts entered into in accordance with Sections 11-5.2 and 11-5.3 of the Illinois Public Aid Code.

(i) Each chief procurement officer may access records necessary to review whether a contract, purchase, or other expenditure is or is not subject to the provisions of this Code, unless such records would be subject to attorney-client privilege.

(j) This Code does not apply to the process used by the Capital Development Board to retain an artist or work or works of art as required in Section 14 of the Capital Development Board Act.

(k) This Code does not apply to the process to procure contracts, or contracts entered into, by the State Board of Elections or the State Electoral Board for hearing officers appointed pursuant to the Election Code.

(l) This Code does not apply to the processes used by the Illinois Student Assistance Commission to procure supplies and services paid for from the private funds of the Illinois Prepaid Tuition Fund. As used in this subsection (l), "private funds" means funds derived from deposits paid into the Illinois Prepaid Tuition Trust Fund and the earnings thereon.

(Source: P.A. 99-801, eff. 1-1-17; 100-43, eff. 8-9-17.)

Section 10. The Illinois Insurance Code is amended by changing Section 35A-10 as follows:

(215 ILCS 5/35A-10)

Sec. 35A-10. RBC Reports.

(a) On or before each March 1 (the "filing date"), every domestic insurer shall prepare and submit to the Director a report of its RBC levels as of the end of the previous calendar year in the form and containing the information required by the RBC Instructions. Every domestic insurer shall also file its RBC Report with the NAIC in accordance with the RBC Instructions. In addition, if requested in writing by the chief insurance regulatory official of any state in which it is authorized to do business, every domestic insurer shall file its RBC Report with that official no later than the later of 15 days after the insurer receives the written request or the filing date.

(b) A life, health, or life and health insurer's or fraternal benefit society's RBC shall be determined under the formula set forth in the RBC Instructions. The formula shall take into account (and may adjust for the covariance between):

(1) the risk with respect to the insurer's assets;

(2) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(3) the interest rate risk with respect to the insurer's business; and

(4) all other business risks and other relevant risks set forth in the RBC Instructions.

These risks shall be determined in each case by applying the factors in the manner set forth in the RBC Instructions. Notwithstanding the foregoing, and notwithstanding the RBC Instructions, health maintenance organizations operating as Medicaid managed care plans under contract with the Department of Healthcare and Family Services shall not be required to include in its RBC calculations any capitation revenue identified by Medicaid managed care plans as authorized under Section 5A-12.6(r) of the Illinois Public Aid Code.

(c) A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC Instructions. The formula shall take into account (and may adjust for the covariance between):

(1) asset risk;

(2) credit risk;

(3) underwriting risk; and

(4) all other business risks and other relevant risks set forth in the RBC Instructions.

These risks shall be determined in each case by applying the factors in the manner set forth in the RBC Instructions.

(d) A health organization's RBC shall be determined in accordance with the formula set forth in the RBC Instructions. The formula shall take the following into account (and may adjust for the covariance between):

(1) asset risk;

(2) credit risk;

(3) underwriting risk; and

(4) all other business risks and other relevant risks set forth in the RBC Instructions.

These risks shall be determined in each case by applying the factors in the manner set forth in the RBC Instructions.

(e) An excess of capital over the amount produced by the risk-based capital requirements contained in this Code and the formulas, schedules, and instructions referenced in this Code is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by this Code. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in this Code.

(f) If a domestic insurer files an RBC Report that, in the judgment of the Director, is inaccurate, the Director shall adjust the RBC Report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment.

(Source: P.A. 98-157, eff. 8-2-13.)

Section 15. The Illinois Public Aid Code is amended by changing Sections 5-5.02, 5-30.1, and 5A-15 and by adding

Sections 5-30.6 and 5-30.7 as follows:

(305 ILCS 5/5-5.02) (from Ch. 23, par. 5-5.02)

Sec. 5-5.02. Hospital reimbursements.

(a) Reimbursement to Hospitals; July 1, 1992 through September 30, 1992. Notwithstanding any other provisions of this Code or the Illinois Department's Rules promulgated under the Illinois Administrative Procedure Act, reimbursement to hospitals for services provided during the period July 1, 1992 through September 30, 1992, shall be as follows:

(1) For inpatient hospital services rendered, or if applicable, for inpatient hospital discharges occurring, on or after July 1, 1992 and on or before September 30, 1992, the Illinois Department shall reimburse hospitals for inpatient services under the reimbursement methodologies in effect for each hospital, and at the inpatient payment rate calculated for each hospital, as of June 30, 1992. For purposes of this paragraph, "reimbursement methodologies" means all reimbursement methodologies that pertain to the provision of inpatient hospital services, including, but not limited to, any adjustments for disproportionate share, targeted access, critical care access and uncompensated care, as defined by the Illinois Department on June 30, 1992.

(2) For the purpose of calculating the inpatient payment rate for each hospital eligible to receive

quarterly adjustment payments for targeted access and critical care, as defined by the Illinois Department on June 30, 1992, the adjustment payment for the period July 1, 1992 through September 30, 1992, shall be 25% of the annual adjustment payments calculated for each eligible hospital, as of June 30, 1992. The Illinois Department shall determine by rule the adjustment payments for targeted access and critical care beginning October 1, 1992.

(3) For the purpose of calculating the inpatient payment rate for each hospital eligible to receive quarterly adjustment payments for uncompensated care, as defined by the Illinois Department on June 30, 1992, the adjustment payment for the period August 1, 1992 through September 30, 1992, shall be one-sixth of the total uncompensated care adjustment payments calculated for each eligible hospital for the uncompensated care rate year, as defined by the Illinois Department, ending on July 31, 1992. The Illinois Department shall determine by rule the adjustment payments for uncompensated care beginning October 1, 1992.

(b) Inpatient payments. For inpatient services provided on or after October 1, 1993, in addition to rates paid for hospital inpatient services pursuant to the Illinois Health Finance Reform Act, as now or hereafter amended, or the Illinois Department's prospective reimbursement methodology,

or any other methodology used by the Illinois Department for inpatient services, the Illinois Department shall make adjustment payments, in an amount calculated pursuant to the methodology described in paragraph (c) of this Section, to hospitals that the Illinois Department determines satisfy any one of the following requirements:

(1) Hospitals that are described in Section 1923 of the federal Social Security Act, as now or hereafter amended, except that for rate year 2015 and after a hospital described in Section 1923(b)(1)(B) of the federal Social Security Act and qualified for the payments described in subsection (c) of this Section for rate year 2014 provided the hospital continues to meet the description in Section 1923(b)(1)(B) in the current determination year; or

(2) Illinois hospitals that have a Medicaid inpatient utilization rate which is at least one-half a standard deviation above the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Illinois Department; or

(3) Illinois hospitals that on July 1, 1991 had a Medicaid inpatient utilization rate, as defined in paragraph (h) of this Section, that was at least the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Illinois Department and which were located in a planning area with one-third or fewer excess beds as determined by the Health

Facilities and Services Review Board, and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area; or

(4) Illinois hospitals that:

(A) have a Medicaid inpatient utilization rate that is at least equal to the mean Medicaid inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Department; and

(B) also have a Medicaid obstetrical inpatient utilization rate that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate for all hospitals in Illinois receiving Medicaid payments from the Department for obstetrical services; or

(5) Any children's hospital, which means a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children shall be considered a children's hospital to the degree that the hospital's Medicaid care is provided to children if either (i) the facility devoted exclusively to caring for children is separately licensed as a hospital by a municipality prior to February 28, 2013; ~~or~~ (ii) the hospital has been designated by the State as a Level III perinatal care facility, has a Medicaid Inpatient Utilization rate greater than 55% for the rate year 2003 disproportionate share determination, and has more than

10,000 qualified children days as defined by the Department in rulemaking; (iii) the hospital has been designated as a Perinatal Level III center by the State as of December 1, 2017, is a Pediatric Critical Care Center designated by the State as of December 1, 2017 and has a 2017 Medicaid inpatient utilization rate equal to or greater than 45%; or (iv) the hospital has been designated as a Perinatal Level II center by the State as of December 1, 2017, has a 2017 Medicaid Inpatient Utilization Rate greater than 70%, and has at least 10 pediatric beds as listed on the IDPH 2015 calendar year hospital profile.

(c) Inpatient adjustment payments. The adjustment payments required by paragraph (b) shall be calculated based upon the hospital's Medicaid inpatient utilization rate as follows:

(1) hospitals with a Medicaid inpatient utilization rate below the mean shall receive a per day adjustment payment equal to $25;

(2) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $25 plus $1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate;

(3) hospitals with a Medicaid inpatient utilization

rate that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $40 plus $7 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and

(4) hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a per day adjustment payment equal to the sum of $90 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate.

(d) Supplemental adjustment payments. In addition to the adjustment payments described in paragraph (c), hospitals as defined in clauses (1) through (5) of paragraph (b), excluding county hospitals (as defined in subsection (c) of Section 15-1 of this Code) and a hospital organized under the University of Illinois Hospital Act, shall be paid supplemental inpatient adjustment payments of $60 per day. For purposes of Title XIX of the federal Social Security Act, these supplemental adjustment payments shall not be classified as adjustment payments to disproportionate share hospitals.

(e) The inpatient adjustment payments described in paragraphs (c) and (d) shall be increased on October 1, 1993 and annually thereafter by a percentage equal to the lesser of (i) the increase in the DRI hospital cost index for the most recent 12 month period for which data are available, or (ii) the percentage increase in the statewide average hospital payment rate over the previous year's statewide average hospital payment rate. The sum of the inpatient adjustment payments under paragraphs (c) and (d) to a hospital, other than a county hospital (as defined in subsection (c) of Section 15-1 of this Code) or a hospital organized under the University of Illinois Hospital Act, however, shall not exceed $275 per day; that limit shall be increased on October 1, 1993 and annually thereafter by a percentage equal to the lesser of (i) the increase in the DRI hospital cost index for the most recent 12-month period for which data are available or (ii) the percentage increase in the statewide average hospital payment rate over the previous year's statewide average hospital payment rate.

(f) Children's hospital inpatient adjustment payments. For children's hospitals, as defined in clause (5) of paragraph (b), the adjustment payments required pursuant to paragraphs (c) and (d) shall be multiplied by 2.0.

(g) County hospital inpatient adjustment payments. For county hospitals, as defined in subsection (c) of Section 15-1 of this Code, there shall be an adjustment payment as

determined by rules issued by the Illinois Department.

(h) For the purposes of this Section the following terms shall be defined as follows:

(1) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act, and the denominator of which is the total number of the hospital's inpatient days in that same period.

(2) "Mean Medicaid inpatient utilization rate" means the total number of Medicaid inpatient days provided by all Illinois Medicaid-participating hospitals divided by the total number of inpatient days provided by those same hospitals.

(3) "Medicaid obstetrical inpatient utilization rate" means the ratio of Medicaid obstetrical inpatient days to total Medicaid inpatient days for all Illinois hospitals receiving Medicaid payments from the Illinois Department.

(i) Inpatient adjustment payment limit. In order to meet the limits of Public Law 102-234 and Public Law 103-66, the Illinois Department shall by rule adjust disproportionate share adjustment payments.

(j) University of Illinois Hospital inpatient adjustment payments. For hospitals organized under the University of Illinois Hospital Act, there shall be an adjustment payment as

determined by rules adopted by the Illinois Department.

(k) The Illinois Department may by rule establish criteria for and develop methodologies for adjustment payments to hospitals participating under this Article.

(l) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

(Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13.)

(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 and transparency.

(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.

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

(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.

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

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

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

(A) such medically necessary covered services

shall be considered rendered in good faith;

(B) such policies and procedures shall be developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of provider associations representing the majority of providers within the identified provider industry; and

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

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

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

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

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

(g-6) MCO Performance Metrics Report.

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

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

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

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

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

(q-7) MCO claims processing and performance analysis. In order to monitor MCO payments to hospital providers, pursuant to this amendatory Act of the 100th General Assembly, the Department shall post an analysis of MCO claims processing and payment performance on its website every 6 months. Such analysis shall include a review and evaluation of a representative sample of hospital claims that are rejected and denied for clean and unclean claims and the top 5 reasons for

such actions and timeliness of claims adjudication, which identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims. The Department shall post the contracted claims report required by HealthChoice Illinois on its website every 3 months.

(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 June 16, 2014 (the effective date of Public Act 98-651).

(Source: P.A. 99-725, eff. 8-5-16; 99-751, eff. 8-5-16; 100-201, eff. 8-18-17.)

(305 ILCS 5/5-30.6 new)

Sec. 5-30.6. Managed care organization contracts procurement requirement. Beginning on the effective date of this amendatory Act of the 100th General Assembly, any new contract between the Department and a managed care organization

as defined in Section 5-30.1 shall be procured in accordance with the Illinois Procurement Code.

(a) Application.

(1) This Section does not apply to the State of Illinois Medicaid Managed Care Organization Request for Proposals (2018-24-001) or any agreement, regardless of what it may be called, related to or arising from this procurement, including, but not limited to, contracts, renewals, renegotiated contracts, amendments, and change orders.

(2) This Section does not apply to Medicare-Medicaid Alignment Initiative contracts executed under Article V-F of this Code.

(b) In the event any provision of this Section or of the Illinois Procurement Code is inconsistent with applicable federal law or would have the effect of foreclosing the use, potential use, or receipt of federal financial participation the applicable federal law or funding condition shall prevail, but only to the extent of such inconsistency.

(305 ILCS 5/5-30.7 new)

Sec. 5-30.7. Encounter data guidelines; provider fee schedule.

(a) No later than 60 days after the effective date of this amendatory Act of the 100th General Assembly, the Department shall publish on its website comprehensive written guidance on

the submission of encounter data by managed care organizations. This information shall be updated and published as needed, but at least quarterly. The Department shall inform providers and managed care organizations of any updates via provider notices.

(b) The Department shall publish on its website provider fee schedules on both a portable document format (PDF) and EXCEL format. The portable document format shall serve as the ultimate source if there is a discrepancy.

(305 ILCS 5/5A-15)

Sec. 5A-15. Protection of federal revenue.

(a) If the federal Centers for Medicare and Medicaid Services finds that any federal upper payment limit applicable to the payments under this Article is exceeded then:

(1) the payments under this Article that exceed the applicable federal upper payment limit shall be reduced uniformly to the extent necessary to comply with the applicable federal upper payment limit; and

(2) any assessment rate imposed under this Article shall be reduced such that the aggregate assessment is reduced by the same percentage reduction applied in paragraph (1); and

(3) any transfers from the Hospital Provider Fund under Section 5A-8 shall be reduced by the same percentage reduction applied in paragraph (1).

(b) Any payment reductions made under the authority granted

in this Section are exempt from the requirements and actions under Section 5A-10.

(c) If any payments made as a result of the requirements of this Article are subject to a disallowance, deferral, or adjustment of federal matching funds then:

(1) the Department shall recoup the payments related to those federal matching funds paid by the Department from the parties paid by the Department;

(2) if the payments that are subject to a disallowance, deferral, or adjustment of federal matching funds were made to MCOs, the Department shall recoup the payments related to the disallowance, deferral, or adjustment from the MCOs no sooner than the Department is required to remit federal matching funds to the Centers for Medicare and Medicaid Services or any other federal agency, and hospitals that received payments from the MCOs that were made with such disallowed, deferred, or adjusted federal matching funds must return those payments to the MCOs at least 10 business days before the MCOs are required to remit such payments to the Department; and

(3) any assessment paid to the Department by hospitals under this Article that is attributable to the payments that are subject to a disallowance, deferral, or adjustment of federal matching funds, shall be refunded to the hospitals by the Department.

If an MCO is unable to recoup funds from a hospital for any

reason, then the Department, upon written notice from an MCO, shall work in good faith with the MCO to mitigate losses associated with the lack of recoupment. Losses by an MCO shall not exceed 1% of the total payments distributed by the MCO to hospitals pursuant to the Hospital Assessment Program.

(Source: P.A. 97-688, eff. 6-14-12; 97-689, eff. 6-14-12.)

Section 99. Effective date. This Act takes effect upon becoming law, but this Act does not take effect at all unless Senate Bill 1773 of the 100th General Assembly, as amended, becomes law.".