



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.

LRB099 19222 KTG 45140 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

1 AN ACT concerning public aid.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 5. The Illinois Public Aid Code is amended by
5 changing Section 5-30.1 and by adding Section 5-30.3 as
6 follows:

7 (305 ILCS 5/5-30.1)

8 Sec. 5-30.1. Managed care protections.

9 (a) As used in this Section:

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

13 "Emergency services" include:

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

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

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

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

1 Act.

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

5 (c) An MCO shall pay any provider of emergency services
6 that does not have in effect a contract with the contracted
7 Medicaid MCO. The default rate of reimbursement shall be the
8 rate paid under Illinois Medicaid fee-for-service program
9 methodology, including all policy adjusters, including but not
10 limited to Medicaid High Volume Adjustments, Medicaid
11 Percentage Adjustments, Outpatient High Volume Adjustments,
12 and all outlier add-on adjustments to the extent such
13 adjustments are incorporated in the development of the
14 applicable MCO capitated rates.

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

17 (1) the MCO authorized such services;

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

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

24 (4) the MCO could not be contacted; or

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

1 agreement concerning the enrollee's care and an affiliated
2 provider was unavailable for a consultation, in which case
3 the MCO must pay for such services rendered by the treating
4 non-affiliated provider until an affiliated provider was
5 reached and either concurred with the treating
6 non-affiliated provider's plan of care or assumed
7 responsibility for the enrollee's care. Such payment shall
8 be made at the default rate of reimbursement paid under
9 Illinois Medicaid fee-for-service program methodology,
10 including all policy adjusters, including but not limited
11 to Medicaid High Volume Adjustments, Medicaid Percentage
12 Adjustments, Outpatient High Volume Adjustments and all
13 outlier add-on adjustments to the extent that such
14 adjustments are incorporated in the development of the
15 applicable MCO capitated rates.

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

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

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

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

1 covered services under the contract.

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

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

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

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

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

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

24 (D) the enrollee is discharged.

25 (f) Network adequacy.

26 (1) The Department shall:

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

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

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

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

13 (g) Timely payment of claims.

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

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

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

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

26 (h) The Department shall not expand mandatory MCO

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

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

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

13 (305 ILCS 5/5-30.3 new)

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

16 (a) Definitions. As used in this Section:

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

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

25 "Composite domains" means the synthesized categories

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

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

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

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

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

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

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

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

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

5 (b) Provider directory transparency.

6 (1) Each Medicaid Managed Care Entity shall:

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

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

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

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

19 (I) the provider's name;

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

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

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

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

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

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

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

9 (IX) whether the provider is accepting new
10 patients;

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

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

17 (XII) the provider's gender.

18 (ii) For hospitals:

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

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

24 (III) the hospital type;

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

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

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

5 (iii) For facilities other than hospitals:

6 (I) the facility's name;

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

10 (III) the facility type;

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

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

16 (iv) For pharmacies other than hospitals:

17 (I) the pharmacy's name;

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

22 (III) the pharmacy's hours of operation.

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

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

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

5 (III) categories of supplies offered; and

6 (IV) the supplier's hours of operation.

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

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

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

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

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

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

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

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

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

7 (i) For health care professionals:

8 (I) the health care professional's name;

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

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

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

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

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

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

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

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

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

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

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

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

12 (XIII) the health care professional's
13 gender.

14 (ii) For hospitals:

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

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

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

22 (IV) the hospital type;

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

26 (VI) the types of services offered at the

1 hospital and at each hospital affiliate; and

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

4 (iii) For facilities other than hospitals:

5 (I) the facility's name;

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

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

11 (IV) the facility type;

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

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

16 (iv) For pharmacies other than hospitals:

17 (I) the pharmacy's name;

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

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

23 (IV) the pharmacy's hours of operation.

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

26 (I) the durable medical equipment

1 supplier's name;
2 (II) the supplier's street address or
3 street addresses if the supplier operates more
4 than one business, including zip codes and
5 county locations;
6 (III) the supplier's telephone numbers
7 and, if applicable, website URL;
8 (IV) categories of supplies offered; and
9 (V) the supplier's hours of operation.
10 (vii) For non-emergency medical transportation
11 providers:
12 (I) the provider's name;
13 (II) the provider's street address or
14 street addresses if the provider operates more
15 than one office, including zip codes and county
16 locations;
17 (III) the provider's telephone number and,
18 if applicable, website URL;
19 (IV) areas where services are available;
20 and
21 (V) the provider's hours of operation.
22 (F) Include a disclosure in any print version of
23 the provider directory that all information required
24 under subparagraph (E) of paragraph (1) of subsection
25 (b) is accurate as of the date of the directory
26 publication and that up-to-date information can be

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

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

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

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

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

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

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

16 (2) The Department shall:

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

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

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

10 (C) Require the client enrollment services broker
11 to conspicuously display near the electronic composite
12 provider directory tool an e-mail address and a
13 toll-free telephone number to which any individual may
14 report inaccuracies in the directory tool. If the
15 client enrollment services broker receives a report
16 that identifies an inaccuracy in the electronic
17 composite provider directory tool, the client
18 enrollment services broker shall report the complaint
19 about the inaccuracy to the appropriate Medicaid
20 Managed Care Entity within 3 business days after the
21 report is received. The Medicaid Managed Care Entity
22 shall investigate the information and, within 3
23 business days, provide the client enrollment services
24 broker updated information in order for the client
25 enrollment services broker to correct the electronic
26 composite provider directory. The Medicaid Managed

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

4 (c) Formulary transparency.

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

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

13 (3) Electronic and print formularies shall display:

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

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

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

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

24 (E) any required cost-sharing;

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

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

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

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

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

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

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

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

18 (d) Grievances and appeals.

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

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

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

20 (e) Medicaid redetermination information.

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

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

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

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

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

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

22 (f) Medicaid care coordination information.

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

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

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

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

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

15 (g) Consumer quality comparison tool.

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

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

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

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

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

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

18 (iii) Adult Core Set measures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Managed Care Entity.

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

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

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

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

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

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

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

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

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

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

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

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

1

INDEX

2

Statutes amended in order of appearance

3

305 ILCS 5/5-30.1

4

305 ILCS 5/5-30.3 new