Rep. Mary E. Flowers

Filed: 2/7/2018

AMENDMENT TO SENATE BILL 1773

AMENDMENT NO. ______. Amend Senate Bill 1773, AS AMENDED, with reference to page and line numbers of House Amendment No. 4 as follows:

on page 152, immediately below line 15, by inserting the following:

"Section 20. The Illinois Public Aid Code is amended by changing the heading of Article V-F and Sections 5F-1, 5F-5, 5F-10, 5F-15, 5F-25, 5F-30, 5F-32, and 5F-33 and by adding Sections 5F-2.5 and 5F-17 as follows:

(305 ILCS 5/Art. V-F heading)

ARTICLE V-F. ~~MEDICARE-MEDICAID ALIGNMENT INITIATIVE (MMAI)~~ NURSING HOME RESIDENTS' MANAGED CARE RIGHTS LAW

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

(305 ILCS 5/5F-1)

Sec. 5F-1. Short title. This Article may be referred to as the ~~Medicare-Medicaid Alignment Initiative (MMAI)~~ Nursing Home Residents' Managed Care Rights Law.

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

(305 ILCS 5/5F-2.5 new)

Sec. 5F-2.5. Declaration. The General Assembly declares it is in the best interest of the citizenry of the State of Illinois for the Department of Healthcare and Family Services to maintain strict oversight of all Medicaid managed care programs covering nursing home residents to ensure that medical care and services are delivered in a manner consistent with the unique needs and circumstances of nursing home residents and that providers are appropriately and promptly paid in full for all services rendered in good faith. Further, the General Assembly expressly prohibits the Department of Healthcare and Family Services from delegating to a third party authority and responsibility for ensuring that provider agreements issued by managed care organizations under contract with the Department are in compliance with all federal and State laws and regulations and the master contract and directs the Department to review all provider agreements and intervene to ensure full compliance.

(305 ILCS 5/5F-5)

Sec. 5F-5. Findings. The General Assembly finds that elderly Illinoisans residing in a nursing home have the right to:

(1) quality health care regardless of the payer;

(2) receive medically necessary care prescribed by their doctors;

(3) a simple appeal process when care is denied; ~~and~~

(4) make decisions about their care and where they receive it; ~~.~~

(5) receive long term services and supports upon achieving a DON score of 29 or higher, without further limitations; and receive medical care, services, and supports in a manner consistent with each individual's level of frailty, mobility, and immediacy of medical condition and consistent with rights and protections contained in State and federal laws and regulations.

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

(305 ILCS 5/5F-10)

Sec. 5F-10. Scope. This Article applies to policies and contracts amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 98th General Assembly for the nursing home component of any Medicaid managed care program established by statute, rule, or contract including, but not limited to, the Medicare-Medicaid Alignment

1 Initiative Program, the Integrated Care Program, the
2 HealthChoices Program, ~~and~~ the Managed Long-Term Services and
3 Support Program, and any and all successor programs. This
4 Article does not diminish a managed care organization's duties
5 and responsibilities under other federal or State laws or rules
6 adopted under those laws and the 3-way Medicare-Medicaid
7 Alignment Initiative contract, the Integrated Care Program
8 contract, the HealthChoices Program contract, ~~and~~ the Managed
9 Long-Term Services and Support Program contract, and
10 contracts, statutes, or rules specific to any and all successor
11 programs.
12 On or after the effective date of this amendatory Act of
13 the 100th General Assembly, the Department shall review the
14 requirements and make all policy changes, adopt administrative
15 rules, modify existing contracts with managed care
16 organizations, and direct the issuance of revised provider
17 agreements necessary to achieve the full implementation of this
18 amendatory Act of the 100th General Assembly.
19 (Source: P.A. 98-651, eff. 6-16-14; 99-719, eff. 1-1-17.)

20 (305 ILCS 5/5F-15)
21 Sec. 5F-15. Definitions. As used in this Article:
22 "Appeal" means any of the procedures that deal with the
23 review of adverse organization determinations on the health
24 care services the enrollee believes he or she is entitled to
25 receive, including delay in providing, arranging for, or

approving the health care services, such that a delay would adversely affect the health of the enrollee or on any amounts the enrollee must pay for a service, as defined under 42 CFR 422.566(b). These procedures include reconsiderations by the managed care organization and, if necessary, an independent review entity as provided by the Health Carrier External Review Act, hearings before administrative law judges, review by the Medicare Appeals Council, and judicial review.

"Demonstration Project" means the nursing home component of the Medicare-Medicaid Alignment Initiative Demonstration Project.

"Department" means the Department of Healthcare and Family Services.

"Enrollee" means an individual who resides in a nursing home or is qualified to be admitted to a nursing home and is enrolled or is a prospective enrollee with a Medicaid managed care organization participating in the Demonstration Project.

"Health care services" means the diagnosis, treatment, and prevention of disease and includes medication, primary care, nursing or medical care, mental health treatment, psychiatric rehabilitation, memory loss services, physical, occupational, and speech rehabilitation, enhanced care, medical supplies and equipment and the repair of such equipment, and assistance with activities of daily living.

"Managed care organization" or "MCO" means an entity that meets the definition of health maintenance organization as

1 defined in the Health Maintenance Organization Act, is
2 licensed, regulated and in good standing with the Department of
3 Insurance, and is authorized to participate in the nursing home
4 component of the Medicare-Medicaid Alignment Initiative
5 Demonstration Project by a 3-way contract with the Department
6 of Healthcare and Family Services and the Centers for Medicare
7 and Medicaid Services or is under contract with the Department
8 to participate in the Integrated Care Program, the Managed
9 Long-Term Services and Support Program, the HealthChoices
10 Program, and any and all successor programs.

11 "Medical professional" means a physician, physician
12 assistant, or nurse practitioner.

13 "Medically necessary" means health care services that a
14 medical professional, exercising prudent clinical judgment,
15 would provide to a patient for the purpose of preventing,
16 evaluating, diagnosing, or treating an illness, injury, or
17 disease or its symptoms, and that are: (i) in accordance with
18 the generally accepted standards of medical practice; (ii)
19 clinically appropriate, in terms of type, frequency, extent,
20 site, and duration, and considered effective for the patient's
21 illness, injury, or disease; and (iii) not primarily for the
22 convenience of the patient, a medical professional, other
23 health care provider, caregiver, family member, or other
24 interested party.

25 "Nursing home" means a facility licensed under the Nursing
26 Home Care Act.

"Nurse practitioner" means an individual properly licensed as a nurse practitioner under the Nurse Practice Act.

"Physician" means an individual licensed to practice in all branches of medicine under the Medical Practice Act of 1987.

"Physician assistant" means an individual properly licensed under the Physician Assistant Practice Act of 1987.

"Resident" means an enrollee who is receiving personal or medical care, including, but not limited to, mental health treatment, psychiatric rehabilitation, physical rehabilitation, and assistance with activities of daily living, from a nursing home.

"RAI Manual" means the most recent Resident Assessment Instrument Manual, published by the Centers for Medicare and Medicaid Services.

"Resident's representative" means a person designated in writing by a resident to be the resident's representative or the resident's guardian, as described by the Nursing Home Care Act.

"SNFist" means a medical professional specializing in the care of individuals residing in nursing homes employed by or under contract with a MCO.

"Transition period" means a period of time immediately following enrollment into a managed care organization the Demonstration Project or an enrollee's movement from one managed care organization to another managed care organization or one care setting to another care setting.

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

(305 ILCS 5/5F-17 new)

Sec. 5F-17. Contracting. All contracts issued by the Department to managed care organizations for Medicaid services provided to nursing home residents shall be solely for services provided to nursing home residents and tailored to meet the unique medical needs and circumstances of nursing home residents and shall be consistent with all federal and State statutes and regulations governing nursing homes and the delivery of care to residents. Contracts governing the delivery of care to nursing home residents shall at a minimum include the following provisions:

(1) 30 minute time and distance standards to primary care physicians and specialists and hospitals regardless of geographic locations;

(2) no longer than 24-hour wait time for physician, laboratory, and medical procedure appointments; and

(3) automatic authorization for custodial care for residents scoring a 29 or higher on the Determination of Need instrument.

(305 ILCS 5/5F-25)

Sec. 5F-25. Care coordination. Care coordination provided to all enrollees ~~in the Demonstration Project~~ shall conform to the following requirements:

(1) care coordination services shall be enrollee-driven and person-centered;

(2) all enrollees ~~in the Demonstration Project~~ shall have the right to receive health care services in the care setting of their choice, except as permitted by Part 4 of Article III of the Nursing Home Care Act with respect to involuntary transfers and discharges; and

(3) decisions shall be based on the enrollee's best interests.

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

(305 ILCS 5/5F-30)

Sec. 5F-30. Continuity of care. When a nursing home resident first transitions to a managed care organization from the fee-for-service system or from another managed care organization, the managed care organization shall honor the existing care plan and any necessary changes to that care plan until the managed care organization ~~MCO~~ has completed a comprehensive assessment and new care plan, to the extent such services are covered benefits ~~under the contract~~, which shall be consistent with the requirements of the RAI Manual.

When an enrollee of a managed care organization is moving from a community setting to a nursing home, and the managed care organization ~~MCO~~ is properly notified of the proposed admission by a network nursing home, and the managed care organization fails to participate in developing a care plan

within the time frames required by nursing home regulations, the managed care organization ~~MCO~~ must honor a care plan developed by the nursing home until the managed care organization ~~MCO~~ has completed a comprehensive assessment and a new care plan to the extent such services are covered benefits ~~under the contract~~, consistent with the requirements of the RAI Manual.

A nursing home shall have the ability to refuse admission of an enrollee for whom care is required that the nursing home determines is outside the scope of its license and healthcare capabilities.

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

(305 ILCS 5/5F-32)

Sec. 5F-32. Non-emergency prior approval and appeal.

(a) Managed care organizations ~~MCOs~~ must have a method of receiving prior approval requests 24 hours a day, 7 days a week, 365 days a year from nursing home residents, physicians, or providers. If a response is not provided within 24 hours of the request and the nursing home is required by regulation to provide a service because a physician ordered it, the managed care organization ~~MCO~~ must pay for the service if it is a covered service under the managed care organization's ~~MCO's~~ contract ~~in the Demonstration Project~~, provided that the request is consistent with the policies and procedures of the managed care organization ~~MCO~~.

In a non-emergency situation, notwithstanding any provisions in State law to the contrary, in the event a resident's physician orders a service, treatment, or test that is not approved by the managed care organization ~~MCO~~, the enrollee, physician, or provider may utilize an expedited appeal to the managed care organization ~~MCO~~.

If an enrollee, physician, or provider requests an expedited appeal pursuant to 42 CFR 438.410, the managed care organization ~~MCO~~ shall notify the individual filing the appeal, whether it is the enrollee, physician, or provider, within 24 hours after the submission of the appeal of all information from the enrollee, physician, or provider that the managed care organization ~~MCO~~ requires to evaluate the appeal. The managed care organization ~~MCO~~ shall notify the individual filing the appeal of the managed care organization's ~~MCO's~~ decision on an expedited appeal within 24 hours after receipt of the required information.

(b) While the appeal is pending or if the ordered service, treatment, or test is denied after appeal, the Department of Public Health may not cite the nursing home for failure to provide the ordered service, treatment, or test. The nursing home shall not be liable or responsible for an injury in any regulatory proceeding for the following:

(1) failure to follow the appealed or denied order; or

(2) injury to the extent it was caused by the delay or failure to perform the appealed or denied service,

1 treatment, or test.
2 Provided however, a nursing home shall continue to monitor,
3 document, and ensure the patient's safety. Nothing in this
4 subsection (b) is intended to otherwise change the nursing
5 home's existing obligations under State and federal law to
6 appropriately care for its residents.
7 (Source: P.A. 98-651, eff. 6-16-14; 99-719, eff. 1-1-17.)

8 (305 ILCS 5/5F-33)
9 Sec. 5F-33. Payment of claims.
10 (a) Clean claims, as defined by the Department by rule,
11 submitted by a provider to a managed care organization in the
12 form and manner requested by the managed care organization
13 shall be reviewed and paid within 30 days of receipt.
14 (b) A managed care organization must provide a status
15 update within 30 ~~60~~ days of the submission of a claim.
16 (c) A claim that is rejected or denied, which shall clearly
17 state the reason for the rejection or denial in sufficient
18 detail to permit the provider to understand the justification
19 for the action.
20 (d) The Department shall work with stakeholders,
21 including, but not limited to, managed care organizations and
22 nursing home providers, to train them on the application of
23 standardized codes for long-term care services.
24 (e) Managed care organizations shall provide a manual
25 clearly explaining billing and claims payment procedures,

1 including points of contact for provider services centers,
2 within 15 days of a provider entering into a contract with a
3 managed care organization. The manual shall include all
4 necessary coding and documentation requirements. Providers
5 under contract with a managed care organization on the
6 effective date of this amendatory Act of the 99th General
7 Assembly shall be provided with an electronic copy of these
8 requirements within 30 days of the effective date of this
9 amendatory Act of the 99th General Assembly. Any changes to
10 these requirements shall be delivered electronically to all
11 providers under contract with the managed care organization 30
12 days prior to the effective date of the change.
13 (Source: P.A. 99-719, eff. 1-1-17.)".