Sen. James F. Clayborne, Jr.

Filed: 3/24/2014

AMENDMENT TO SENATE BILL 3450

AMENDMENT NO. _____. Amend Senate Bill 3450 by replacing everything after the enacting clause with the following:

"Section 1. Short title. This Act may be cited as the Nursing Home Residents' Managed Care Rights Act.

Section 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 doctor;

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

(4) make decisions about their care; and

(5) continue to live in the nursing home they call home.

Section 10. Scope. This Act applies to policies and

contracts amended, delivered, issued, or renewed on or after the effective date of this Act. This Act does not diminish a managed care organization's duties and responsibilities under other federal or State laws or rules adopted under those laws.

Section 15. Definitions.

(a) As used in this Act:

"Advanced practice nurse" means an individual properly licensed as an advanced practice nurse under the Nurse Practice Act.

"Appeal" means any of the procedures that deal with the review of adverse organization determinations on the health care services the enrollee believes he or she is entitled to 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, hearings before administrative law judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

"Authorized medical professional" means a physician, physician assistant, or advanced practice nurse.

"Community" means a geographic area within a 15-mile or 30-minute radius from the enrollee's zip code of residence

prior to becoming a nursing home resident or from the zip code of the enrollee's spouse's residence if the spouse relocated after the enrollee became a nursing home resident.

"Demonstration plan" means a 3-way contract entered into by a managed care organization with the United States Department of Health and Human Services' Centers for Medicare & Medicaid Services and the Department of Healthcare and Family Services to provide health care services, and any chosen flexible benefits, including long-term care and services.

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

"Emergency" or "medical emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

"Enhanced care" means a level of care in excess of traditional long-term care and includes, but is not limited to, ventilator care, traumatic brain injury services, pain management, wound care, bariatric services, and services provided to residents with diagnoses such as serious mental illness or Alzheimer's disease and other dementia-related

diseases.

"Enrollee" means any individual who resides in a nursing home or is qualified to be admitted to a nursing home and is enrolled with a managed care organization participating in one of the demonstration projects.

"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, and assistance with activities of daily living.

"Managed care organization" means an entity that meets the definition of health maintenance organization as defined in the Health Maintenance Organization Act and operates under a 3-way contract that administers a health plan under the Integrated Care Program or the Medicare-Medicaid Alignment Initiative.

"Marketing" means any written or oral communication from a managed care organization or its representative or a third-party broker under contract with the Department that can reasonably be interpreted as intended to influence a resident to enroll, not to enroll, or to disenroll from a health care delivery system.

"Medically necessary" means health care services that an authorized medical professional, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness,

injury, or disease or its symptoms, and that are (i) in accordance with the generally accepted standards of medical practice; (ii) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and (iii) not primarily for the convenience of the patient, an authorized medical professional, or other health care provider. Health care services that are ordered by an authorized medical professional shall be presumed medically necessary absent clear and substantial evidence to the contrary. Managed care organizations are responsible for ensuring the delivery of a all medically necessary services.

"Nursing home" means all facilities licensed under the Nursing Home Care 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 who is living in a nursing home.

"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.

"Single-case resident choice agreement" means an agreement between an out-of-network nursing home and a managed care organization to provide for the provision of long-term care services to an individual enrollee.

"Transition care period" means a period of time within which the enrollee may remain in the nursing home where the enrollee currently resides whether or not the nursing home has a contract with a managed care organization participating in the demonstration project established under Section 20 of this Act or whether or not the nursing home has a contract with the managed care organization in which the resident is enrolled.

Section 20. Authorization.

(a) The Department of Healthcare and Family Services is authorized to establish a managed care demonstration project to test the delivery of long-term care and services to Medicaid beneficiaries using private managed care organizations under a 3-way contract with the Department and the Center for Medicare & Medicaid. Two separate demonstration projects are authorized, with each focused on separate and distinct populations. The Integrated Care Program (ICP) is authorized to serve individuals who qualify for Medicaid-only assistance, and the Medicare-Medicaid Alignment Initiative (MMAI) is authorized to serve individuals who qualify for both Medicaid and Medicare assistance. The ICP program shall sunset on July

1, 2016 and the MMAI program shall sunset on August 1, 2017. Either or both programs may be extended in whole or part, but only after an independent evaluation conducted by a university based in the State of Illinois determines that the plan has not adversely impacted the accessibility, availability, and quality of health care services and medications in nursing home settings in an arbitrary and capricious manner.

(b) Individual counties shall be identified to participate in one or both demonstration projects. Network Adequacy shall include the availability of 2 or more nursing homes in each affected community.

(c) Care coordination services offered by managed care organizations shall be resident-driven and person-centered. All Medicaid beneficiaries shall have the right to receive health care services in the care setting of their choice, to remain in the nursing home they reside in, and to live in their local community. Decision-making standards shall be based on the best interests of the Medicaid beneficiary. Managed care organizations are prohibited from using a cost-based or resource utilization model. Health care services ordered by an authorized medical professional shall be presumed to be medically necessary and subject to payment by the managed care organization.

(d) Employees of the Department, the Department of Insurance, the managed care organizations, and third-party brokers having contact with enrollees shall be culturally

competent and trained in working with the elderly, individuals diagnosed with serious mental illness, and individuals with dementia. Translators shall be made available for individuals for whom English is a second language or individuals who are blind or deaf.

(e) The State of Illinois shall retain the responsibility for oversight and compliance issues, which shall be proactive and ongoing. The State shall establish uniform policy and procedures to increase the effectiveness of the State's compliance monitoring, reduce beneficiary and provider confusion, and increase the quality of health care services provided.

(f) Managed care organizations are required to ensure seamless delivery and payment of health care services as enrollees migrate from managed care organization to managed care organization and from one care setting to another.

(g) Any and all providers willing to accept the terms and conditions offered by the managed care organization shall be offered a contract and shall be allowed to renew the contract at the end of the contract period. No managed care organization shall offer a contract to a provider or group of providers that includes terms and conditions designed to discourage the participation of one or more providers.

(h) All Medicaid beneficiaries receiving long-term care and services shall have available to them the same package of health care services and ancillary services, regardless of

whether they reside in a managed care demonstration county or a fee-for-service county. All providers shall be held to the same standards as set forth in federal and State statutes, rules, and regulations regardless of whether they are located in a managed care demonstration county or a fee-for-service county.

(i) No managed care organization shall penalize a nursing home for advocating on behalf of its residents, including the filing of appeals on behalf of the residents or on behalf of themselves.

(j) Managed care organizations shall be required to pay all providers within 30 days after receipt of a valid invoice for health care services or be subject to penalties. All payments for health care services rendered shall be backed by the full faith and credit of the State.

Section 25. Right to stay in their nursing home and community.

(a) To achieve network adequacy, managed care organizations shall solicit contracts with all nursing homes located in demonstration counties and shall enter into contracts with any nursing home willing to accept the terms and conditions of the managed care organization, provided that the nursing home meets all applicable State and federal requirements for participation in the Medicaid program. No managed care organization shall be determined to achieve adequacy if it does not offer each enrollee at least 2 nursing

homes within a 15-mile or 30-minute radius from an enrollee's zip code of residence within each county of the service area.

(b) Each resident shall be afforded a 180-day transition care period triggered by any one of the following qualifying events:

(1) A resident of a nursing home becomes enrolled with a managed care organization either voluntarily or as assigned by the Department.

(2) The nursing home in which the resident resides is not renewed or terminated or terminates or does not renew its contract with the managed care organization in which the resident is enrolled.

(3) The managed care organization in which the resident is enrolled is not renewed or terminated or terminates or does not renew its contract with the Department.

A resident who in the course of a 180-day transition care period experiences a subsequent qualifying event shall have the transition care period extended by an additional 180 days. During the course of a 180-day transition care period triggered by paragraph (1) or (3) of subsection (b) of this Section, a resident may exercise the right to voluntarily select another managed care organization without effecting the length of the transition care period or the rights guaranteed a resident during or after a transition care period.

(c) A resident described in subsection (b) of this Section shall have 180 days to move to a nursing home under contract

with the managed care organization in which the resident is enrolled or select a managed care organization under contract with the nursing home in which the resident resides. If, by the end of the 180-day transition care period, the nursing home in which the resident resides chooses not to enter into a contract with the managed care organization and the resident does not elect to move to a network nursing home or enroll in managed care organization under contract with the nursing home in which the resident resides, the managed care organization in which the resident is enrolled shall enter into a single-case resident choice agreement with the nursing home in which the resident resides.

(d) An enrollee shall be guaranteed the right to receive health care services in the enrollee's community. A managed care organization unable to offer the enrollee 2 or more nursing home options shall offer the enrollee the opportunity to select an out-of-network nursing home within the enrollee's community. The managed care organization shall enter into a single-case resident choice agreement with the selected nursing home.

(e) An enrollee with an order signed by an authorized medical professional for enhanced care shall be entitled to receive such enhanced care within enrollee's community. If the managed care organization does not have a contract with a nursing home offering the type of enhanced care ordered in the enrollee's community, the enrollee shall be permitted to select

an out-of-network nursing home providing the enhanced care. The managed care organization shall enter into a single-case resident choice agreement with the selected nursing home.

(f) A single-case resident choice agreement shall be subject to the same terms, conditions, and reimbursement of an agreement offered by the managed care organization for participation in demonstration project network. Only those nursing homes meeting all applicable State and federal requirements for participation in the Medicaid and Medicare programs are eligible to enter into a single-case resident choice agreement. The single-case resident choice agreement shall remain in force until the end of the demonstration period or the resident is discharged, which ever is longer. A resident who leaves the facility for a family visit or to receive diagnostic tests or treatment with the intent of returning to the nursing home shall not be deemed to have been discharged.

Section 30. Continuity of care.

(a) Continuity of care provisions shall cover, but need not be limited to, the following circumstances:

(1) Events contained in subsection (b) of Section 25 of this Act.

(2) The resident voluntarily changes managed care organization enrollment.

(3) An enrollee is admitted into a nursing home, regardless of whether the enrollee has been determined to

qualify for Medicaid long-term care assistance prior to admission.

(b) An interdisciplinary transition care team shall be assigned to each enrollee covered by this Section. The following provisions shall apply:

(1) The interdisciplinary transition care team shall develop an individualized continuity of care plan, which shall guide all aspects of the transition to ensure continuity of care.

(2) The requirements of the individualized continuity of care plan shall be established by rule, but shall at a minimum include the following:

(A) All on-going course of treatments and an evaluation of any proposed changes as the result of the transition to another managed care organization or a different care setting.

(B) All enhanced care needs.

(C) A medical evaluation.

(D) A comprehensive medical history completed within 14 calendar days prior to the development of the plan.

(E) A plan for the approval of all health care services required during and immediately following a transition from one care setting to another or from one managed care organization to another.

(3) The interdisciplinary transition care team shall

include the enrollee, the resident representative, if any, a member of the enrollee's family at the enrollee's discretion, at least one nursing home designee of the nursing home's choosing, at least one authorized medical professional with first-hand knowledge of the enrollees physical and behavior medical needs and current course of treatment, and at least one representatives of the managed care organization.

(4) The individualized continuity of care plan shall be signed by all members of the team and presented for approval to the enrollee, the resident representative, if any, and a member of the enrollee's family, at the enrollee's discretion. The enrollee or, in lieu of the enrollee, the resident representative or family member designated by the enrollee to act on the enrollee's behalf, may reject the plan or any portion of the plan. The enrollee or, in lieu of enrollee, the resident representative or a family member designated by the enrollee to act on the enrollee's behalf may appeal the plan in the name of the enrollee. If an appeal is initiated, all provisions of Section 35 shall apply. A plan shall not be agreed upon until the enrollee or, in lieu of the enrollee, the resident representative or a family member designated by the enrollee to act on their behalf has signed off on the plan in its entirety.

(5) Both managed care organizations involved in an

enrollee's transition from one managed care organization to another managed care organization shall share equally in the responsibility to ensure a seamless transition and the continuity of the enrollee's care.

(c) Health care services provided pursuant to a medical order signed by an authorized medical professional during the first 7 days after an enrollee transitions from one managed care organization to another or one care setting to another shall be deemed approved.

(1) The nursing home shall, no later than the first business day after the beginning of such a transition, request post-approval of the health care services specified in the medical order in a form and manner established by rule.

(2) The period of deemed approval shall be extended if at the end of the 7 days the nursing home has not received from the managed care organization an individual transition care plan signed by the enrollee or, in lieu of the enrollee, the resident's representative or a family member designated by the enrollee to act on enrollee's behalf, accompanied by the corresponding medical orders issued by the resident's physician after an in-person examination. All orders for health care services accompanying the individualized transition care plan shall be approved by the managed care organization prior to being conveyed to the nursing home.

(3) The managed care organization shall be responsible for the payment of all health care services provided pursuant to this Section.

Section 35. Appeals and grievances.

(a) The Department of Insurance shall establish by rule an appeal and grievance process that permits an enrollee to simultaneously file an appeal or grievance under Medicare and Medicaid, except Medicare Part D. The process shall at a minimum provide for the following:

(1) submission of appeals orally, in writing, and on the Internet;

(2) notices, timeframes, deadlines, and extensions;

(3) a multi-level appeal process, including recourse to State or federal court, independent review entity hearings before administrative law judges, and the Medicare Appeals Council (MAC); and

(4) an expedited appeal.

(b) If an appeal to the managed care organization is incorporated into the appeal process, the managed care organization shall be limited to 24 hours, or one calendar day, to review and act on the appeal and shall provide access to an appeal process during non-business hours.

(c) Enrollees shall have the right to assign their appeal or grievance rights to nursing homes or other providers.

(d) At a minimum, enrollees and nursing homes shall have

the right to appeal or grieve the following:

(1) coverage determinations, including, but not limited, to emergency care;

(2) determinations of medical necessity;

(3) denials of preauthorization or the appropriate date of preauthorization;

(4) eligibility determinations;

(5) recoupments or offsets of payments; and

(6) timeliness of payments.

(e) The managed care organization shall have the burden of proof in all appeals and grievances and all decisions shall be made based on the best interest of the enrollee.

(f) For all appeals or grievances involving medical necessity, health care services that are ordered by an authorized medical professional shall be presumed medically necessary absent clear and substantial evidence to the contrary. The managed care organization shall be responsible for compensating the nursing home for all such health care services consistent with Section 60 of this Act.

(g) Nothing shall limit an enrollee's right to seek relief by appealing or grieving directly to the Director of Insurance or directly through a court of jurisdiction at any time during the appeal process.

(h) The managed care organization shall be liable for all costs associated with an appeal or grievance upon a finding in favor of the plaintiff.

Section 40. Marketing.

(a) Managed care marketing practices shall comply with all State and federal laws. Any additional rights and responsibilities created pursuant to this Section are in addition to those created by other State and federal laws. In the event of a conflict with another State law, provisions of this Act shall govern.

(b) All marketing materials shall be approved in advance by the Director of Insurance, including, but not limited to, all written materials, promotional videos, websites, and scripts.

(c) All marketing to nursing home residents shall involve a third-party broker under contract with the Department, which shall be required to comply with standards established by rule. These standards shall, at a minimum, include the following:

(1) All solicitations shall be conducted based on the best interests of the resident.

(2) All solicitations shall be face-to-face and shall involve the resident, the resident's representative, where applicable, and a member of the resident's family, at the resident's discretion.

(3) Every nursing home resident residing in a demonstration county shall receive at least one face-to-face visit by the third-party broker at least 30 days prior to the Department selecting a plan on behalf of the resident.

(4) Brokers shall notify the nursing home in advance, arrange a mutually acceptable date and time, and present credentials to the nursing home administrator or the administrator's designee upon entering the building.

(5) Brokers may not randomly approach residents and shall immediately cease contact at the resident's request.

(6) Brokers shall provide the nursing home administrator with contact information, which may be provided to the resident, the resident's representative, or a member of the resident's family upon request.

(d) Managed care organizations and third-party brokers under contract with the State are prohibited from the following:

(1) The use of games, promotional giveaways, and any other monetary or non-monetary incentive to encourage a resident, the resident's representatives, or the resident's family to select one managed care organization over another.

(2) Mailing promotional or informational materials directly to a nursing home resident or from soliciting a nursing home resident, the resident's representative, or a member of the resident's family by telephone.

(3) Marketing directly to a resident for whom the court has appointed a legal guardian. Managed care organizations or brokers shall work with the nursing home administrator or their designee to determine, which residents, if any,

have court-appointed guardians. If a resident has a court-appointed guardian, all marketing shall be directed to the court-appointed guardian. The resident shall be held harmless if the court-appointed guardian fails to respond. Brokers and managed care organizations may contact the court of jurisdiction for assistance.

(4) Marketing directly to a resident with an Alzheimer's or other dementia-related disease diagnosis. Managed care organizations or brokers shall work with the nursing home administrator or their designee to identify those residents with Alzheimer's or another dementia-related disease. If a legal guardian has not been appointed, the facility shall, upon request, provide the managed care organization or the broker the contact information for the resident's representative or family member acting on the resident's behalf.

Section 45. Policies and procedures.

(a) The Department shall define by rule minimum standards governing the relationship between managed care organizations, enrollees, and nursing homes. The list in this subsection (a) is not intended to be all-inclusive, but serves as examples of terms and conditions that require uniformity across all managed care organizations. Rules shall be adopted for the following:

(1) best interest of the resident standard;

(2) presumption of approval;

(3) medication prior approval;

(4) prior-approval procedures;

(5) post-approval procedures;

(6) post-emergency approval procedures;

(7) elective services;

(8) services that are not prior-approval services;

(9) clean claims;

(10) billing codes;

(11) look-back periods, which shall be at a minimum 10 days;

(12) prompt payment; and

(13) reporting requirements.

(b) All managed care organizations shall establish a process for authorization or denial of health care services available 365 days a year, 24 hours a day, 7 days a week. The call line must at a minimum have a 2 minute or less hold time, with at least 80% of the calls answered in 30 seconds and no more than 5% of the calls disconnected.

(c) Medication prior approval forms and procedures shall:

(1) permit the nursing home staff to seek an exception to approval policies when making the initial request;

(2) prohibit denial based on:

(A) lack of a culture; or

(B) multiple drugs of a same class for the same diagnosis; and

(3) acknowledge the presumption that all medications

ordered by an authorized medical professional are medically necessary.

Section 50. Contractual requirements

(a) Contracts between managed care organizations and nursing homes are prohibited from including terms and conditions that:

(1) limit or prohibit a nursing home from advocating on behalf of its residents to include the filing of appeals and grievances in the name of the resident at the resident's request or on behalf of the nursing home;

(2) require prior approval of health care services if the managed care organization does not have a prior approval process available 365 days per year, 24 hours a day, 7 days a week;

(3) offer incentives or disincentives that limit access to specific types of health care services; or

(4) establish requirements in excess of federal and State law.

(b) Managed care organizations shall offer contracts with at least a 36-month duration to any and all nursing homes in demonstration counties that meet all applicable State and federal requirements for participation in the Medicaid and Medicare Programs.

(c) Renewals shall be consistent with the provisions of subsection (b) of this Section. A nursing home denied a renewal

or whose contract is terminated may appeal the denial or termination to the Director of Insurance. The appeal shall stay the termination or nonrenewal of the contract and the notification of enrollees residing in the nursing home pending the outcome of the appeal. The decision rendered by the Director of Insurance pursuant to this subsection (c) shall be a final appealable decision under the Administrative Review Law. The burden of proof shall rest with the managed care organization. It is the responsibility of the managed care organization to notify all enrollees affected by the termination or nonrenewal within 15 days after notice provided to the nursing home or within 15 days after final action on the appeal, whichever is later. Notice shall include a proposed transition plan consistent with the provisions of Sections 25 and 30 of this Act.

(d) A nursing home has the right to terminate its contract with a managed care organization with 90 days' written notice, with or without cause. The managed care organization shall immediately notify all residents of all rights and responsibilities during and after the resident's 90-day transition period.

(e) The managed care organization shall enter into a single-case resident choice agreement as required by Section 25 of this Act.

Section 55. Prohibition. No managed care organization or

contract shall contain any provision, policy, or procedure that limits, restricts, or waives any rights set forth in this Act or is expressly prohibited by this Act. Any such policy or procedure shall be void and unenforceable.

Section 60. Reimbursement.

(a) Nursing homes shall be reimbursed no less than the Illinois fee-for-service Medicaid rate at the time the health care services were rendered. The fee-for-service Medicaid rate shall include the amounts established by the Department for the direct care, support, and capital components of the rate and any and all add-ons.

(b) The Department shall provide each managed care organization with the quarterly facility-specific RUG-IV nursing component per diem along with any add-ons for enhanced care services, support component per diem, and capital component per diem effective for each nursing home under contract with the managed care organization.

(c) A nursing home under a single-case resident choice agreement shall be reimbursed at the rate paid a nursing home under contract with the managed care organization to provide services to Medicaid beneficiaries in the Demonstration Project.

(d) Prior approval and post approval shall be secured in the form and manner established by rule pursuant to Section 45 of this Act.

(e) The managed care organization shall be liable for all health care services rendered. Payment may be denied if and only if:

(1) health care services were provided outside the window of a deemed approval period and prior approval was not received;

(2) a medical emergency did not exist and prior approval was not received;

(3) health care services claimed were not delivered;

(4) health care services were contrary to the instructions of the managed care organization and the nursing home was notified prior to the health care services being delivered; or

(5) the resident was not an enrollee of the managed care organization.

(f) A nursing home shall receive reimbursement for all health care services rendered no later than 30 days after a valid invoice is submitted to the managed care organization. If the managed care organization fails to reimburse the nursing home within 30 days, the managed care organization shall be liable for a past due penalty equal to the interest rate that lending institutions are charging for loans secured by State receivables.

(g) A managed care organization failing to pay a nursing home or group of nursing homes in excess of 60 days after the date that a valid invoice was submitted shall be considered in

default. Upon notification that a managed care organization is in default, the Department shall notify the Comptroller to place a hold on all payments to the managed care organization until such time that all outstanding payments and past due penalties have been paid. The Department shall immediately notify nursing homes under contract with the managed care organization that copies of all outstanding invoices and all future invoices shall be sent directly to the Department for processing.

(h) A managed care organization that either terminates or is terminated from participation in a Medicaid long-term care demonstration program in one or more areas of the State shall be liable for payment for all health care services rendered during the period of time the contract with the Department was in force. The Department shall notify all nursing homes under contract with the managed care organization within 10 business days after the date that the managed care organization notified the Department of its intent to terminate or the date the Department notifies the managed care organization of their intent to terminate the contract. Notice to nursing homes shall include a plan for the reassignment of all residents under contract with the managed care organization and procedures for the submission of any outstanding invoices directly to the Department for payment. The reassignment plan shall ensure that all medical orders in place are honored, that the resident does not experience an interruption in health care services, and

that the provider does not experience an interruption in payment.

(i) A managed care organization that authorizes the admission of an enrollee into a nursing home assumes responsibility for compensation owed the nursing home for the provision of all health care services as specified in subsection (d) of this Section, regardless of whether the enrollee has been found eligible for Medicaid long-term care services.

(j) The State of Illinois shall guarantee the payment of all valid invoices by managed care organizations subject to this Act.

Section 65. Compliance.

(a) The Department of Insurance shall be responsible for ensuring compliance with this Act.

(b) Within 30 days after the effective date of this Act, the Department of Insurance shall notify all nursing homes in all demonstration counties of the Department's compliance responsibility and the policy and procedures for notifying the Director of Insurance of any violations of the provisions this Act. The Department of Insurance shall accept both oral and written complaints. An Internet-based reporting option shall be offered.

(c) A managed care organization that is found to have used marketing materials or scripts that were not approved in

advance or provided such materials for use to a third-party or an employee, agent, or contractor of the State shall be subject to sanctions. An employee, agent, or contractor of the State using marketing materials or scripts that have not been approved in advance shall also be subject sanctions.

(d) All sanctioning guidelines shall be established by rule and shall include monetary sanctions, termination, loss of privileges to sell products or policies or otherwise enroll individuals in health plans in the State of Illinois, and criminal charges. Monetary sanctions for a first offense shall not be less than $1,000 per offense per resident per nursing home per day. Second offenses shall not be less than $5,000 per offense per resident per nursing home per day. Third and subsequence offenses shall be double the previous sanction.

(e) All monetary sanctions shall be paid into the Nursing Home Resident Managed Care Fund, which is hereby created in the State treasury. Disbursements from the Fund shall be subject to appropriations and shall be used to hire and train nursing home resident advocates in both the Senior Health Insurance Program and the Senior Health Assistance Program. Nursing home residents insurance advocates employed by the Senior Health Insurance Program shall assist nursing home residents, resident's representatives, and the resident's family to file appeals and grievance for the purpose of securing medically necessary health care services. Nursing home residents health assistance advocates employed by the Senior Health Assistance

Program shall assist residents, resident's representatives, and the resident's family to file applications and secure appropriate documentation to secure Medicaid long-term care coverage and to assist with the family in securing spousal impoverishment coverage. Moneys remaining in the fund at the end of each fiscal year shall be made available through competitive grants to nursing homes the following fiscal year for innovative programming to improve the quality of life of nursing home residents and the staff that serve them and transition assistance or modernization assistance. Grants shall be awarded by the Director of Public Health with the advice of the Department of Public Health's Long Term Care Advisory Committee. Moneys paid into the Fund may not be used for any purpose other than those specified in this subsection (e).

Section 70. Solvency. The Department of Insurance shall ensure that all managed care organizations contracting with the State shall meet the solvency requirements enumerated in the Illinois Health Maintenance Organization Act and the rules adopted under that Act by the Department of Insurance. The Department of Insurance shall adopt such rules as are necessary to carry out the provisions of this Section.

Section 75. Applicability. This Act applies to all contracts in effect on or after the effective date of this Act

and all claims that accrue after the effective date of this Act.

Section 900. The Health Maintenance Organization Act is amended by changing Section 1-2 as follows:

(215 ILCS 125/1-2) (from Ch. 111 1/2, par. 1402)

Sec. 1-2. Definitions. As used in this Act, unless the context otherwise requires, the following terms shall have the meanings ascribed to them:

(1) "Advertisement" means any printed or published material, audiovisual material and descriptive literature of the health care plan used in direct mail, newspapers, magazines, radio scripts, television scripts, billboards and similar displays; and any descriptive literature or sales aids of all kinds disseminated by a representative of the health care plan for presentation to the public including, but not limited to, circulars, leaflets, booklets, depictions, illustrations, form letters and prepared sales presentations.

(2) "Director" means the Director of Insurance.

(3) "Basic health care services" means emergency care, and inpatient hospital and physician care, outpatient medical services, mental health services and care for alcohol and drug abuse, including any reasonable deductibles and co-payments, all of which are subject to the limitations described in Section 4-20 of this Act and as determined by the Director

pursuant to rule.

(4) "Enrollee" means an individual who has been enrolled in a health care plan.

(5) "Evidence of coverage" means any certificate, agreement, or contract issued to an enrollee setting out the coverage to which he is entitled in exchange for a per capita prepaid sum.

(6) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group.

(7) "Health care plan" means any arrangement whereby any organization undertakes to provide or arrange for and pay for or reimburse the cost of basic health care services, excluding any reasonable deductibles and copayments, from providers selected by the Health Maintenance Organization and such arrangement consists of arranging for or the provision of such health care services, as distinguished from mere indemnification against the cost of such services, except as otherwise authorized by Section 2-3 of this Act, on a per capita prepaid basis, through insurance or otherwise. A "health care plan" also includes any arrangement whereby an organization undertakes to provide or arrange for or pay for or reimburse the cost of any health care service for persons who are enrolled under Article V of the Illinois Public Aid Code or under the Children's Health Insurance Program Act through providers selected by the organization and the arrangement

consists of making provision for the delivery of health care services, as distinguished from mere indemnification. A "health care plan" also includes any arrangement pursuant to Section 4-17. Nothing in this definition, however, affects the total medical services available to persons eligible for medical assistance under the Illinois Public Aid Code.

(8) "Health care services" means any services included in the furnishing to any individual of medical or dental care, or the hospitalization or incident to the furnishing of such care or hospitalization as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness or injury.

(9) "Health Maintenance Organization" means any organization formed under the laws of this or another state to provide or arrange for one or more health care plans under a system which causes any part of the risk of health care delivery to be borne by the organization or its providers.

(10) "Net worth" means admitted assets, as defined in Section 1-3 of this Act, minus liabilities.

(11) "Organization" means any insurance company, a nonprofit corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act, or a corporation organized under the laws of this or another state for the purpose of operating one or more health care plans and doing no business other than that of a Health Maintenance Organization or an insurance company. "Organization" shall

also mean the University of Illinois Hospital as defined in the University of Illinois Hospital Act.

(12) "Provider" means any physician, hospital facility, facility licensed under the Nursing Home Care Act, or other person which is licensed or otherwise authorized to furnish health care services and also includes any other entity that arranges for the delivery or furnishing of health care service.

(13) "Producer" means a person directly or indirectly associated with a health care plan who engages in solicitation or enrollment.

(14) "Per capita prepaid" means a basis of prepayment by which a fixed amount of money is prepaid per individual or any other enrollment unit to the Health Maintenance Organization or for health care services which are provided during a definite time period regardless of the frequency or extent of the services rendered by the Health Maintenance Organization, except for copayments and deductibles and except as provided in subsection (f) of Section 5-3 of this Act.

(15) "Subscriber" means a person who has entered into a contractual relationship with the Health Maintenance Organization for the provision of or arrangement of at least basic health care services to the beneficiaries of such contract.

(Source: P.A. 97-1148, eff. 1-24-13.)

Section 905. The Managed Care Reform and Patient Rights Act

is amended by changing Section 10 as follows:

(215 ILCS 134/10)

Sec. 10. Definitions:

"Adverse determination" means a determination by a health care plan under Section 45 or by a utilization review program under Section 85 that a health care service is not medically necessary.

"Clinical peer" means a health care professional who is in the same profession and the same or similar specialty as the health care provider who typically manages the medical condition, procedures, or treatment under review.

"Department" means the Department of Insurance.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

"Emergency medical screening examination" means a medical screening examination and evaluation by a physician licensed to

practice medicine in all its branches, or to the extent permitted by applicable laws, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine in all its branches to determine whether the need for emergency services exists.

"Emergency services" means, with respect to an enrollee of a health care plan, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency services" does not refer to post-stabilization medical services.

"Enrollee" means any person and his or her dependents enrolled in or covered by a health care plan.

"Health care plan" means a plan that establishes, operates, or maintains a network of health care providers that has entered into an agreement with the plan to provide health care services to enrollees to whom the plan has the ultimate obligation to arrange for the provision of or payment for services through organizational arrangements for ongoing quality assurance, utilization review programs, or dispute resolution. Nothing in this definition shall be construed to mean that an independent practice association or a physician hospital organization that subcontracts with a health care plan is, for purposes of that subcontract, a health care plan.

For purposes of this definition, "health care plan" shall

not include the following:

(1) indemnity health insurance policies including those using a contracted provider network;

(2) health care plans that offer only dental or only vision coverage;

(3) preferred provider administrators, as defined in Section 370g(g) of the Illinois Insurance Code;

(4) employee or employer self-insured health benefit plans under the federal Employee Retirement Income Security Act of 1974;

(5) health care provided pursuant to the Workers' Compensation Act or the Workers' Occupational Diseases Act; and

(6) not-for-profit voluntary health services plans with health maintenance organization authority in existence as of January 1, 1999 that are affiliated with a union and that only extend coverage to union members and their dependents.

"Health care professional" means a physician, a registered professional nurse, or other individual appropriately licensed or registered to provide health care services.

"Health care provider" means any physician, hospital facility, facility licensed under the Nursing Home Care Act, or other person that is licensed or otherwise authorized to deliver health care services. Nothing in this Act shall be construed to define Independent Practice Associations or

Physician-Hospital Organizations as health care providers.

"Health care services" means any services included in the furnishing to any individual of medical care, or the hospitalization incident to the furnishing of such care, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing, or healing human illness or injury including home health and pharmaceutical services and products.

"Medical director" means a physician licensed in any state to practice medicine in all its branches appointed by a health care plan.

"Person" means a corporation, association, partnership, limited liability company, sole proprietorship, or any other legal entity.

"Physician" means a person licensed under the Medical Practice Act of 1987.

"Post-stabilization medical services" means health care services provided to an enrollee that are furnished in a licensed hospital by a provider that is qualified to furnish such services, and determined to be medically necessary and directly related to the emergency medical condition following stabilization.

"Stabilization" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the

condition is likely to result.

"Utilization review" means the evaluation of the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities.

"Utilization review program" means a program established by a person to perform utilization review.

(Source: P.A. 91-617, eff. 1-1-00.)

Section 910. The Illinois Public Aid Code is amended by adding Section 5B-8.1 as follows:

(305 ILCS 5/5B-8.1 new)

Sec. 5B-8.1. Guarantee of payment.

(a) Any money owed to a nursing home by a managed care organization, as that term is defined in the Nursing Home Residents' Managed Care Rights Act, shall be guaranteed by this State. Upon a finding that a managed care organization is in default, as described in Section 60 of the Nursing Home Residents' Managed Care Rights Act, the Department shall immediately notify the Comptroller to place on hold all outstanding payments to the managed care organization until such time as the managed care organization has paid all past due invoices and interest penalties. From the moneys owed the managed care organization by this State, the Department shall pay directly to all nursing homes under contract with the managed care all past due invoices and all future invoices

until such time as the managed care organization is no longer in default.

(b) A managed care organization that terminates its managed care contract for long-term care services or is terminated by the Department from providing managed long-term care services during the life of the demonstration project and at the sunset of each demonstration plan shall submit to the Department a release from each nursing home under contract with the managed care organization stipulating that moneys due the nursing home now and in the future were paid in full prior to the Department sending to the Comptroller for payment an amount equivalent to the last 60 days of payment due the managed care organization.

(c) All payments owed providers for health care services rendered which are payable under this Code shall be considered guaranteed by this State, and shall carry with it the full faith and credit of this State. Outstanding payments shall be considered receivables owed by this State for the purposes of borrowing against future payments or otherwise collateralizing or capitalizing these guaranteed funds.

Section 915. The State Finance Act is amended by adding Section 5.855 as follows:

(30 ILCS 105/5.855 new)

Sec. 5.855. The Nursing Home Resident Managed Care Fund.

Section 999. Effective date. This Act takes effect upon becoming law.".