AN ACT concerning State government.

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

Section 5. The Illinois Public Aid Code is amended by changing Sections 5F-10 and 5F-32 and by adding Sections 5-30.3 and 5F-33 as follows:

(305 ILCS 5/5-30.3 new)

Sec. 5-30.3. Provider inquiry portal. The Department shall establish, no later than January 1, 2018, a web-based portal to accept inquiries and requests for assistance from managed care organizations under contract with the State and providers under contract with managed care organizations to provide direct care.

(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 the Medicare-Medicaid Alignment Initiative and the Managed Long-Term Services and Support Program. This Article does not diminish a managed care organization's duties and responsibilities under other federal or State laws or rules

adopted under those laws and the 3-way Medicare-Medicaid Alignment Initiative contract and the Managed Long-Term Services and Support Program contract.

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

(305 ILCS 5/5F-32)

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

(a) MCOs must have a method of receiving prior approval requests 24 hours a day, 7 days a week, 365 days a year from ~~for~~ 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 MCO must pay for the service if it is a covered service under the MCO's contract in the Demonstration Project, provided that the request is consistent with the policies and procedures of the 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 MCO, the enrollee, physician, or ~~and the~~ provider may utilize an expedited appeal to the MCO.

If an enrollee, physician, or provider requests an expedited appeal pursuant to 42 CFR 438.410, the 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 MCO requires to evaluate the appeal. The MCO shall notify the individual filing the appeal of the MCO's ~~render a~~ 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, treatment, or test.

Provided however, a nursing home shall continue to monitor, document, and ensure the patient's safety. Nothing in this subsection (b) is intended to otherwise change the nursing home's existing obligations under State and federal law to appropriately care for its residents.

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

(305 ILCS 5/5F-33 new)

Sec. 5F-33. Payment of claims.

(a) Clean claims, as defined by the Department, submitted by a provider to a managed care organization in the form and manner requested by the managed care organization shall be

reviewed and paid within 30 days of receipt.

(b) A managed care organization must provide a status update within 60 days of the submission of a claim.

(c) A claim that is rejected or denied shall clearly state the reason for the rejection or denial in sufficient detail to permit the provider to understand the justification for the action.

(d) The Department shall work with stakeholders, including, but not limited to, managed care organizations and nursing home providers, to train them on the application of standardized codes for long-term care services.

(e) Managed care organizations shall provide a manual clearly explaining billing and claims payment procedures, including points of contact for provider services centers, within 15 days of a provider entering into a contract with a managed care organization. The manual shall include all necessary coding and documentation requirements. Providers under contract with a managed care organization on the effective date of this amendatory Act of the 99th General Assembly shall be provided with an electronic copy of these requirements within 30 days of the effective date of this amendatory Act of the 99th General Assembly. Any changes to these requirements shall be delivered electronically to all providers under contract with the managed care organization 30 days prior to the effective date of the change.