

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 as follows:

6 (305 ILCS 5/5-30.1)

7 Sec. 5-30.1. Managed care protections.

8 (a) As used in this Section:

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

12 "Emergency services" include:

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

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

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

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

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

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

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

16 (1) the MCO authorized such services;

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

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

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

24 (5) the MCO and the treating provider, if the treating
25 provider is a non-affiliated provider, could not reach an
26 agreement concerning the enrollee's care and an affiliated

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

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

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

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

24 (3) The MCO shall have no obligation to cover medical
25 services provided on an emergency basis that are not
26 covered services under the contract.

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

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

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

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

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

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

23 (D) the enrollee is discharged.

24 (f) Network adequacy and transparency.

25 (1) The Department shall:

26 (A) ensure that an adequate provider network is in

1 place, taking into consideration health professional
2 shortage areas and medically underserved areas;

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

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

7 (D) require MCOs to maintain an updated and public
8 list of network providers.

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

17 (g) Timely payment of claims.

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

21 (2) The MCO shall notify the billing party of its
22 inability to adjudicate a claim within 30 days of receiving
23 that claim.

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

1 (4) The Department may establish a process for MCOs to
2 expedite payments to providers based on criteria
3 established by the Department.

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

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

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

22 (A) such medically necessary covered services
23 shall be considered rendered in good faith;

24 (B) such policies and procedures shall be
25 developed in consultation with industry
26 representatives of the Medicaid managed care health

1 plans and representatives of provider associations
2 representing the majority of providers within the
3 identified provider industry; and

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

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

10 (A) the extension of the timely filing period;

11 (B) retroactive prior authorizations; and

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

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

18 (g-6) MCO Performance Metrics Report.

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

23 (A) claims payment, including timeliness and
24 accuracy;

25 (B) prior authorizations;

26 (C) grievance and appeals;

- 1 (D) utilization statistics;
2 (E) provider disputes;
3 (F) provider credentialing; and
4 (G) member and provider customer service.

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

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

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

15 (h) The Department shall not expand mandatory MCO
16 enrollment into new counties beyond those counties already
17 designated by the Department as of June 1, 2014 for the
18 individuals whose eligibility for medical assistance is not the
19 seniors or people with disabilities population until the
20 Department provides an opportunity for accountable care
21 entities and MCOs to participate in such newly designated
22 counties.

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

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

2 Section 99. Effective date. This Act takes effect upon
3 becoming law.