



Sen. Donne E. Trotter

Filed: 5/11/2016

09900SB3080sam001

LRB099 20371 KTG 48604 a

1 AMENDMENT TO SENATE BILL 3080

2 AMENDMENT NO. _____. Amend Senate Bill 3080 by replacing
3 everything after the enacting clause with the following:

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

1 Patient Rights Act;

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

5 (4) emergency medical conditions, as defined by
6 Section 10 of the Managed Care Reform and Patient Rights
7 Act.

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

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

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

23 (1) the MCO authorized such services;

24 (2) such services were administered to maintain the
25 enrollee's stabilized condition within one hour after a
26 request to the MCO for authorization of further

1 post-stabilization services;

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

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

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

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

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

26 (2) The MCO shall cover emergency services provided to

1 enrollees who are temporarily away from their residence and
2 outside the contracting area to the extent that the
3 enrollees would be entitled to the emergency services if
4 they still were within the contracting area.

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

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

12 (5) The determination of the attending emergency
13 physician, or the provider actually treating the enrollee,
14 of whether an enrollee is sufficiently stabilized for
15 discharge or transfer to another facility, shall be binding
16 on the MCO. The MCO shall cover emergency services for all
17 enrollees whether the emergency services are provided by an
18 affiliated or non-affiliated provider.

19 (6) The MCO's financial responsibility for
20 post-stabilization care services it has not pre-approved
21 ends when:

22 (A) a plan physician with privileges at the
23 treating hospital assumes responsibility for the
24 enrollee's care;

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

1 (C) a contracting entity representative and the
2 treating physician reach an agreement concerning the
3 enrollee's care; or

4 (D) the enrollee is discharged.

5 (f) Network adequacy and transparency.

6 (1) The Department shall:

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

10 (B) publicly release an explanation of its process
11 for analyzing network adequacy;

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

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

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

24 (g) Timely payment of claims.

25 (1) The MCO shall pay a claim within 30 days of
26 receiving a claim that contains all the essential

1 information needed to adjudicate the claim.

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

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

8 (4) The Department may establish a process for MCOs to
9 expedite payments to providers based on criteria
10 established by the Department.

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

14 (1) in no instance shall a medically necessary covered
15 service rendered in good faith, based upon eligibility
16 information documented by the provider, be denied coverage
17 or diminished in payment amount if the eligibility or
18 coverage information available at the time the service was
19 rendered is later found to be inaccurate; and

20 (2) the Department shall, by December 31, 2016, adopt
21 rules establishing policies that shall be included in the
22 Medicaid managed care policy and procedures manual
23 addressing payment resolutions in situations in which a
24 provider renders services based upon information obtained
25 after verifying a patient's eligibility and coverage plan
26 through either the Department's current enrollment system

1 or a system operated by the coverage plan identified by the
2 patient presenting for services:

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

5 (B) such policies and procedures shall be
6 developed in consultation with industry
7 representatives of the Medicaid managed care health
8 plans and representatives of provider associations
9 representing the majority of providers within the
10 identified provider industry; and

11 (C) such rules shall be published for a review and
12 comment period of no less than 30 days on the
13 Department's website with final rules remaining
14 available on the Department's website.

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

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

18 (B) retroactive prior authorizations; and

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

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

25 (g-6) MCO Performance Metrics Report.

26 (1) The Department shall publish on at least a

1 quarterly basis, each MCO's operational performance,
2 including, but not limited to, the following categories of
3 metrics:

4 (A) claims payment, including timeliness and
5 accuracy;

6 (B) prior authorizations;

7 (C) grievance and appeals;

8 (D) utilization statistics;

9 (E) provider disputes;

10 (F) provider credentialing; and

11 (G) member and provider customer service.

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

14 (3) The metrics shall be developed in consultation with
15 industry representatives of the Medicaid managed care
16 health plans and representatives of associations
17 representing the majority of providers within the
18 identified industry.

19 (4) Metrics shall be defined and incorporated into the
20 applicable Managed Care Policy Manual issued by the
21 Department.

22 (h) The Department shall not expand mandatory MCO
23 enrollment into new counties beyond those counties already
24 designated by the Department as of June 1, 2014 for the
25 individuals whose eligibility for medical assistance is not the
26 seniors or people with disabilities population until the

1 Department provides an opportunity for accountable care
2 entities and MCOs to participate in such newly designated
3 counties.

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

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

9 Section 99. Effective date. This Act takes effect upon
10 becoming law."