

201 South Grand Avenue East  
Springfield, Illinois 62763-0002Telephone: (217) 782-1200  
TTY: (800) 526-5812**OMNIBUS MEDICAID BILL  
SENATE BILL 741, AS AMENDED BY HOUSE AMENDMENT #1****CHANGES FOR HOSPITALS****Rate Reform**

The current Medicaid rate reimbursement methodology would sunset on June 30, 2014. SB 741 establishes that the new rate methodology (APR-DRG, EAPG) will be in effect on July 1, 2014, subject to a rule pending before JCAR in June. \$290 million is set aside to assist hospitals transitioning to the new rate system, for a transition period due to sunset on July 1, 2018. \$10 million is added to rates for safety net hospitals. SB 741 includes other new provisions negotiated during the legislative process.

**Assessments**

Two current hospital assessment programs would sunset on January 1, 2015. SB 741 extends the sunset dates to July 1, 2018. This will continue \$2 billion in payments to hospitals, providing stability for four years in this era of health care reform and change.

**ACA 400**

SB 741 provides that HFS will request federal approval for new federal dollars for hospitals serving newly eligible Medicaid recipients ("ACA adults") who are reimbursed by the federal government at 100% match. This will provide roughly \$400 million new annual federal dollars, to be distributed to hospitals across the state – thus this new pool of federal dollars for hospitals is dubbed "ACA 400". The distribution will mirror the two current hospital assessment distributions. When the federal match for ACA adults is no longer 100% federally funded (January 1, 2017), the state will not bear responsibility for any portion of the ACA 400 distribution; instead, the hospital share of hospital assessment taxes will increase proportionately to cover the state's liability for ACA 400 payments.

**Managed Care**

SB 741 clarifies the responsibilities of Managed Care Organizations (MCO), Accountable Care Entities (ACEs) and hospitals with regards to the enrollment of Medicaid clients into managed care under the state mandate. It covers issues such as:

- MCO-ACE parity: MCOs and ACEs must follow same regulations and certifications as MCOs, if managed care is expanded into new counties; MCOs and ACEs must be given equal chance to participate
- Prompt payment: within 30 days, MCOs will pay hospitals or notify them of faulty claim
- MCO network adequacy: HFS will ensure adequate networks and publish its criteria; MCOs must list their network providers online

- Out-of-network care: MCOs must pay commensurate rates for out-of-network care to providers for emergency and stabilization services
- Quality of care: all managed care entities will be measured using the same quality metrics; MCOs, and other entities with full-risk capitated payments for 1 year, and serving 5,000+ seniors and persons with disabilities or 15,000+ other Medicaid clients, must be accredited by a national accreditation organization within 2 years after the date the MCO becomes eligible for accreditation

### **Access Assurance Payments**

SB 741 provides that HFS may increase capitation payments to MCOs, equal to the amount of reduction in assessment dollars relative to each person in Medicaid fee-for-service who is transitioned into managed care. The aggregate amount of all increased capitated payments to MCOs will be equal to the amount needed to avoid reduction in federally matched payments authorized by the federal government. Payments will be actuarially sound and will be published by HFS each year. The increased capitation payments will be guaranteed by a surety bond, obtained by the MCO, in an amount equal to one month's liability of payments of the increased capitation.

### **CHANGES FOR NURSING HOMES**

#### **Managed Care**

SB 741 clarifies the responsibilities of MCOs and nursing homes for Medicaid clients enrolled in the Medicare-Medicaid Alignment Initiative (dual-eligible Medicare-Medicaid clients). It covers issues such as:

- Any willing provider: MCOs must offer contract to all nursing homes (NH) but NH must comply with MCO's published quality standards; nursing homes may limit contracts to existing residents
- Continuity of care: MCOs must reimburse according to NF care plan for each resident until MCO develops its own care plan
- Prior authorization: MCO must have 24/7/365 option to authorize services and must respond within 24 hours or pay for care until it responds
- Termination of contract: MCO may terminate or refuse to renew NH contract for failure to grant access to MCO's care coordinators, Specialized Nursing Facility physicians (SNFists), providers, for termination from the Medicare or Medicaid program or for termination of NH licensure

#### **Long Term Care (LTC) Pending Medicaid Backlog**

LTC eligibility processing is a more lengthy process than regular Medicaid eligibility, and thus a large backlog of applications for LTC has resulted, including for persons receiving care in nursing homes. SB 741 provides for expedited LTC eligibility processing by simplifying certain eligibility verification policies, redeploying certain caseworkers trained in LTC eligibility, foregoing resource review for certain cases, and transmitting certain information and Medicaid applications electronically. Prescreening information and accompanying materials required for nursing home admission will be transmitted by the hospital when the patient is discharged to a nursing home. The State will compile data on pending applications and post monthly reports on its websites.

By June 30, 2014, HFS will issue vouchers up to \$50 million to NHs with significant outstanding Medicaid liability related to services to residents with pending applications. Any facility that is given an advance will repay the state, either in 3 or 6 equal monthly installments, by June 30, 2015.

### **CHANGES FOR SPECIALIZED MENTAL HEALTH REHABILITATION FACILITIES (SMHRF)**

There are currently 24 SMHRFs across Illinois and a moratorium on more; SB 741 permits SMHRFs to apply to

the Health Facilities and Services Review Board to relocate to an underserved area of the state. The state will develop and implement a service authorization system, available 24/7, for approval of services in the 3 levels of care in SMHRFs: crisis stabilization, recovery and rehabilitation supports, and transitional living units. SMHRFs may locate a triage unit, or short-term crisis stabilization center, in a separate facility within 1,000 feet of the SMHRF. SB 741 also clarifies provisions agreed upon between SMHRFs and Illinois Department of Public Health.

### **MEDICAID BENEFIT CHANGES**

SB 741 makes changes to current benefits that are offered under Illinois Medicaid:

- Restoration of dental care for adults
- Restoration of podiatry services for adults
- Elimination of prior authorization under the 4-script policy for anti-psychotic drugs
- Elimination of prior authorization under the 4-script policy for children with complex medical needs who are enrolled in a care coordination entity (CCE) solely to coordinate care for these children, if the CCE has a comprehensive drug reconciliation program
- Elimination of maximum 20 visits for speech, hearing, language, occupational, and physical therapy, replaced by prior approval for all such services
- Coverage for one or more vendors procured by Chicago Public Schools to manufacture eyeglasses for children in CPS
- Coverage for kidney transplantations for noncitizens with end-stage renal disease who are otherwise not eligible for Medicaid coverage, with some restrictions

### **RATE INCREASES**

SB 741 provides for rate increases for the following:

- Nursing homes for the support component of NH rate, for base rates for nursing component of NH rate, and add-on for certain residents with severe mental illness and Alzheimer's Disease/dementia
- Supportive living facilities, plus a new provider assessment if approved by federal CMS
- Residential facilities and transitional facilities who serve children with clinically complex needs
- Home health services
- SMHRFs – one-time FY14 payment

### **FEDERAL COMPLIANCE**

Currently state law provides Medicaid coverage if children have been without health insurance for 12 months. SB 741 brings the state in compliance with federal law by providing Medicaid coverage for children without private insurance for 3 months.

Currently state law provides that Medicaid can be reinstated, without a new application, if a client is cancelled during eligibility redetermination and then produces documentation within 1 month. SB 741 brings the state into compliance with federal law by reinstating clients with documentation up to 3 months.

### **MISCELLANEOUS**

SB 741 gives HFS and contracted Managed Care Entities (MCEs) access to IDPH's immunization data, essential for care coordination.

SB 741 allows Cook County to apply to the Department of Insurance for a Health Maintenance Organization (HMO) license to offer CountyCare to a broader population than Medicaid.