HB2730

LRB10109317KTG54412b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB2730

by Rep. Bob Morgan

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.1

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that a provider who has exhausted the written internal appeals process of a managed care organization (MCO) shall be entitled to an external independent third-party review of the MCO's final decision that denies, in whole or in part, a health care service to an enrollee or a claim for reimbursement to a provider for a health care service rendered to an enrollee of the Medicaid managed care organization. Requires a MCO's final decision letter to a provider to include: (i) a statement that the provider's internal appeal rights within the MCO have been exhausted; (ii) a statement that the provider is entitled to an external independent third-party review; (iii) the time period granted to request an external independent third-party review; and (iv) the mailing address to initiate an external independent third-party review. Provides that a party shall be entitled to appeal a final decision of the external independent third-party review within 30 days after the date upon which the appealing party receives the external independent third-party review. Provides that a final decision by the Director of Healthcare and Family Services shall be final and reviewable under the Administrative Review Law. Contains provisions concerning fees to help defray the cost of the administrative hearings; the specific claims of services that are appealable; and the Department's rulemaking authority. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

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 Section 5-30.1 as follows:

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

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

"Emergency services" include:

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

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

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

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

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

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

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

(1) the MCO authorized such services;

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

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

(4) the MCO could not be contacted; or

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

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

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

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

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

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

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

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

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

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

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

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

(D) the enrollee is discharged.

(f) Network adequacy and transparency.

(1) The Department shall:

(A) ensure that an adequate provider network is in

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

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

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

(D) require MCOs, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet provider directory requirements under Section 5-30.3.

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

(g) Timely payment of claims.

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

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

(3) The MCO shall pay a penalty that is at least equal

to the penalty imposed under the Illinois Insurance Code for any claims not timely paid.

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

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

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

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

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

(B) such policies and procedures shall be

developed in consultation with industry representatives of the Medicaid managed care health plans and representatives of provider associations representing the majority of providers within the identified provider industry; and

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

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

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

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

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

(g-6) MCO Performance Metrics Report.

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

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

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

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

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

(g-7) MCO claims processing and performance analysis. In order to monitor MCO payments to hospital providers, pursuant to this amendatory Act of the 100th General Assembly, the Department shall post an analysis of MCO claims processing and payment performance on its website every 6 months. Such analysis shall include a review and evaluation of a representative sample of hospital claims that are rejected and denied for clean and unclean claims and the top 5 reasons for such actions and timeliness of claims adjudication, which identifies the percentage of claims adjudicated within 30, 60,

90, and over 90 days, and the dollar amounts associated with those claims. The Department shall post the contracted claims report required by HealthChoice Illinois on its website every 3 months.

(g-8) External independent review and administrative appeal hearing.

(1) Notwithstanding any other law to the contrary, a provider who has exhausted the written internal appeals process of an MCO shall be entitled to an external independent third-party review of the MCO's final decision that denies, in whole or in part, a health care service to an enrollee or a claim for reimbursement to a provider for a health care service rendered by the provider to an enrollee of the Medicaid managed care organization. Multiple claims may be determined in one action upon request of a party in accordance with administrative rules adopted by the Department.

(2) An MCO's letter to a provider reflecting the final decision of the provider's internal appeal shall include:

(A) a statement that the provider's internal appeal rights within the MCO have been exhausted;

(B) a statement that the provider is entitled to an external independent third-party review;

(C) the time period granted to request an external independent third-party review; and

(D) the mailing address to initiate an external

independent third-party review.

(3) A party shall be entitled to appeal a final decision of the external independent third-party review through the administrative hearing process within the Department, in accordance with 89 Ill. Adm. Code 104.200 through 104.295. An appeal shall be filed within 30 days after the date upon which the appealing party receives the final decision of the external independent third-party review. A final decision by the Director shall be final and reviewable under the Administrative Review Law. The Department may, by rule, establish reasonable fees, not to exceed $1,000, to defray expenses associated with an administrative hearing that shall be paid by the party who does not prevail in the Director's final decision after an administrative hearing.

(4) The requirements of this subsection shall apply to claims for services provided on or after the first day of the month that begins 120 days after the effective date of this amendatory Act of the 101st General Assembly. Within 120 days after the effective date of this amendatory Act of the 101st General Assembly, the Department shall adopt administrative rules to implement this subsection.

(h) The Department shall not expand mandatory MCO enrollment into new counties beyond those counties already designated by the Department as of June 1, 2014 for the individuals whose eligibility for medical assistance is not the

seniors or people with disabilities population until the Department provides an opportunity for accountable care entities and MCOs to participate in such newly designated counties.

(i) The requirements of this Section apply to contracts with accountable care entities and MCOs entered into, amended, or renewed after June 16, 2014 (the effective date of Public Act 98-651).

(Source: P.A. 99-725, eff. 8-5-16; 99-751, eff. 8-5-16; 100-201, eff. 8-18-17; 100-580, eff. 3-12-18; 100-587, eff. 6-4-18.)

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