SB1697

LRB10109318KTG54413b

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

SB1697

Introduced 2/15/2019, by Sen. Heather A. Steans

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.1
305 ILCS 5/5-30.11 new

Amends the Medical Assistance Article of the Illinois Public Aid Code. Require managed care organizations (MCOs) to ensure (i) that contracted providers shall be paid for any medically necessary service rendered to any of the MCO's enrollees, regardless of inclusion on the MCO's published and publicly available roster of available providers; and (ii) that all contracted providers are contained on an updated roster within 7 days of entering into a contract with the MCO and that such roster be readily accessible by all medical assistance enrollees for purposes of selecting an approved healthcare provider. Requires the Department of Healthcare and Family Services to develop a single standard list of all additional clinical information that shall be considered essential information and may be requested from a hospital to adjudicate a claim. Provides that a provider shall not be required to submit additional information, justifying medical necessity, for a service which has previously received a service authorization by the MCO or its agent. Contains provisions concerning a timely payment interest penalty; an expedited provider payment schedule; a single list of standard codes to identify the reason for nonpayment on a claim; payments under the Department's fee-for-service system; a 90-day correction period for providers to correct errors or omissions in a payment claim; service authorization requests; discharge notification and facility placement; and other matters. Defines terms. 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 and by adding Section 5-30.11 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.

"Claim Rejection" means a claim which is not correctly formatted and therefore cannot be processed when submitted for payment due to errors that cannot be corrected by the MCO.

"Claim payment rate adjustment" means any retroactive change to the rate or rates of payment from an MCO to a provider that results in a change in the total payment to the provider from the amount originally paid to the provider for the service. Such rate adjustments shall include, but not be limited to, either positive or negative rate adjustments, incentive payments, bonuses, or settlement adjustments.

"Claim recoupment adjustment" means any reduction to the initial final claim payment amount that is applied as an off-set for the purpose of recouping amounts due from the provider and owed to the MCO or the Department. All recoupment adjustments must be clearly and separately noted on any remittance advice when paying the provider. The rate-based total payment amount must be clearly and separately delineated from any applied recoupment adjustment.

"Claim denial" means a determination of nonpayment by the MCO of a properly formatted claim for services rendered by the provider. "Denial" means the MCO has determined that it has no liability under the Medical Assistance Program, the MCO contract with the Department, an existing contract with the provider, or other applicable provisions of law. Examples of an acceptable denial include, but are not limited to: (i) the

determination that the service rendered is not covered under the Medical Assistance Program, the MCO contract with the Department, an existing contract with the provider, or other applicable provisions of law; (ii) the beneficiary listed on the claim is not enrolled in the MCO; or (iii) a contractually required service authorization was not requested by the provider.

"Service authorization" means any service for which an MCO requires a provider, as specified in its service agreement, contract, or handbook, to submit a request for medical review authorizing the service, either prior to, concurrent with, or following the delivery of the service. Service authorization includes, but is not limited to, the following terms: precertification, preadmission review, pre-service review, prior authorization, prior approval, notification, concurrent review, retrospective review, prepayment review, and post payment review.

(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; and ~~.~~

(E) require MCOs to: (i) ensure that any provider under contract with an MCO on the date of service is paid for any medically necessary service rendered to any of the MCO's enrollees, regardless of inclusion on the MCO's published and publicly available roster of available providers; and (ii) ensure that all contracted providers are listed on an updated roster within 7 days of entering into a contract with the MCO and that such roster is readily accessible to all medical assistance enrollees for purposes of selecting an approved healthcare provider.

(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.

(A) The Department shall develop a single standard list of all additional clinical information, beyond

the standard uniform national billing requirements, which shall be considered essential information that may be requested from a hospital to adjudicate a claim. An MCO shall not require a hospital to provide information to adjudicate a claim, other than information stated on the standard list developed by the Department.

(B) The Department shall include the standard list of essential information in the agreement between each MCO and the Department and the Department shall publish the standard list of essential information on its website.

(C) The standard list of essential information shall be developed by the Department, in consultation with MCOs and the statewide association representing a majority of hospitals in the State. The Department may update the standard list of all essential information to adjudicate a claim no more frequently than annually.

(2) If an MCO requires information from the standard list of essential information to adjudicate a claim, it must request this additional information within 5 business days of receipt of the claim. ~~The MCO shall notify the billing party of its inability to adjudicate a claim within 30 days of receiving that claim.~~

(A) Under no circumstance shall a provider be required to submit additional information, justifying

medical necessity, for a service which has previously received a service authorization by the MCO or its agent. All services rendered in good faith by a provider based on a service authorization from an MCO or its agent shall be timely paid by the MCO at a rate associated with the service authorized and consistent with the contractual agreement between the MCO and the provider or, if there is no contractual agreement, at a rate otherwise required by law.

(B) Any request for additional information, necessary for the final adjudication of payment, may only temporarily suspend the 30-day timely payment requirement from the date additional information is requested from the provider until the date it is received from the provider.

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

(A) When an MCO is required to pay a timely payment interest penalty to a provider, the MCO must automatically calculate and pay the timely payment interest penalty that is due to the provider within 30 days after the payment of the claim. In no event shall a provider be required to request or apply for payment of any owed timely payment interest penalties.

(B) A MCO shall report at the time of payment to

each provider all timely payment interest penalty payments made to that provider, with such payments being reported separately from the claim payment for services rendered to the MCO's enrollee. Timely interest penalty payments shall not be considered a claim payment rate adjustment, as defined in this Section, and shall be considered separately due and payable by the MCO to the provider.

(4) The Department shall require MCOs to expedite payments to providers based on criteria that include, but are not limited to: ~~The Department may establish a process for MCOs to expedite payments to providers based on criteria established by the Department~~.

(A) At a minimum, each MCO shall ensure that providers identified on the Department's expedited provider list, determined in accordance with 89 Ill. Adm. Code 140.71(b), are paid by the MCO on a schedule at least as frequently as the providers are paid under the Department's fee-for-service expedited provider schedule.

(B) Compliance with the expedited provider requirement may be satisfied by an MCO through the use of a Periodic Interim Payment (PIP) program that has been mutually agreed to and documented between the MCO and the provider, if the PIP program ensures that any expedited provider receives regular and periodic

payments based on prior period payment experience from that MCO. Total payments under the PIP program may be reconciled against future PIP payments on a schedule mutually agreed to between the MCO and the provider.

(5) The Department shall establish a single list of standard codes, by provider industry, to identify the reason or reasons a claim is not to be paid. The list must include an explanation of each code and the action or actions required by the provider to correct all errors, if any.

(A) The Department and each MCO shall use the standard code set and descriptions published by the Department on the Explanation of Payment, and make available a system which maps the standard codes and descriptions to the applicable American National Standard Institute codes and includes all necessary corrective actions, if possible to move the claim, whether submitted in electronic format or non-electronic, to a payable status.

(B) The requirement under this Section is meant to provide a more descriptive supplement to any required notifications subject to the ASC X12 electronic transaction standards adopted under the federal Health Insurance Portability and Accountability Act.

(C) The single list of standard codes 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.

(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) Notwithstanding any other law, whenever the resolution of a dispute between an MCO and a provider related to the MCO's obligation to pay a claim results in the determination that the recipient's coverage on the date of service was under the Department's fee-for-service system, the provider shall be afforded an additional 120 days from the date of notice of such determination to submit the claim to the Department for payment under the fee-for-service system. The Department shall expedite the processing and adjudication of such claims.

(A) In such instances, there shall be no dispute as to the Department's liability under the fee-for-service system for a validly rendered service.

(B) Any requirement of prior service authorization by the State shall be waived in such circumstances.

(C) In such instances, if a claim for payment derives from a transfer from one hospital to another, resulting in continuous care by both hospitals, there shall be no dispute in the assignment of coverage for the service, such that if the initiating hospital service was covered under the Department's fee-for-service system, then the liability for the entire claim shall remain under the Department's

fee-for-service system.

(9-9) Notwithstanding any other provisions of law, if the Department or an MCO requires submission of a claim for payment in a non-electronic format, a provider shall always be afforded a period of no less than 90 business days, as a correction period, following any notification of rejection by either the Department or the MCO to correct errors or omissions in the original submission.

Under no circumstances, either by an MCO or under the Department's fee-for-service system, shall a provider be denied payment for failure to comply with any timely claims submission requirements of this Code or under any existing contract, unless the non-electronic format claim submission occurs after the initial 180 days following the latest date of service on the claim, or after the 90 business days correction period following notification to the provider of rejection or denial of payment.

(g-10) Medical necessity determination.

(1) Any MCO under contract with the Department that requires service authorization for any service, in order for payment to be made, must have an electronic system that accepts and preserves electronically for both parties all service authorization requests, related clinical documentation, and service authorization determinations. A transaction tracking number must be issued to the provider at the time of the request, noting the level of care

requested for the service authorization, and must be transmitted to the requesting provider either electronically or provided telephonically.

(2) A MCO must authorize or reject a request for service authorization, submitted prior to the delivery of the service, within 4 calendar days of the day when all information requested by the MCO, in order to rule on the request, has been provided. Such service authorization or rejection must contain the transaction tracking number and level of care being authorized or rejected. If the enrollee's medical condition is such that a time frame of 4 days could seriously jeopardize the enrollee's life or health, the MCO must authorize or reject a request within 48 hours. Time frames for authorization of post-stabilization services are governed by subsection (d) of this Section. If no authorization or denial is provided within the appropriate time frame outlined in this subsection, the request for service authorization shall be considered approved, and the service associated with the authorization shall be deemed payable by the MCO at the standard contractual rate of reimbursement for the service or as required by law.

(3) If a service authorization is given, the MCO cannot request further clinical data for the purpose of a medical necessity review prior to payment when a claim for the service is received by the MCO, unless the service on the

claim differs significantly from the service which was approved. Unless the service is deemed to significantly differ from the service authorized when the service authorization was given by the MCO, the service shall be deemed medically necessary and authorized for payment at the rate consistent with the service initially authorized by the MCO and shall be paid.

(4) If the service on a claim differs significantly from the service previously approved, the provider must have at least 30 days from receiving a request from the MCO to submit clinical information to show medical necessity of the service that was billed. If the clinical information demonstrates that the billed service was medically necessary, the claim shall be paid.

(5) If a service did not require a service authorization under the MCO's policies, and the MCO undertakes a medical necessity review prior to paying the claim, the MCO must request all necessary information for the review from the provider within 5 business days of the receipt of the claim and the provider shall have at least 30 business days from the receipt of the request to provide the information requested by the MCO.

(6) Before an MCO can recover payments made based on a post-payment audit, the MCO must give the provider a 60 day written notice of each claim for which recovery is sought and the reasons for the recovery using a standard code from

the list established under paragraph (5) of subsection (g). Record requests in a post payment audit may not exceed the standards set forth in the Medicare Fee for Service Recovery Audit Program for the provider type being audited, adjusted for the provider's Medicaid volumes. Post-payment recovery based on lack of medical necessity for claims that were previously approved based on a medical necessity review can only occur if it is demonstrated by the MCO that the information provided at the time of the previous review was knowingly materially inaccurate or incomplete at the time the information was provided by the provider.

(7) If an MCO denies payment of or reduces the rate of payment of a claim for a service which was:

(A) provided in good faith following the receipt of a service authorization by the MCO and the denial is for lack of service authorization, the MCO shall be required to pay the provider double the amount due the provider as a penalty add-on, in addition to the standard contractual rate of reimbursement, or as required by law, that would have been due for the service if no denial had occurred; or

(B) provided in good faith and denied for insufficient documentation and subsequently determined that the claim contained all information necessary to process and approve payment of the claim, the MCO shall be required to pay the provider a penalty add-on, in

addition to the standard contractual rate of reimbursement or as required by law, equal to the value of the amount owed the provider pursuant to the standard contractual rate of reimbursement or as required by law. Such penalty add-on shall be due and payable to the provider within 30 days of payment of the original claim payment.

The penalties imposed under this paragraph shall be due in addition to any interest owed pursuant to the timely payment provisions of subsection (g).

(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).

(j) The requirements of this Section added by this amendatory Act of the 101st General Assembly shall apply to services provided on or after the first day of the month that begins 60 days after the effective date of this amendatory Act

of the 101st General Assembly.

(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.)

(305 ILCS 5/5-30.11 new)

Sec. 5-30.11. Discharge notification and facility placement of individuals; managed care. Whenever a hospital provides notice to a managed care organization (MCO) that an individual covered under the State's medical assistance program has received a discharge order from the attending physician and is ready for discharge from an inpatient hospital stay to another level of care, the MCO shall secure the individual's placement in or transfer to another facility within 24 hours of receiving the hospital's notification, or shall pay the hospital a daily rate equal to the hospital's daily rate associated with the stay ending, including all applicable add-on adjustment payments.

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