HB2117

101ST GENERAL ASSEMBLY

State of Illinois

2019 and 2020

HB2117

by Rep. David McSweeney

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.1

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires managed care organizations (MCOs) to publish, at least quarterly for the preceding quarter, on their websites: (1) the total number of claims received by the MCO; (2) the number and monetary amount of claims payments made to a service provider; (3) the dates of services rendered for the claims payments made under item (2); (4) the dates the claims were received by the MCO for the claims payments made under item (2); and (5) the dates on which claims payments under item (2) were released. Effective July 1, 2019.

LRB101 08161 KTG 53227 b

A BILL FOR

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

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.

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

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

1 to the penalty imposed under the Illinois Insurance Code
2 for any claims not timely paid.
3 (4) The Department may establish a process for MCOs to
4 expedite payments to providers based on criteria
5 established by the Department.
6 (g-5) Recognizing that the rapid transformation of the
7 Illinois Medicaid program may have unintended operational
8 challenges for both payers and providers:
9 (1) in no instance shall a medically necessary covered
10 service rendered in good faith, based upon eligibility
11 information documented by the provider, be denied coverage
12 or diminished in payment amount if the eligibility or
13 coverage information available at the time the service was
14 rendered is later found to be inaccurate; and
15 (2) the Department shall, by December 31, 2016, adopt
16 rules establishing policies that shall be included in the
17 Medicaid managed care policy and procedures manual
18 addressing payment resolutions in situations in which a
19 provider renders services based upon information obtained
20 after verifying a patient's eligibility and coverage plan
21 through either the Department's current enrollment system
22 or a system operated by the coverage plan identified by the
23 patient presenting for services:
24 (A) such medically necessary covered services
25 shall be considered rendered in good faith;
26 (B) such policies and procedures shall be

1 developed in consultation with industry
2 representatives of the Medicaid managed care health
3 plans and representatives of provider associations
4 representing the majority of providers within the
5 identified provider industry; and
6 (C) such rules shall be published for a review and
7 comment period of no less than 30 days on the
8 Department's website with final rules remaining
9 available on the Department's website.
10 (3) The rules on payment resolutions shall include, but
11 not be limited to:
12 (A) the extension of the timely filing period;
13 (B) retroactive prior authorizations; and
14 (C) guaranteed minimum payment rate of no less than
15 the current, as of the date of service, fee-for-service
16 rate, plus all applicable add-ons, when the resulting
17 service relationship is out of network.
18 (4) The rules shall be applicable for both MCO coverage
19 and fee-for-service coverage.
20 (g-6) MCO Performance Metrics Report.
21 (1) The Department shall publish, on at least a
22 quarterly basis, each MCO's operational performance,
23 including, but not limited to, the following categories of
24 metrics:
25 (A) claims payment, including timeliness and
26 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,

1 90, and over 90 days, and the dollar amounts associated with
2 those claims. The Department shall post the contracted claims
3 report required by HealthChoice Illinois on its website every 3
4 months.
5 (h) The Department shall not expand mandatory MCO
6 enrollment into new counties beyond those counties already
7 designated by the Department as of June 1, 2014 for the
8 individuals whose eligibility for medical assistance is not the
9 seniors or people with disabilities population until the
10 Department provides an opportunity for accountable care
11 entities and MCOs to participate in such newly designated
12 counties.
13 (h-5) MCOs shall be required to publish, at least quarterly
14 for the preceding quarter, on their websites:
15 (1) the total number of claims received by the MCO;
16 (2) the number and monetary amount of claims payments
17 made to a service provider as defined in Section 2-16 of
18 this Code;
19 (3) the dates of services rendered for the claims
20 payments made under paragraph (2);
21 (4) the dates the claims were received by the MCO for
22 the claims payments made under paragraph (2); and
23 (5) the dates on which claims payments under paragraph
24 (2) were released.
25 (i) The requirements of this Section apply to contracts
26 with accountable care entities and MCOs entered into, amended,

1 or renewed after June 16, 2014 (the effective date of Public
2 Act 98-651).
3 (Source: P.A. 99-725, eff. 8-5-16; 99-751, eff. 8-5-16;
4 100-201, eff. 8-18-17; 100-580, eff. 3-12-18; 100-587, eff.
5 6-4-18.)

6 Section 99. Effective date. This Act takes effect July 1,
7 2019.