Sen. Ann Gillespie

Filed: 4/16/2021

1 AMENDMENT TO SENATE BILL 1041

2 AMENDMENT NO. ______. Amend Senate Bill 1041 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
10 which contracts with the Department to provide services where
11 payment for medical services is made on a capitated basis.
12 "Emergency services" include:
13 (1) emergency services, as defined by Section 10 of
14 the 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
10 Care 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
22 as 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
10 treating non-affiliated provider until an affiliated
11 provider was reached and either concurred with the
12 treating 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
23 determining 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

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 timely payment interest penalty imposed under Section 368a of 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 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) Such payments shall be reported separately from the claim payment for services rendered to the MCO's enrollee and clearly identified as interest payments.

(4)(A) The Department shall require MCOs to expedite payments to providers identified on the Department's expedited provider list, determined in accordance with 89 Ill. Adm. Code 140.71(b), 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, and 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.

(C) The Department shall share at least monthly its expedited provider list and the frequency with which it pays providers on the expedited list.

(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 in the assignment of coverage responsibility between MCOs or the fee-for-service system, except for instances when an individual is deemed to have not been eligible for

1 coverage under the Illinois Medicaid program; and
2 (2) the Department shall, by December 31, 2016, adopt
3 rules establishing policies that shall be included in the
4 Medicaid managed care policy and procedures manual
5 addressing payment resolutions in situations in which a
6 provider renders services based upon information obtained
7 after verifying a patient's eligibility and coverage plan
8 through either the Department's current enrollment system
9 or a system operated by the coverage plan identified by
10 the patient presenting for services:
11 (A) such medically necessary covered services
12 shall be considered rendered in good faith;
13 (B) such policies and procedures shall be
14 developed in consultation with industry
15 representatives of the Medicaid managed care health
16 plans and representatives of provider associations
17 representing the majority of providers within the
18 identified provider industry; and
19 (C) such rules shall be published for a review and
20 comment period of no less than 30 days on the
21 Department's website with final rules remaining
22 available on the Department's website.
23 The rules on payment resolutions shall include, but not be
24 limited to:
25 (A) the extension of the timely filing period;
26 (B) retroactive prior authorizations; and

1 (C) guaranteed minimum payment rate of no less than
2 the current, as of the date of service, fee-for-service
3 rate, plus all applicable add-ons, when the resulting
4 service relationship is out of network.
5 The rules shall be applicable for both MCO coverage and
6 fee-for-service coverage.
7 If the fee-for-service system is ultimately determined to
8 have been responsible for coverage on the date of service, the
9 Department shall provide for an extended period for claims
10 submission outside the standard timely filing requirements.
11 (g-6) MCO Performance Metrics Report.
12 (1) The Department shall publish, on at least a
13 quarterly basis, each MCO's operational performance,
14 including, but not limited to, the following categories of
15 metrics:
16 (A) claims payment, including timeliness and
17 accuracy;
18 (B) prior authorizations;
19 (C) grievance and appeals;
20 (D) utilization statistics;
21 (E) provider disputes;
22 (F) provider credentialing; and
23 (G) member and provider customer service.
24 (2) The Department shall ensure that the metrics
25 report is accessible to providers online by January 1,
26 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) Dispute resolution process. The Department shall maintain a provider complaint portal through which a provider can submit to the Department unresolved disputes with an MCO. An unresolved dispute means an MCO's decision that denies in

1 whole or in part a claim for reimbursement to a provider for
2 health care services rendered by the provider to an enrollee
3 of the MCO with which the provider disagrees. Disputes shall
4 not be submitted to the portal until the provider has availed
5 itself of the MCO's internal dispute resolution process.
6 Disputes that are submitted to the MCO internal dispute
7 resolution process may be submitted to the Department of
8 Healthcare and Family Services' complaint portal no sooner
9 than 30 days after submitting to the MCO's internal process
10 and not later than 30 days after the unsatisfactory resolution
11 of the internal MCO process or 60 days after submitting the
12 dispute to the MCO internal process. Multiple claim disputes
13 involving the same MCO may be submitted in one complaint,
14 regardless of whether the claims are for different enrollees,
15 when the specific reason for non-payment of the claims
16 involves a common question of fact or policy. Within 10
17 business days of receipt of a complaint, the Department shall
18 present such disputes to the appropriate MCO, which shall then
19 have 30 days to issue its written proposal to resolve the
20 dispute. The Department may grant one 30-day extension of this
21 time frame to one of the parties to resolve the dispute. If the
22 dispute remains unresolved at the end of this time frame or the
23 provider is not satisfied with the MCO's written proposal to
24 resolve the dispute, the provider may, within 30 days, request
25 the Department to review the dispute and make a final
26 determination. Within 30 days of the request for Department

review of the dispute, both the provider and the MCO shall present all relevant information to the Department for resolution and make individuals with knowledge of the issues available to the Department for further inquiry if needed. Within 30 days of receiving the relevant information on the dispute, or the lapse of the period for submitting such information, the Department shall issue a written decision on the dispute based on contractual terms between the provider and the MCO, contractual terms between the MCO and the Department of Healthcare and Family Services and applicable Medicaid policy. The decision of the Department shall be final. By January 1, 2020, the Department shall establish by rule further details of this dispute resolution process. Disputes between MCOs and providers presented to the Department for resolution are not contested cases, as defined in Section 1-30 of the Illinois Administrative Procedure Act, conferring any right to an administrative hearing.

(g-9)(1) The Department shall publish annually on its website a report on the calculation of each managed care organization's medical loss ratio showing the following:

(A) Premium revenue, with appropriate adjustments.

(B) Benefit expense, setting forth the aggregate amount spent for the following:

(i) Direct paid claims.

(ii) Subcapitation payments.

(iii) Other claim payments.

1 (iv) Direct reserves.
2 (v) Gross recoveries.
3 (vi) Expenses for activities that improve health
4 care quality as allowed by the Department.
5 (2) The medical loss ratio shall be calculated consistent
6 with federal law and regulation following a claims runout
7 period determined by the Department.
8 (g-10)(1) "Liability effective date" means the date on
9 which an MCO becomes responsible for payment for medically
10 necessary and covered services rendered by a provider to one
11 of its enrollees in accordance with the contract terms between
12 the MCO and the provider. The liability effective date shall
13 be the later of:
14 (A) The execution date of a network participation
15 contract agreement.
16 (B) The date the provider or its representative
17 submits to the MCO the complete and accurate standardized
18 roster form for the provider in the format approved by the
19 Department.
20 (C) The provider effective date contained within the
21 Department's provider enrollment subsystem within the
22 Illinois Medicaid Program Advanced Cloud Technology
23 (IMPACT) System.
24 (2) The standardized roster form may be submitted to the
25 MCO at the same time that the provider submits an enrollment
26 application to the Department through IMPACT.

1 (3) By October 1, 2019, the Department shall require all
2 MCOs to update their provider directory with information for
3 new practitioners of existing contracted providers within 30
4 days of receipt of a complete and accurate standardized roster
5 template in the format approved by the Department provided
6 that the provider is effective in the Department's provider
7 enrollment subsystem within the IMPACT system. Such provider
8 directory shall be readily accessible for purposes of
9 selecting an approved health care provider and comply with all
10 other federal and State requirements.
11 (g-11) The Department shall work with relevant
12 stakeholders on the development of operational guidelines to
13 enhance and improve operational performance of Illinois'
14 Medicaid managed care program, including, but not limited to,
15 improving provider billing practices, reducing claim
16 rejections and inappropriate payment denials, and
17 standardizing processes, procedures, definitions, and response
18 timelines, with the goal of reducing provider and MCO
19 administrative burdens and conflict. The Department shall
20 include a report on the progress of these program improvements
21 and other topics in its Fiscal Year 2020 annual report to the
22 General Assembly.
23 (h) The Department shall not expand mandatory MCO
24 enrollment into new counties beyond those counties already
25 designated by the Department as of June 1, 2014 for the
26 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) Health care information released to managed care organizations. A health care provider shall release to a Medicaid managed care organization, upon request, and subject to the Health Insurance Portability and Accountability Act of 1996 and any other law applicable to the release of health information, the health care information of the MCO's enrollee, if the enrollee has completed and signed a general release form that grants to the health care provider permission to release the recipient's health care information to the recipient's insurance carrier.

(Source: P.A. 100-201, eff. 8-18-17; 100-580, eff. 3-12-18; 100-587, eff. 6-4-18; 101-209, eff. 8-5-19.)

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