SB3372

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

SB3372

Introduced 2/7/2024, by Sen. Ann Gillespie

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.1

Amends the Medical Assistance Article of the Illinois Public Aid Code. Makes changes to provisions requiring Medicaid managed care organizations (MCO) to make payments for emergency services. Requires an MCO to pay any provider of emergency services, including inpatient stabilization services provided during the inpatient stabilization period, that does not have in effect a contract with the MCO. Defines "inpatient stabilization period" to mean the initial 72 hours of inpatient stabilization services, beginning from the date and time of the order for inpatient admission to the hospital. Provides that when determining payment for all emergency services, including inpatient stabilization services provided during the inpatient stabilization period, the MCO shall: (i) not impose any service authorization requirements, including, but not limited to, prior authorization, prior approval, pre-certification, concurrent review, or certification of admission; (ii) have no obligation to cover emergency services provided on an emergency basis that are not covered services under the MCO's contract with the Department of Healthcare and Family Services; and (iii) not condition coverage for emergency services on the treating provider notifying the MCO of the enrollee's emergency medical screening examination and treatment within 10 days after presentation for emergency services. Provides that the determination of the attending emergency physician, or the practitioner responsible for the enrollee's care at the hospital, of whether an enrollee requires inpatient stabilization services, can be stabilized in the outpatient setting, or is sufficiently stabilized for discharge or transfer to another facility, shall be binding on the MCO. Provides that an MCO shall not reimburse inpatient stabilization services billed on an inpatient institutional claim under the outpatient reimbursement methodology and shall not reimburse providers for emergency services in cases of fraud. Requires the Department to impose sanctions on a MCO for noncompliance, including, but not limited to, financial penalties, suspension of enrollment of new enrollees, and termination of the MCO's contract with the Department. Effective immediately.

LRB103 37676 KTG 67803 b

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" means health care items and services, including inpatient and outpatient hospital services, furnished or required to evaluate and stabilize an emergency medical condition. "Emergency services" include inpatient stabilization services furnished during the inpatient stabilization period. "Emergency services" do not include post-stabilization medical 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;~~

1 ~~(3) post-stabilization medical services, as defined by~~
2 ~~Section 10 of the Managed Care Reform and Patient Rights~~
3 ~~Act; and~~
4 ~~(4) emergency medical conditions, as defined by~~
5 ~~Section 10 of the Managed Care Reform and Patient Rights~~
6 ~~Act.~~
7 "Emergency medical condition" means a medical condition
8 manifesting itself by acute symptoms of sufficient severity,
9 regardless of the final diagnosis given, such that a prudent
10 layperson, who possesses an average knowledge of health and
11 medicine, could reasonably expect the absence of immediate
12 medical attention to result in:
13 (1) placing the health of the individual (or, with
14 respect to a pregnant woman, the health of the woman or her
15 unborn child) in serious jeopardy;
16 (2) serious impairment to bodily functions;
17 (3) serious dysfunction of any bodily organ or part;
18 (4) inadequately controlled pain; or
19 (5) with respect to a pregnant woman who is having
20 contractions:
21 (A) inadequate time to complete a safe transfer to
22 another hospital before delivery; or
23 (B) a transfer to another hospital may pose a
24 threat to the health or safety of the woman or unborn
25 child.
26 "Emergency medical screening examination" means a medical

1 screening examination and evaluation by a physician licensed
2 to practice medicine in all its branches or, to the extent
3 permitted by applicable laws, by other appropriately licensed
4 personnel under the supervision of or in collaboration with a
5 physician licensed to practice medicine in all its branches to
6 determine whether the need for emergency services exists.

7 "Inpatient stabilization period" means the initial 72
8 hours of inpatient stabilization services, beginning from the
9 date and time of the order for inpatient admission to the
10 hospital.

11 "Inpatient stabilization services" mean emergency services
12 furnished in the inpatient setting at a licensed hospital
13 pursuant to an order for inpatient admission by a physician or
14 other qualified practitioner who has admitting privileges at
15 the hospital, as permitted by State law, to stabilize an
16 emergency medical condition following an emergency medical
17 screening examination.

18 "Post-stabilization medical services" means health care
19 services provided to an enrollee that are furnished in a
20 licensed hospital by a provider that is qualified to furnish
21 such services and determined to be medically necessary and
22 directly related to the emergency medical condition following
23 stabilization.

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

(c) An MCO shall pay any provider of emergency services, including inpatient stabilization services provided during the inpatient stabilization period, 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.~~

(d) Notwithstanding any other provision of law, the ~~(c) The~~ following requirements apply to MCOs in determining payment for all emergency services, including inpatient stabilization services provided during the inpatient stabilization period:

(1) The MCO ~~MCOs~~ shall not impose any service authorization requirements for ~~prior approval of~~ emergency services, including, but not limited to, prior authorization, prior approval, pre-certification, concurrent review, or certification of admission.

(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 emergency ~~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 emergency medical screening examination and treatment within 10 days after presentation for emergency services.

(5) The determination of the attending emergency physician, or the practitioner responsible for the enrollee's care at the hospital, ~~the provider actually treating the enrollee,~~ of whether an enrollee requires inpatient stabilization services, can be stabilized in the outpatient setting, or is sufficiently stabilized for discharge or transfer to another facility, shall be binding on the MCO. The MCO shall cover and reimburse providers for emergency services as billed by the provider for all enrollees whether the emergency services are provided by an affiliated or non-affiliated provider, except in cases of fraud. The MCO shall not reimburse inpatient stabilization services provided during the inpatient stabilization period and billed on an inpatient institutional claim under the outpatient reimbursement methodology.

(6) The MCO's financial responsibility for

post-stabilization medical ~~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.

(e) An MCO shall pay for all post-stabilization medical 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 the State's 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.

(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;

(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;

(E) require MCOs to ensure that any

1 Medicaid-certified provider under contract with an MCO
2 and previously submitted on a roster on the date of
3 service is paid for any medically necessary,
4 Medicaid-covered, and authorized service rendered to
5 any of the MCO's enrollees, regardless of inclusion on
6 the MCO's published and publicly available directory
7 of available providers; and
8 (F) require MCOs, including Medicaid Managed Care
9 Entities as defined in Section 5-30.2, to meet each of
10 the requirements under subsection (d-5) of Section 10
11 of the Network Adequacy and Transparency Act; with
12 necessary exceptions to the MCO's network to ensure
13 that admission and treatment with a provider or at a
14 treatment facility in accordance with the network
15 adequacy standards in paragraph (3) of subsection
16 (d-5) of Section 10 of the Network Adequacy and
17 Transparency Act is limited to providers or facilities
18 that are Medicaid certified.
19 (2) Each MCO shall confirm its receipt of information
20 submitted specific to physician or dentist additions or
21 physician or dentist deletions from the MCO's provider
22 network within 3 days after receiving all required
23 information from contracted physicians or dentists, and
24 electronic physician and dental directories must be
25 updated consistent with current rules as published by the
26 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, 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.

(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

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

1 (A) the extension of the timely filing period;
2 (B) retroactive prior authorizations; and
3 (C) guaranteed minimum payment rate of no less
4 than the current, as of the date of service,
5 fee-for-service rate, plus all applicable add-ons,
6 when the resulting service relationship is out of
7 network.
8 The rules shall be applicable for both MCO coverage
9 and fee-for-service coverage.
10 If the fee-for-service system is ultimately determined to
11 have been responsible for coverage on the date of service, the
12 Department shall provide for an extended period for claims
13 submission outside the standard timely filing requirements.
14 (g-6) MCO Performance Metrics Report.
15 (1) The Department shall publish, on at least a
16 quarterly basis, each MCO's operational performance,
17 including, but not limited to, the following categories of
18 metrics:
19 (A) claims payment, including timeliness and
20 accuracy;
21 (B) prior authorizations;
22 (C) grievance and appeals;
23 (D) utilization statistics;
24 (E) provider disputes;
25 (F) provider credentialing; and
26 (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 Public Act 100-580, 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.

(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

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

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

21 (A) Premium revenue, with appropriate adjustments.

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

24 (i) Direct paid claims.

25 (ii) Subcapitation payments.

26 (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 (g-12) Notwithstanding any other provision of law, if the
24 Department or an MCO requires submission of a claim for
25 payment in a non-electronic format, a provider shall always be
26 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 State's fee-for-service system, shall a provider be denied payment for failure to comply with any timely submission requirements under 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.

(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.

(h-5) Leading indicator data sharing. By January 1, 2024, the Department shall obtain input from the Department of Human Services, the Department of Juvenile Justice, the Department of Children and Family Services, the State Board of Education, managed care organizations, providers, and clinical experts to identify and analyze key indicators from assessments and data

1 sets available to the Department that can be shared with
2 managed care organizations and similar care coordination
3 entities contracted with the Department as leading indicators
4 for elevated behavioral health crisis risk for children. To
5 the extent permitted by State and federal law, the identified
6 leading indicators shall be shared with managed care
7 organizations and similar care coordination entities
8 contracted with the Department within 6 months of
9 identification for the purpose of improving care coordination
10 with the early detection of elevated risk. Leading indicators
11 shall be reassessed annually with stakeholder input.

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

16 (j) Health care information released to managed care
17 organizations. A health care provider shall release to a
18 Medicaid managed care organization, upon request, and subject
19 to the Health Insurance Portability and Accountability Act of
20 1996 and any other law applicable to the release of health
21 information, the health care information of the MCO's
22 enrollee, if the enrollee has completed and signed a general
23 release form that grants to the health care provider
24 permission to release the recipient's health care information
25 to the recipient's insurance carrier.

26 (k) The Department of Healthcare and Family Services,

managed care organizations, a statewide organization representing hospitals, and a statewide organization representing safety-net hospitals shall explore ways to support billing departments in safety-net hospitals.

(l) The requirements of this Section added by Public Act 102-4 shall apply to services provided on or after the first day of the month that begins 60 days after April 27, 2021 (the effective date of Public Act 102-4).

(m) The Department shall impose sanctions on a managed care organization for violating any provision under this Section, including, but not limited to, financial penalties, suspension of enrollment of new enrollees, and termination of the MCO's contract with the Department.

(Source: P.A. 102-4, eff. 4-27-21; 102-43, eff. 7-6-21; 102-144, eff. 1-1-22; 102-454, eff. 8-20-21; 102-813, eff. 5-13-22; 103-546, eff. 8-11-23.)

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