HB2788

LRB09908001MLM28141b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB2788

by Rep. Laura Fine

SYNOPSIS AS INTRODUCED:

215 ILCS 134/80
215 ILCS 134/85

Amends the Managed Care Reform and Patient Rights Act. Provides that the Department of Public Health shall accept evidence of accreditation with regard to the health care network quality management and performance improvement standards of the Accreditation Association for Ambulatory Health Care. Provides that the Department of Insurance shall recognize the Accreditation Association for Ambulatory Health Care among the list of accreditors from which utilization organizations may receive accreditation and qualify for reduced registration and renewal fees.

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A BILL FOR

AN ACT concerning insurance.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 5. The Managed Care Reform and Patient Rights Act is amended by changing Sections 80 and 85 as follows:

(215 ILCS 134/80)

Sec. 80. Quality assessment program.

(a) A health care plan shall develop and implement a quality assessment and improvement strategy designed to identify and evaluate accessibility, continuity, and quality of care. The health care plan shall have:

(1) an ongoing, written, internal quality assessment program;

(2) specific written guidelines for monitoring and evaluating the quality and appropriateness of care and services provided to enrollees requiring the health care plan to assess:

(A) the accessibility to health care providers;

(B) appropriateness of utilization;

(C) concerns identified by the health care plan's medical or administrative staff and enrollees; and

(D) other aspects of care and service directly related to the improvement of quality of care;

(3) a procedure for remedial action to correct quality problems that have been verified in accordance with the written plan's methodology and criteria, including written procedures for taking appropriate corrective action;

(4) follow-up measures implemented to evaluate the effectiveness of the action plan.

(b) The health care plan shall establish a committee that oversees the quality assessment and improvement strategy which includes physician and enrollee participation.

(c) Reports on quality assessment and improvement activities shall be made to the governing body of the health care plan not less than quarterly.

(d) The health care plan shall make available its written description of the quality assessment program to the Department of Public Health.

(e) With the exception of subsection (d), the Department of Public Health shall accept evidence of accreditation with regard to the health care network quality management and performance improvement standards of:

(1) the National Commission on Quality Assurance (NCQA);

(2) the American Accreditation Healthcare Commission (URAC);

(3) the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); ~~or~~

(4) the Accreditation Association for Ambulatory

Health Care (AAAHC); or

(5) ~~(4)~~ any other entity that the Director of Public Health deems has substantially similar or more stringent standards than provided for in this Section.

(f) If the Department of Public Health determines that a health care plan is not in compliance with the terms of this Section, it shall certify the finding to the Department of Insurance. The Department of Insurance shall subject a health care plan to penalties, as provided in this Act, for such non-compliance.

(Source: P.A. 91-617, eff. 1-1-00.)

(215 ILCS 134/85)

Sec. 85. Utilization review program registration.

(a) No person may conduct a utilization review program in this State unless once every 2 years the person registers the utilization review program with the Department and certifies compliance with the Health Utilization Management Standards of the American Accreditation Healthcare Commission (URAC) sufficient to achieve American Accreditation Healthcare Commission (URAC) accreditation or submits evidence of accreditation by the American Accreditation Healthcare Commission (URAC) for its Health Utilization Management Standards. Nothing in this Act shall be construed to require a health care plan or its subcontractors to become American Accreditation Healthcare Commission (URAC) accredited.

(b) In addition, the Director of the Department, in consultation with the Director of the Department of Public Health, may certify alternative utilization review standards of national accreditation organizations or entities in order for plans to comply with this Section. Any alternative utilization review standards shall meet or exceed those standards required under subsection (a).

(b-5) The Department shall recognize the Accreditation Association for Ambulatory Health Care among the list of accreditors from which utilization organizations may receive accreditation and qualify for reduced registration and renewal fees.

(c) The provisions of this Section do not apply to:

(1) persons providing utilization review program services only to the federal government;

(2) self-insured health plans under the federal Employee Retirement Income Security Act of 1974, however, this Section does apply to persons conducting a utilization review program on behalf of these health plans;

(3) hospitals and medical groups performing utilization review activities for internal purposes unless the utilization review program is conducted for another person.

Nothing in this Act prohibits a health care plan or other entity from contractually requiring an entity designated in item (3) of this subsection to adhere to the utilization review

program requirements of this Act.

(d) This registration shall include submission of all of the following information regarding utilization review program activities:

(1) The name, address, and telephone number of the utilization review programs.

(2) The organization and governing structure of the utilization review programs.

(3) The number of lives for which utilization review is conducted by each utilization review program.

(4) Hours of operation of each utilization review program.

(5) Description of the grievance process for each utilization review program.

(6) Number of covered lives for which utilization review was conducted for the previous calendar year for each utilization review program.

(7) Written policies and procedures for protecting confidential information according to applicable State and federal laws for each utilization review program.

(e) (1) A utilization review program shall have written procedures for assuring that patient-specific information obtained during the process of utilization review will be:

(A) kept confidential in accordance with applicable State and federal laws; and

(B) shared only with the enrollee, the enrollee's

designee, the enrollee's health care provider, and those who are authorized by law to receive the information.

Summary data shall not be considered confidential if it does not provide information to allow identification of individual patients or health care providers.

(2) Only a health care professional may make determinations regarding the medical necessity of health care services during the course of utilization review.

(3) When making retrospective reviews, utilization review programs shall base reviews solely on the medical information available to the attending physician or ordering provider at the time the health care services were provided.

(4) When making prospective, concurrent, and retrospective determinations, utilization review programs shall collect only information that is necessary to make the determination and shall not routinely require health care providers to numerically code diagnoses or procedures to be considered for certification, unless required under State or federal Medicare or Medicaid rules or regulations, but may request such code if available, or routinely request copies of medical records of all enrollees reviewed. During prospective or concurrent review, copies of medical records shall only be required when necessary to verify that the health care services subject to review are medically necessary. In these cases, only the necessary or

relevant sections of the medical record shall be required.

(f) If the Department finds that a utilization review program is not in compliance with this Section, the Department shall issue a corrective action plan and allow a reasonable amount of time for compliance with the plan. If the utilization review program does not come into compliance, the Department may issue a cease and desist order. Before issuing a cease and desist order under this Section, the Department shall provide the utilization review program with a written notice of the reasons for the order and allow a reasonable amount of time to supply additional information demonstrating compliance with requirements of this Section and to request a hearing. The hearing notice shall be sent by certified mail, return receipt requested, and the hearing shall be conducted in accordance with the Illinois Administrative Procedure Act.

(g) A utilization review program subject to a corrective action may continue to conduct business until a final decision has been issued by the Department.

(h) Any adverse determination made by a health care plan or its subcontractors may be appealed in accordance with subsection (f) of Section 45.

(i) The Director may by rule establish a registration fee for each person conducting a utilization review program. All fees paid to and collected by the Director under this Section shall be deposited into the Insurance Producer Administration Fund.

(Source: P.A. 91-617, eff. 7-1-00.)