HB5559

LRB09919046KTG45001b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB5559

by Rep. Litesa E. Wallace

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.1

Amends the Medical Assistance Article of the Illinois Public Aid Code. In a provision concerning managed care organizations (MCOs) contracted with the Department of Healthcare and Family Services to provide health services, requires the Department to develop a procedure no later than January 1, 2017 to directly test the provider network directories submitted to the State by each MCO. Provides that the procedure must directly test the accuracy of the information contained in the provider directories, the ability of prospective patients to obtain an appointment, and the timeliness of appointments offered to prospective patients. Requires the Department to develop the procedure in consultation with MCOs, providers, consumer advocacy organizations, and other relevant stakeholders and to contract with a third party with experience developing or evaluating procedures to directly test Medicaid provider availability and access in Illinois and other states. Sets forth certain provider types the Department is required to test for each MCO and mandatory managed care region, including: (i) primary care; (ii) mental health treatment; (iii) adult specialty; (iv) child specialty; and (v) any additional provider types the Department has reason to believe may not exist in sufficient numbers in one or more mandatory managed care regions. Requires the Department to annually publish the data collected in its External Quality Review Technical Report. Permits the Department to adopt any rules necessary to implement these responsibilities. 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 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.

(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.

(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 to maintain an updated and public list of network providers.

(f-5) Medicaid access monitoring.

(1) The Department shall develop a procedure to directly test the provider network directories submitted to the State by each MCO contracted with the State to furnish health services. The procedure must directly test the accuracy of the information contained in the provider directories, the ability of prospective patients to obtain an appointment, and the timeliness of appointments offered to prospective patients. In developing the procedure, the Department shall consult with MCOs, providers, consumer advocacy organizations, and other relevant stakeholders. The Department shall fulfill its obligation under this paragraph by contracting with a third party with experience developing or evaluating procedures to directly test Medicaid provider availability and access in Illinois and other states. The procedure shall be developed no later than January 1, 2017.

(2) The Department shall test the following provider

types for each MCO contracted with the State to furnish health care services and for each mandatory managed care region:

(A) Primary care.

(B) Obstetrics and gynecology.

(C) Psychiatry.

(D) Mental health treatment.

(E) Substance abuse treatment.

(F) Hospital.

(G) Dental.

(H) Adult specialty, including at least 3 subspecialties that commonly practice in an outpatient setting, are identified as being in high demand, and are presenting some degree of difficulty in access as reported through public input.

(I) Child specialty, including at least 3 subspecialties that commonly practice in an outpatient setting, are identified as being in high demand, and are presenting some degree of difficulty in access as reported through public input.

(J) Any additional provider types the Department has reason to believe may not exist in sufficient numbers in one or more mandatory managed care regions.

(3) The Department shall collect the following data for each provider network tested:

(A) the percentage of providers listed in the MCO

provider directory who practice at the address listed in the MCO provider directory;

(B) the percentage of providers listed in the MCO provider directory who can be reached using the contact information listed in the MCO provider directory;

(C) the percentage of providers listed in the MCO provider directory who report they are participating in the MCO;

(D) the percentage of providers who report they are participating in the MCO and are accepting new patients enrolled in the MCO; and

(E) the percentage of providers who report they are accepting new patients enrolled in the MCO and can offer appointments to the prospective patient within the timeframes required under 42 U.S.C. 1396u-2 and State MCO contracts.

(4) The procedure established under paragraph (1) must use a published, peer-reviewed methodology to directly test each provider network for each MCO and mandatory managed care region. The procedure shall:

(A) use inquiries from researchers posing as a prospective patient or someone acting on behalf of a prospective patient as the direct testing method;

(B) ensure a statistically significant sample is tested for each MCO, mandatory managed care region, and required provider type; and

(C) be conducted at least annually starting in 2017.

(5) The Department and its contractors shall provide all information and logistical support that is necessary to pose authentically as a prospective patient enrolled in an MCO to any entity developing or conducting the direct test described under this subsection. Such information may include, but is not limited to, simulated Medicaid Recipient Identification Numbers, simulated MCO membership, and any other inputs into the Medicaid Management Information System or other databases used by providers to verify information provided by prospective patients seeking to make an appointment.

(6) The Department shall annually publish the data collected under paragraph (3) in the External Quality Review Technical Report required under 42 U.S.C. 1396u-2.

(7) The Department shall fulfill its obligations under this subsection by contracting with an external quality review organization, provided they meet all federal competence and independence standards.

(8) On or before January 1, 2017, the Director of Healthcare and Family Services may adopt rules necessary to implement the Department's responsibilities under this subsection.

(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 penalty imposed under the Illinois Insurance Code for any claims not timely paid.

(4) The Department may establish a process for MCOs to expedite payments to providers based on criteria established by the Department.

(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 the effective date of this amendatory Act of the 98th General Assembly.

(Source: P.A. 98-651, eff. 6-16-14.)

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