HB5671

LRB09919589KTG44852b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB5671

by Rep. Greg Harris

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.1

Amends the Medical Assistance Article of the Illinois Public Aid Code. In a provision concerning network adequacy for managed care organizations (MCO) contracted with the Department of Healthcare and Family Services, provides that each MCO shall (i) on a monthly basis, jointly validate with contracted providers any changes in provider information, including, but not limited to, changes concerning new providers, terminated providers, updated address information, hours of operation, or other information that is material to a Medicaid beneficiary in the enrollment and provider selection process; and (ii) be required to produce system reports that validate that all MCO systems reflect updated provider information. Provides that in situations in which an enrolled Medicaid provider renders services based on information obtained after verifying a patient's eligibility and coverage plan through either the Department's current enrollment system or the coverage plan identified by the patient presenting for services, such services shall be considered rendered in good faith. Requires the Department to create and maintain a MCO Performance Metrics Comparison Tool that provides periodic reporting, on at least a quarterly basis, of each MCO's performance in various administrative measures. Requires the tool to be accessible in both a print and online format, with the online format allowing for Medicaid beneficiaries and providers to access additional detailed MCO performance information. 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 <u>and transparency</u>.

(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.

(2) Each MCO shall:

(A) on a monthly basis, jointly validate with contracted providers, including contracted provider groups, any changes in provider information, including, but not limited to, changes concerning new providers, terminated providers, updated address information, hours of operation, or other information that is material to a Medicaid beneficiary in the enrollment and provider selection process; and

(B) be required to produce system reports that validate that all MCO systems reflect updated provider information.

(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.

(q-5) In situations in which an enrolled Medicaid provider renders services based on information obtained after verifying a patient's eligibility and coverage plan through either the Department's current enrollment system or the coverage plan identified by the patient presenting for services, such services shall be considered rendered in good faith. In no instance shall a service rendered in good faith be denied coverage or payment if the information available at the time the service was rendered is later found to be inaccurate.

(1) The provider of services shall be reimbursed by the MCO identified at the time services were rendered and based either on the current contract between the provider and the MCO or, when a contract does not exist, at the current Medicaid fee-for-service rate, including all applicable adjustors.

(2) The MCO as identified in paragraph (1) of this subsection, which pays the provider of services, shall be responsible for contacting either the Department or the appropriate MCO to request reimbursement for expenses

incurred to reimburse the provider of services.

(3) The responsible MCO may not attempt any collection efforts through subrogation on the provider of services if the provider can document that the services were provided based on information obtained at the time the services were rendered.

(q-6) MCO Performance Metrics Comparison Tool.

(1) The Department shall create and maintain a MCO Performance Metrics Comparison Tool that provides periodic reporting, on at least a quarterly basis, of each MCO's performance in various administrative measures, including, but not limited to, the following:

(A) Timely payment of claims, which shall mean the number of days between the date upon which the MCO receives a clean claim, as provided in Section 368a of the Illinois Insurance Code, and the date upon which payment from the MCO is received by the provider.

(B) Accuracy of the payment of claims, which shall mean the expected amount of reimbursement as defined in the provider's contract or the Medicaid fee-for-service rate, whichever is applicable, compared to the actual reimbursement amount received by the provider.

(C) Total number of provider denials.

(D) Total number of provider denials appealed and overturned.

(E) Total number of patient complaints and grievances.

(F) Total timeframe average for completion of provider credentialing, which shall mean the difference between the date upon which a clean application is submitted to the MCO and the date upon which the MCO gives final approval and assigns an effective date for participation in the MCO's network, for the applicable reporting period.

(G) Total timeframe average for loading provider information into the MCO's approved provider directory, which shall mean the date upon which the provider is approved to the time in which the MCO validates loading in its directory system.

(H) Total timeframe average for loading provider information into the MCO's claims system, which shall mean the date upon which the provider is approved to the time in which the provider appears in the MCO's claim system.

(I) Total timeframe average for response times from MCO staff, which shall mean the length of time from initial contact by the provider to the time in which an identified issue is officially documented as resolved.

(J) Total timeframe average for responses from the MCO that approve the provider's request to render care

to the patient.

(2) The Department shall ensure that the tool shall be accessible in both a print and online format, with the online format allowing for Medicaid beneficiaries and providers to access additional detailed MCO performance information.

(3) At a minimum, the print version of the tool shall be provided by the Department on an annual basis to providers and to Medicaid beneficiaries who are required by the Department to enroll in a MCO during an enrollees open enrollment period.

(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.