SB3373

LRB10337683KTG67810b

103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

SB3373

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

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.18 new

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services to adopt rules, by no later than January 1, 2025, to establish a process under which any provider meeting certain performance standards outlined in the amendatory Act shall be certified for a service authorization exemption from all service authorization programs for a period of no less than one year. Provides that qualification for a service authorization exemption shall be determined by the Department, or its contracted utilization review organization (URO), and shall be binding on a managed care organization (MCO) or the MCO's contracted URO. Provides that a provider shall be eligible for a service authorization exemption if the provider submitted at least 25 service authorization requests to a service authorization program in the preceding calendar year and the service authorization program approved at least 80% of the service authorization requests. Provides that no later than December 1 of each calendar year, each service authorization program shall provide written notification to all providers who qualify for a service authorization exemption for the subsequent calendar year. Requires the Department to adopt rules by January 1, 2025 to establish: (i) a standard method the Department, or its contracted URO, shall use to evaluate whether a provider meets the criteria to qualify for a service authorization exemption; (ii) a standard method the Department, or its contracted URO, shall use to accept and process provider appeals of denied or rescinded exemptions; and (iii) a standard method the MCOs shall use to accept and process professional claims and facility claims, as billed by the provider, for a health care service that is rendered, prescribed, or ordered by a provider granted a service authorization exemption, except in cases of fraud. Contains provisions concerning annual reviews by the Department of service authorization denials made under each service authorization program; quarterly reports issued by the Department that detail the performance of each service authorization program; sanctions on MCOs for noncompliance with any provision of the amendatory Act. Effective immediately.

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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 adding Section 5-30.18 as follows:

(305 ILCS 5/5-30.18 new)

Sec. 5-30.18. Service authorization program performance.

(a) Definitions. As used in this Section:

"Health care service" means any medical or behavioral health service covered under the medical assistance program that is rendered in the inpatient or outpatient hospital setting and subject to review under a service authorization program.

"Provider" means a facility or individual, or group of individuals operating under the same tax identification number, actively enrolled in the medical assistance program and licensed or otherwise authorized to order, prescribe, refer, or render health care services in this State.

"Service authorization determination" means a decision made by a service authorization program to approve, change the level of care, partially deny, or deny coverage and reimbursement for a health care service upon review of a service authorization request submitted by a provider.

"Service authorization exemption" means an exception granted by a service authorization program to a provider under which all service authorization requests for covered health care services are automatically deemed to be medically necessary, clinically appropriate, and approved for reimbursement as ordered.

"Service authorization program" means any utilization review, utilization management, peer review, quality review, or other medical management activity conducted in advance of, concurrent to, or after the provision of a health care service by a Medicaid managed care organization, either directly or through a contracted utilization review organization (URO), including, but not limited to, prior authorization, pre-certification, certification of admission, concurrent review, and retrospective review of health care services.

"Service authorization request" means a request by a provider to a service authorization program to determine whether a health care service that is otherwise covered under the medical assistance program meets the reimbursement requirements established by the managed care organization (MCO), or its contracted URO, for medically necessary, clinically appropriate care and to issue a service authorization determination.

"Utilization review organization" or "URO" means a managed care organization or other entity that has established or administers one or more service authorization programs.

(b) By no later than January 1, 2025, the Department shall adopt rules to establish a process under which any provider meeting the performance standards outlined in subsection (c) shall be certified for a service authorization exemption from all service authorization programs for a period of no less than one year. Qualification for a service authorization exemption shall be determined by the Department, or its contracted URO, and shall be binding on the MCO or the MCO's contracted URO.

(c) A provider shall be eligible for a service authorization exemption if the provider submitted at least 25 service authorization requests to a service authorization program in the preceding calendar year and the service authorization program approved at least 80% of the service authorization requests. A provider shall not be required to request a service authorization exemption to qualify for such exemption.

(d) No later than December 1 of each calendar year, each service authorization program shall provide written notification to all providers who qualify for a service authorization exemption, as determined by the Department, for the subsequent calendar year.

(e) A service authorization program shall not deny, partially deny, reduce the level of care, or otherwise limit reimbursement to the rendering or supervising provider, including the rendering facility, for health care services

ordered by a provider who qualifies for a service authorization exemption, except in cases of fraud.

(f) In consultation with the Medicaid managed care organizations, a statewide association representing managed care organizations, a statewide association representing the majority of Illinois hospitals, a statewide association representing physicians, and a statewide association representing nursing homes, the Department shall by January 1, 2025 adopt administrative rules to establish:

(1) a standard method the Department, or its contracted URO, shall use to evaluate whether a provider meets the criteria to qualify for a service authorization exemption under subsection (c) and to determine the conditions under which a service authorization exemption may be rescinded, including review of the provider's utilization during the preceding calendar year.

(2) a standard method the Department, or its contracted URO, shall use to accept and process provider appeals of denied or rescinded exemptions;

(3) a standard method the MCOs shall use to accept and process professional claims and facility claims, as billed by the provider, for a health care service that is rendered, prescribed, or ordered by a provider granted a service authorization exemption, except in cases of fraud.

(g) To ensure covered services furnished to individuals enrolled in an MCO are no less in amount, duration, and scope

than the same services furnished to individuals enrolled in the State's fee-for-service medical assistance program, beginning January 1, 2026, the Department, or its external quality review organization, shall conduct and make publicly available the results of an annual review of a sample of service authorization denials made under each service authorization program, stratified by MCO during the preceding calendar year, including denials based on initial review of a service authorization request and denials overturned on appeal to the service authorization program's internal process. The review shall, at a minimum, evaluate whether the determinations were made:

(1) using consistent application of established, evidence-based, and professionally recognized medical necessity criteria that is no more restrictive that the criteria used in the State's fee-for-service medical assistance program; and

(2) in compliance with the Department's administrative rules, the terms of the contract between the Department and the MCOs, and other applicable federal and State laws, regulations, and policies.

(h) The Department shall publish quarterly reports detailing the performance of each service authorization program, stratified by MCO, including concurrent review and continued stay review requests, that details, at a minimum, the number of service authorization requests received, the

number of requests approved based on review of the initial request, the number of requests denied based on review of the initial request and the reasons for the denials, the number of requests downgraded to a lower level of care and the reasons for the change in level of care, and the number of denied requests overturned on appeal and the reasons the requests were overturned.

(i) The Department shall impose sanctions on a managed care organization for violating provisions of this Section that include, but are not limited to, financial penalties, suspension of enrollment of new enrollees, and termination of the MCO's contract with the Department.

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