Rep. Jackie Haas

Filed: 3/25/2021

1 AMENDMENT TO HOUSE BILL 2832

2 AMENDMENT NO. ______. Amend House Bill 2832 by replacing
3 everything after the enacting clause with the following:

4 "Section 5. The Illinois Public Aid Code is amended by
5 adding Section 5-43 and by changing Section 5-30.1 and by
6 adding Section 5-30.12a as follows:

7 (305 ILCS 5/5-30.1)
8 Sec. 5-30.1. Managed care protections.
9 (a) As used in this Section:
10 "Managed care organization" or "MCO" means any entity
11 which contracts with the Department to provide services where
12 payment for medical services is made on a capitated basis.
13 "Emergency services" include:
14 (1) emergency services, as defined by Section 10 of
15 the Managed Care Reform and Patient Rights Act;
16 (2) emergency medical screening examinations, as

1 defined by Section 10 of the Managed Care Reform and
2 Patient Rights Act;
3 (3) post-stabilization medical services, as defined by
4 Section 10 of the Managed Care Reform and Patient Rights
5 Act; and
6 (4) emergency medical conditions, as defined by
7 Section 10 of the Managed Care Reform and Patient Rights
8 Act.
9 (b) As provided by Section 5-16.12, managed care
10 organizations are subject to the provisions of the Managed
11 Care Reform and Patient Rights Act.
12 (c) An MCO shall pay any provider of emergency services
13 that does not have in effect a contract with the contracted
14 Medicaid MCO. The default rate of reimbursement shall be the
15 rate paid under Illinois Medicaid fee-for-service program
16 methodology, including all policy adjusters, including but not
17 limited to Medicaid High Volume Adjustments, Medicaid
18 Percentage Adjustments, Outpatient High Volume Adjustments,
19 and all outlier add-on adjustments to the extent such
20 adjustments are incorporated in the development of the
21 applicable MCO capitated rates.
22 (d) An MCO shall pay for all post-stabilization services
23 as a covered service in any of the following situations:
24 (1) the MCO authorized such services;
25 (2) such services were administered to maintain the
26 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.

1 (2) The MCO shall cover emergency services provided to
2 enrollees who are temporarily away from their residence
3 and outside the contracting area to the extent that the
4 enrollees would be entitled to the emergency services if
5 they still were within the contracting area.
6 (3) The MCO shall have no obligation to cover medical
7 services provided on an emergency basis that are not
8 covered services under the contract.
9 (4) The MCO shall not condition coverage for emergency
10 services on the treating provider notifying the MCO of the
11 enrollee's screening and treatment within 10 days after
12 presentation for emergency services.
13 (5) The determination of the attending emergency
14 physician, or the provider actually treating the enrollee,
15 of whether an enrollee is sufficiently stabilized for
16 discharge or transfer to another facility, shall be
17 binding on the MCO. The MCO shall cover emergency services
18 for all enrollees whether the emergency services are
19 provided by an affiliated or non-affiliated provider.
20 (6) The MCO's financial responsibility for
21 post-stabilization care services it has not pre-approved
22 ends when:
23 (A) a plan physician with privileges at the
24 treating hospital assumes responsibility for the
25 enrollee's care;
26 (B) a plan physician assumes responsibility for

1 the enrollee's care through transfer;
2 (C) a contracting entity representative and the
3 treating physician reach an agreement concerning the
4 enrollee's care; or
5 (D) the enrollee is discharged.
6 (f) Network adequacy and transparency.
7 (1) The Department shall:
8 (A) ensure that an adequate provider network is in
9 place, taking into consideration health professional
10 shortage areas and medically underserved areas;
11 (B) publicly release an explanation of its process
12 for analyzing network adequacy;
13 (C) periodically ensure that an MCO continues to
14 have an adequate network in place; and
15 (D) require MCOs, including Medicaid Managed Care
16 Entities as defined in Section 5-30.2, to meet
17 provider directory requirements under Section 5-30.3.
18 (2) Each MCO shall confirm its receipt of information
19 submitted specific to physician or dentist additions or
20 physician or dentist deletions from the MCO's provider
21 network within 3 days after receiving all required
22 information from contracted physicians or dentists, and
23 electronic physician and dental directories must be
24 updated consistent with current rules as published by the
25 Centers for Medicare and Medicaid Services or its
26 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 for any claims not timely paid at an interest rate of 9%, annually, compounded semiannually, from the date payment was required to be made to the date of the late payment ~~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, and 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

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

The rules on payment resolutions shall include, but not be limited to:

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

(C) guaranteed minimum payment rate of no less than the current, as of the date of service, fee-for-service rate, plus all applicable add-ons, when the resulting service relationship is out of network.

The rules shall be applicable for both MCO coverage and fee-for-service coverage.

If the fee-for-service system is ultimately determined to have been responsible for coverage on the date of service, the Department shall provide for an extended period for claims submission outside the standard timely filing requirements.

(g-6) MCO Performance Metrics Report.

(1) The Department shall publish, on at least a quarterly basis, each MCO's operational performance, including, but not limited to, the following categories of metrics:

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(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 this amendatory Act of the 100th General Assembly, 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. The Department shall post the contracted claims report required by HealthChoice Illinois on its website every 3 months.

1 (g-8) Dispute resolution process. The Department shall
2 maintain a provider complaint portal through which a provider
3 can submit to the Department unresolved disputes with an MCO.
4 An unresolved dispute means an MCO's decision that denies in
5 whole or in part a claim for reimbursement to a provider for
6 health care services rendered by the provider to an enrollee
7 of the MCO with which the provider disagrees. Disputes shall
8 not be submitted to the portal until the provider has availed
9 itself of the MCO's internal dispute resolution process.
10 Disputes that are submitted to the MCO internal dispute
11 resolution process may be submitted to the Department of
12 Healthcare and Family Services' complaint portal no sooner
13 than 30 days after submitting to the MCO's internal process
14 and not later than 30 days after the unsatisfactory resolution
15 of the internal MCO process or 60 days after submitting the
16 dispute to the MCO internal process. Multiple claim disputes
17 involving the same MCO may be submitted in one complaint,
18 regardless of whether the claims are for different enrollees,
19 when the specific reason for non-payment of the claims
20 involves a common question of fact or policy. Within 10
21 business days of receipt of a complaint, the Department shall
22 present such disputes to the appropriate MCO, which shall then
23 have 30 days to issue its written proposal to resolve the
24 dispute. The Department may grant one 30-day extension of this
25 time frame to one of the parties to resolve the dispute. If the
26 dispute remains unresolved at the end of this time frame or the

provider is not satisfied with the MCO's written proposal to resolve the dispute, the provider may, within 30 days, request the Department to review the dispute and make a final determination. Within 30 days of the request for Department review of the dispute, both the provider and the MCO shall present all relevant information to the Department for resolution and make individuals with knowledge of the issues available to the Department for further inquiry if needed. Within 30 days of receiving the relevant information on the dispute, or the lapse of the period for submitting such information, the Department shall issue a written decision on the dispute based on contractual terms between the provider and the MCO, contractual terms between the MCO and the Department of Healthcare and Family Services and applicable Medicaid policy. The decision of the Department shall be final. By January 1, 2020, the Department shall establish by rule further details of this dispute resolution process. Disputes between MCOs and providers presented to the Department for resolution are not contested cases, as defined in Section 1-30 of the Illinois Administrative Procedure Act, conferring any right to an administrative hearing.

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

(A) Premium revenue, with appropriate adjustments.

(B) Benefit expense, setting forth the aggregate

amount spent for the following:

(i) Direct paid claims.

(ii) Subcapitation payments.

(iii) Other claim payments.

(iv) Direct reserves.

(v) Gross recoveries.

(vi) Expenses for activities that improve health care quality as allowed by the Department.

(2) The medical loss ratio shall be calculated consistent with federal law and regulation following a claims runout period determined by the Department.

(g-10)(1) "Liability effective date" means the date on which an MCO becomes responsible for payment for medically necessary and covered services rendered by a provider to one of its enrollees in accordance with the contract terms between the MCO and the provider. The liability effective date shall be the later of:

(A) The execution date of a network participation contract agreement.

(B) The date the provider or its representative submits to the MCO the complete and accurate standardized roster form for the provider in the format approved by the Department.

(C) The provider effective date contained within the Department's provider enrollment subsystem within the Illinois Medicaid Program Advanced Cloud Technology

1 (IMPACT) System.
2 (2) The standardized roster form may be submitted to the
3 MCO at the same time that the provider submits an enrollment
4 application to the Department through IMPACT.
5 (3) By October 1, 2019, the Department shall require all
6 MCOs to update their provider directory with information for
7 new practitioners of existing contracted providers within 30
8 days of receipt of a complete and accurate standardized roster
9 template in the format approved by the Department provided
10 that the provider is effective in the Department's provider
11 enrollment subsystem within the IMPACT system. Such provider
12 directory shall be readily accessible for purposes of
13 selecting an approved health care provider and comply with all
14 other federal and State requirements.
15 (g-11) The Department shall work with relevant
16 stakeholders on the development of operational guidelines to
17 enhance and improve operational performance of Illinois'
18 Medicaid managed care program, including, but not limited to,
19 improving provider billing practices, reducing claim
20 rejections and inappropriate payment denials, and
21 standardizing processes, procedures, definitions, and response
22 timelines, with the goal of reducing provider and MCO
23 administrative burdens and conflict. The Department shall
24 include a report on the progress of these program improvements
25 and other topics in its Fiscal Year 2020 annual report to the
26 General Assembly.

1 (h) The Department shall not expand mandatory MCO
2 enrollment into new counties beyond those counties already
3 designated by the Department as of June 1, 2014 for the
4 individuals whose eligibility for medical assistance is not
5 the seniors or people with disabilities population until the
6 Department provides an opportunity for accountable care
7 entities and MCOs to participate in such newly designated
8 counties.
9 (i) The requirements of this Section apply to contracts
10 with accountable care entities and MCOs entered into, amended,
11 or renewed after June 16, 2014 (the effective date of Public
12 Act 98-651).
13 (j) Health care information released to managed care
14 organizations. A health care provider shall release to a
15 Medicaid managed care organization, upon request, and subject
16 to the Health Insurance Portability and Accountability Act of
17 1996 and any other law applicable to the release of health
18 information, the health care information of the MCO's
19 enrollee, if the enrollee has completed and signed a general
20 release form that grants to the health care provider
21 permission to release the recipient's health care information
22 to the recipient's insurance carrier.
23 (Source: P.A. 100-201, eff. 8-18-17; 100-580, eff. 3-12-18;
24 100-587, eff. 6-4-18; 101-209, eff. 8-5-19.)

25 (305 ILCS 5/5-30.12a new)

Sec. 5-30.12a. Medical Electronic Data Interchange system upgrade. By July 1, 2022, the Department of Healthcare and Family Services shall explore the availability of and, if reasonably available, procure technology that: (i) allows the Department's Medical Electronic Data Interchange (MEDI) system to update recipient eligibility and coverage information for providers in real time; and (ii) allows the Department to transmit updated recipient eligibility and coverage information to managed care organizations under contract with the Department to ensure the information contained in the MEDI system corresponds with the information maintained by managed care organizations in their web-based provider portals.

(305 ILCS 5/5-43 new)

Sec. 5-43. MCO post-payment audit; time period limitation. Notwithstanding any provision of this Code to the contrary, in order to recover an overpayment by recoupment or offset of future payments, a managed care organization's post-payment audit of any claim submitted by a provider must be completed no later than 2 years after the claim's payment date. The 2-year time limit does not apply to claims that are (i) submitted fraudulently, (ii) known, or should have been known, by the provider to be a pattern of inappropriate billing according to standard provider billing practices, or (iii) subject to any federal law or regulation that permits post-payment audits beyond 2 years.

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