

# HB3069



## 102ND GENERAL ASSEMBLY

### State of Illinois

2021 and 2022

HB3069

Introduced 2/19/2021, by Rep. Bob Morgan

#### SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.1

Amends the Medical Assistance Article of the Illinois Public Aid Code. Removes a provision that requires the Department of Healthcare and Family Services to post the contracted claims report required by HealthChoice Illinois on its website every 3 months. Effective immediately.

LRB102 13330 KTG 18674 b

A BILL FOR

1 AN ACT concerning public aid.

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

4 Section 5. The Illinois Public Aid Code is amended by  
5 changing Section 5-30.1 as follows:

6 (305 ILCS 5/5-30.1)

7 Sec. 5-30.1. Managed care protections.

8 (a) As used in this Section:

9 "Managed care organization" or "MCO" means any entity  
10 which contracts with the Department to provide services where  
11 payment for medical services is made on a capitated basis.

12 "Emergency services" include:

13 (1) emergency services, as defined by Section 10 of  
14 the Managed Care Reform and Patient Rights Act;

15 (2) emergency medical screening examinations, as  
16 defined by Section 10 of the Managed Care Reform and  
17 Patient Rights Act;

18 (3) post-stabilization medical services, as defined by  
19 Section 10 of the Managed Care Reform and Patient Rights  
20 Act; and

21 (4) emergency medical conditions, as defined by  
22 Section 10 of the Managed Care Reform and Patient Rights  
23 Act.

1 (b) As provided by Section 5-16.12, managed care  
2 organizations are subject to the provisions of the Managed  
3 Care Reform and Patient Rights Act.

4 (c) An MCO shall pay any provider of emergency services  
5 that does not have in effect a contract with the contracted  
6 Medicaid MCO. The default rate of reimbursement shall be the  
7 rate paid under Illinois Medicaid fee-for-service program  
8 methodology, including all policy adjusters, including but not  
9 limited to Medicaid High Volume Adjustments, Medicaid  
10 Percentage Adjustments, Outpatient High Volume Adjustments,  
11 and all outlier add-on adjustments to the extent such  
12 adjustments are incorporated in the development of the  
13 applicable MCO capitated rates.

14 (d) An MCO shall pay for all post-stabilization services  
15 as a covered service in any of the following situations:

16 (1) the MCO authorized such services;

17 (2) such services were administered to maintain the  
18 enrollee's stabilized condition within one hour after a  
19 request to the MCO for authorization of further  
20 post-stabilization services;

21 (3) the MCO did not respond to a request to authorize  
22 such services within one hour;

23 (4) the MCO could not be contacted; or

24 (5) the MCO and the treating provider, if the treating  
25 provider is a non-affiliated provider, could not reach an  
26 agreement concerning the enrollee's care and an affiliated

1 provider was unavailable for a consultation, in which case  
2 the MCO must pay for such services rendered by the  
3 treating non-affiliated provider until an affiliated  
4 provider was reached and either concurred with the  
5 treating non-affiliated provider's plan of care or assumed  
6 responsibility for the enrollee's care. Such payment shall  
7 be made at the default rate of reimbursement paid under  
8 Illinois Medicaid fee-for-service program methodology,  
9 including all policy adjusters, including but not limited  
10 to Medicaid High Volume Adjustments, Medicaid Percentage  
11 Adjustments, Outpatient High Volume Adjustments and all  
12 outlier add-on adjustments to the extent that such  
13 adjustments are incorporated in the development of the  
14 applicable MCO capitated rates.

15 (e) The following requirements apply to MCOs in  
16 determining payment for all emergency services:

17 (1) MCOs shall not impose any requirements for prior  
18 approval of emergency services.

19 (2) The MCO shall cover emergency services provided to  
20 enrollees who are temporarily away from their residence  
21 and outside the contracting area to the extent that the  
22 enrollees would be entitled to the emergency services if  
23 they still were within the contracting area.

24 (3) The MCO shall have no obligation to cover medical  
25 services provided on an emergency basis that are not  
26 covered services under the contract.

1           (4) The MCO shall not condition coverage for emergency  
2 services on the treating provider notifying the MCO of the  
3 enrollee's screening and treatment within 10 days after  
4 presentation for emergency services.

5           (5) The determination of the attending emergency  
6 physician, or the provider actually treating the enrollee,  
7 of whether an enrollee is sufficiently stabilized for  
8 discharge or transfer to another facility, shall be  
9 binding on the MCO. The MCO shall cover emergency services  
10 for all enrollees whether the emergency services are  
11 provided by an affiliated or non-affiliated provider.

12           (6) The MCO's financial responsibility for  
13 post-stabilization care services it has not pre-approved  
14 ends when:

15                   (A) a plan physician with privileges at the  
16 treating hospital assumes responsibility for the  
17 enrollee's care;

18                   (B) a plan physician assumes responsibility for  
19 the enrollee's care through transfer;

20                   (C) a contracting entity representative and the  
21 treating physician reach an agreement concerning the  
22 enrollee's care; or

23                   (D) the enrollee is discharged.

24           (f) Network adequacy and transparency.

25           (1) The Department shall:

26                   (A) ensure that an adequate provider network is in

1 place, taking into consideration health professional  
2 shortage areas and medically underserved areas;

3 (B) publicly release an explanation of its process  
4 for analyzing network adequacy;

5 (C) periodically ensure that an MCO continues to  
6 have an adequate network in place; and

7 (D) require MCOs, including Medicaid Managed Care  
8 Entities as defined in Section 5-30.2, to meet  
9 provider directory requirements under Section 5-30.3.

10 (2) Each MCO shall confirm its receipt of information  
11 submitted specific to physician or dentist additions or  
12 physician or dentist deletions from the MCO's provider  
13 network within 3 days after receiving all required  
14 information from contracted physicians or dentists, and  
15 electronic physician and dental directories must be  
16 updated consistent with current rules as published by the  
17 Centers for Medicare and Medicaid Services or its  
18 successor agency.

19 (g) Timely payment of claims.

20 (1) The MCO shall pay a claim within 30 days of  
21 receiving a claim that contains all the essential  
22 information needed to adjudicate the claim.

23 (2) The MCO shall notify the billing party of its  
24 inability to adjudicate a claim within 30 days of  
25 receiving that claim.

26 (3) The MCO shall pay a penalty that is at least equal

1 to the timely payment interest penalty imposed under  
2 Section 368a of the Illinois Insurance Code for any claims  
3 not timely paid.

4 (A) When an MCO is required to pay a timely payment  
5 interest penalty to a provider, the MCO must calculate  
6 and pay the timely payment interest penalty that is  
7 due to the provider within 30 days after the payment of  
8 the claim. In no event shall a provider be required to  
9 request or apply for payment of any owed timely  
10 payment interest penalties.

11 (B) Such payments shall be reported separately  
12 from the claim payment for services rendered to the  
13 MCO's enrollee and clearly identified as interest  
14 payments.

15 (4) (A) The Department shall require MCOs to expedite  
16 payments to providers identified on the Department's  
17 expedited provider list, determined in accordance with 89  
18 Ill. Adm. Code 140.71(b), on a schedule at least as  
19 frequently as the providers are paid under the  
20 Department's fee-for-service expedited provider schedule.

21 (B) Compliance with the expedited provider requirement  
22 may be satisfied by an MCO through the use of a Periodic  
23 Interim Payment (PIP) program that has been mutually  
24 agreed to and documented between the MCO and the provider,  
25 and the PIP program ensures that any expedited provider  
26 receives regular and periodic payments based on prior

1 period payment experience from that MCO. Total payments  
2 under the PIP program may be reconciled against future PIP  
3 payments on a schedule mutually agreed to between the MCO  
4 and the provider.

5 (C) The Department shall share at least monthly its  
6 expedited provider list and the frequency with which it  
7 pays providers on the expedited list.

8 (g-5) Recognizing that the rapid transformation of the  
9 Illinois Medicaid program may have unintended operational  
10 challenges for both payers and providers:

11 (1) in no instance shall a medically necessary covered  
12 service rendered in good faith, based upon eligibility  
13 information documented by the provider, be denied coverage  
14 or diminished in payment amount if the eligibility or  
15 coverage information available at the time the service was  
16 rendered is later found to be inaccurate in the assignment  
17 of coverage responsibility between MCOs or the  
18 fee-for-service system, except for instances when an  
19 individual is deemed to have not been eligible for  
20 coverage under the Illinois Medicaid program; and

21 (2) the Department shall, by December 31, 2016, adopt  
22 rules establishing policies that shall be included in the  
23 Medicaid managed care policy and procedures manual  
24 addressing payment resolutions in situations in which a  
25 provider renders services based upon information obtained  
26 after verifying a patient's eligibility and coverage plan



1 through either the Department's current enrollment system  
2 or a system operated by the coverage plan identified by  
3 the patient presenting for services:

4 (A) such medically necessary covered services  
5 shall be considered rendered in good faith;

6 (B) such policies and procedures shall be  
7 developed in consultation with industry  
8 representatives of the Medicaid managed care health  
9 plans and representatives of provider associations  
10 representing the majority of providers within the  
11 identified provider industry; and

12 (C) such rules shall be published for a review and  
13 comment period of no less than 30 days on the  
14 Department's website with final rules remaining  
15 available on the Department's website.

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

18 (A) the extension of the timely filing period;

19 (B) retroactive prior authorizations; and

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

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

26 If the fee-for-service system is ultimately determined to

1 have been responsible for coverage on the date of service, the  
2 Department shall provide for an extended period for claims  
3 submission outside the standard timely filing requirements.

4 (g-6) MCO Performance Metrics Report.

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

9 (A) claims payment, including timeliness and  
10 accuracy;

11 (B) prior authorizations;

12 (C) grievance and appeals;

13 (D) utilization statistics;

14 (E) provider disputes;

15 (F) provider credentialing; and

16 (G) member and provider customer service.

17 (2) The Department shall ensure that the metrics  
18 report is accessible to providers online by January 1,  
19 2017.

20 (3) The metrics shall be developed in consultation  
21 with industry representatives of the Medicaid managed care  
22 health plans and representatives of associations  
23 representing the majority of providers within the  
24 identified industry.

25 (4) Metrics shall be defined and incorporated into the  
26 applicable Managed Care Policy Manual issued by the

1 Department.

2 (g-7) MCO claims processing and performance analysis. In  
3 order to monitor MCO payments to hospital providers, pursuant  
4 to this amendatory Act of the 100th General Assembly, the  
5 Department shall post an analysis of MCO claims processing and  
6 payment performance on its website every 6 months. Such  
7 analysis shall include a review and evaluation of a  
8 representative sample of hospital claims that are rejected and  
9 denied for clean and unclean claims and the top 5 reasons for  
10 such actions and timeliness of claims adjudication, which  
11 identifies the percentage of claims adjudicated within 30, 60,  
12 90, and over 90 days, and the dollar amounts associated with  
13 those claims. ~~The Department shall post the contracted claims~~  
14 ~~report required by HealthChoice Illinois on its website every~~  
15 ~~3 months.~~

16 (g-8) Dispute resolution process. The Department shall  
17 maintain a provider complaint portal through which a provider  
18 can submit to the Department unresolved disputes with an MCO.  
19 An unresolved dispute means an MCO's decision that denies in  
20 whole or in part a claim for reimbursement to a provider for  
21 health care services rendered by the provider to an enrollee  
22 of the MCO with which the provider disagrees. Disputes shall  
23 not be submitted to the portal until the provider has availed  
24 itself of the MCO's internal dispute resolution process.  
25 Disputes that are submitted to the MCO internal dispute  
26 resolution process may be submitted to the Department of

1 Healthcare and Family Services' complaint portal no sooner  
2 than 30 days after submitting to the MCO's internal process  
3 and not later than 30 days after the unsatisfactory resolution  
4 of the internal MCO process or 60 days after submitting the  
5 dispute to the MCO internal process. Multiple claim disputes  
6 involving the same MCO may be submitted in one complaint,  
7 regardless of whether the claims are for different enrollees,  
8 when the specific reason for non-payment of the claims  
9 involves a common question of fact or policy. Within 10  
10 business days of receipt of a complaint, the Department shall  
11 present such disputes to the appropriate MCO, which shall then  
12 have 30 days to issue its written proposal to resolve the  
13 dispute. The Department may grant one 30-day extension of this  
14 time frame to one of the parties to resolve the dispute. If the  
15 dispute remains unresolved at the end of this time frame or the  
16 provider is not satisfied with the MCO's written proposal to  
17 resolve the dispute, the provider may, within 30 days, request  
18 the Department to review the dispute and make a final  
19 determination. Within 30 days of the request for Department  
20 review of the dispute, both the provider and the MCO shall  
21 present all relevant information to the Department for  
22 resolution and make individuals with knowledge of the issues  
23 available to the Department for further inquiry if needed.  
24 Within 30 days of receiving the relevant information on the  
25 dispute, or the lapse of the period for submitting such  
26 information, the Department shall issue a written decision on

1 the dispute based on contractual terms between the provider  
2 and the MCO, contractual terms between the MCO and the  
3 Department of Healthcare and Family Services and applicable  
4 Medicaid policy. The decision of the Department shall be  
5 final. By January 1, 2020, the Department shall establish by  
6 rule further details of this dispute resolution process.  
7 Disputes between MCOs and providers presented to the  
8 Department for resolution are not contested cases, as defined  
9 in Section 1-30 of the Illinois Administrative Procedure Act,  
10 conferring any right to an administrative hearing.

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

14 (A) Premium revenue, with appropriate adjustments.

15 (B) Benefit expense, setting forth the aggregate  
16 amount spent for the following:

17 (i) Direct paid claims.

18 (ii) Subcapitation payments.

19 (iii) Other claim payments.

20 (iv) Direct reserves.

21 (v) Gross recoveries.

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

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

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

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

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

13 (C) The provider effective date contained within the  
14 Department's provider enrollment subsystem within the  
15 Illinois Medicaid Program Advanced Cloud Technology  
16 (IMPACT) System.

17 (2) The standardized roster form may be submitted to the  
18 MCO at the same time that the provider submits an enrollment  
19 application to the Department through IMPACT.

20 (3) By October 1, 2019, the Department shall require all  
21 MCOs to update their provider directory with information for  
22 new practitioners of existing contracted providers within 30  
23 days of receipt of a complete and accurate standardized roster  
24 template in the format approved by the Department provided  
25 that the provider is effective in the Department's provider  
26 enrollment subsystem within the IMPACT system. Such provider

1 directory shall be readily accessible for purposes of  
2 selecting an approved health care provider and comply with all  
3 other federal and State requirements.

4 (g-11) The Department shall work with relevant  
5 stakeholders on the development of operational guidelines to  
6 enhance and improve operational performance of Illinois'  
7 Medicaid managed care program, including, but not limited to,  
8 improving provider billing practices, reducing claim  
9 rejections and inappropriate payment denials, and  
10 standardizing processes, procedures, definitions, and response  
11 timelines, with the goal of reducing provider and MCO  
12 administrative burdens and conflict. The Department shall  
13 include a report on the progress of these program improvements  
14 and other topics in its Fiscal Year 2020 annual report to the  
15 General Assembly.

16 (h) The Department shall not expand mandatory MCO  
17 enrollment into new counties beyond those counties already  
18 designated by the Department as of June 1, 2014 for the  
19 individuals whose eligibility for medical assistance is not  
20 the seniors or people with disabilities population until the  
21 Department provides an opportunity for accountable care  
22 entities and MCOs to participate in such newly designated  
23 counties.

24 (i) The requirements of this Section apply to contracts  
25 with accountable care entities and MCOs entered into, amended,  
26 or renewed after June 16, 2014 (the effective date of Public

1 Act 98-651).

2 (j) Health care information released to managed care  
3 organizations. A health care provider shall release to a  
4 Medicaid managed care organization, upon request, and subject  
5 to the Health Insurance Portability and Accountability Act of  
6 1996 and any other law applicable to the release of health  
7 information, the health care information of the MCO's  
8 enrollee, if the enrollee has completed and signed a general  
9 release form that grants to the health care provider  
10 permission to release the recipient's health care information  
11 to the recipient's insurance carrier.

12 (Source: P.A. 100-201, eff. 8-18-17; 100-580, eff. 3-12-18;  
13 100-587, eff. 6-4-18; 101-209, eff. 8-5-19.)

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