HB4663

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

HB4663

Introduced 1/21/2022, by Rep. Robyn Gabel

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.1

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services to be responsible for and actively oversee managed care organization compliance and shall immediately modify all contractual arrangements with each of the managed care organizations in conflict with the provisions of the amendatory Act. Provides that a managed care organization's failure to agree to all necessary amendments to its contract with the State shall constitute the company's notice of withdrawal from the medical assistance program. Requires the Department to attest to each managed care organization's compliance with all provisions of the amendatory Act within 60 days after the effective date of the amendatory Act. Provides that if the Department cannot attest to each managed care organization's compliance by the end of the 60 days or after any of the audits required under the amendatory Act, then the Department shall prohibit the managed care organization from managing skilled nursing facilities patients under the medical assistance managed care program. Contains provisions concerning the transition of network residents to managed care organizations in good standing; quarterly audits of each managed care organization's business practices; monthly audits of each managed care organization's information technology and systems; Medicaid fee-for-service reimbursement rates for nursing facilities under contract with managed care organizations; fines for non-compliance; and other matters.

LRB102 24646 KTG 33885 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.

(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

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

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;

(D) require MCOs, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet provider directory requirements under Section 5-30.3; ~~and~~

(E) require MCOs to ensure that any Medicaid-certified provider under contract with an MCO and previously submitted on a roster on the date of service is paid for any medically necessary, Medicaid-covered, and authorized service rendered to any of the MCO's enrollees, regardless of inclusion on the MCO's published and publicly available directory of available providers; and~~.~~

(F) ~~(E)~~ require MCOs, including Medicaid Managed Care Entities as defined in Section 5-30.2, to meet each of the requirements under subsection (d-5) of Section 10 of the Network Adequacy and Transparency Act; with necessary exceptions to the MCO's network to ensure that admission and treatment with a provider or at a treatment facility in accordance with the network adequacy standards in paragraph (3) of subsection

1 (d-5) of Section 10 of the Network Adequacy and
2 Transparency Act is limited to providers or facilities
3 that are Medicaid certified.
4 (2) Each MCO shall confirm its receipt of information
5 submitted specific to physician or dentist additions or
6 physician or dentist deletions from the MCO's provider
7 network within 3 days after receiving all required
8 information from contracted physicians or dentists, and
9 electronic physician and dental directories must be
10 updated consistent with current rules as published by the
11 Centers for Medicare and Medicaid Services or its
12 successor agency.
13 (g) Timely payment of claims.
14 (1) The MCO shall pay a claim within 30 days of
15 receiving a claim that contains all the essential
16 information needed to adjudicate the claim.
17 (2) The MCO shall notify the billing party of its
18 inability to adjudicate a claim within 30 days of
19 receiving that claim.
20 (3) The MCO shall pay a penalty that is at least equal
21 to the timely payment interest penalty imposed under
22 Section 368a of the Illinois Insurance Code for any claims
23 not timely paid.
24 (A) When an MCO is required to pay a timely payment
25 interest penalty to a provider, the MCO must calculate
26 and pay the timely payment interest penalty that is

1 due to the provider within 30 days after the payment of
2 the claim. In no event shall a provider be required to
3 request or apply for payment of any owed timely
4 payment interest penalties.

5 (B) Such payments shall be reported separately
6 from the claim payment for services rendered to the
7 MCO's enrollee and clearly identified as interest
8 payments.

9 (4)(A) The Department shall require MCOs to expedite
10 payments to providers identified on the Department's
11 expedited provider list, determined in accordance with 89
12 Ill. Adm. Code 140.71(b), on a schedule at least as
13 frequently as the providers are paid under the
14 Department's fee-for-service expedited provider schedule.

15 (B) Compliance with the expedited provider requirement
16 may be satisfied by an MCO through the use of a Periodic
17 Interim Payment (PIP) program that has been mutually
18 agreed to and documented between the MCO and the provider,
19 if the PIP program ensures that any expedited provider
20 receives regular and periodic payments based on prior
21 period payment experience from that MCO. Total payments
22 under the PIP program may be reconciled against future PIP
23 payments on a schedule mutually agreed to between the MCO
24 and the provider.

25 (C) The Department shall share at least monthly its
26 expedited provider list and the frequency with which it

1 pays providers on the expedited list.
2 (g-5) Recognizing that the rapid transformation of the
3 Illinois Medicaid program may have unintended operational
4 challenges for both payers and providers:
5 (1) in no instance shall a medically necessary covered
6 service rendered in good faith, based upon eligibility
7 information documented by the provider, be denied coverage
8 or diminished in payment amount if the eligibility or
9 coverage information available at the time the service was
10 rendered is later found to be inaccurate in the assignment
11 of coverage responsibility between MCOs or the
12 fee-for-service system, except for instances when an
13 individual is deemed to have not been eligible for
14 coverage under the Illinois Medicaid program; and
15 (2) the Department shall, by December 31, 2016, adopt
16 rules establishing policies that shall be included in the
17 Medicaid managed care policy and procedures manual
18 addressing payment resolutions in situations in which a
19 provider renders services based upon information obtained
20 after verifying a patient's eligibility and coverage plan
21 through either the Department's current enrollment system
22 or a system operated by the coverage plan identified by
23 the patient presenting for services:
24 (A) such medically necessary covered services
25 shall be considered rendered in good faith;
26 (B) such policies and procedures shall be

1 developed in consultation with industry
2 representatives of the Medicaid managed care health
3 plans and representatives of provider associations
4 representing the majority of providers within the
5 identified provider industry; and
6 (C) such rules shall be published for a review and
7 comment period of no less than 30 days on the
8 Department's website with final rules remaining
9 available on the Department's website.
10 The rules on payment resolutions shall include, but
11 not be limited to:
12 (A) the extension of the timely filing period;
13 (B) retroactive prior authorizations; and
14 (C) guaranteed minimum payment rate of no less
15 than the current, as of the date of service,
16 fee-for-service rate, plus all applicable add-ons,
17 when the resulting service relationship is out of
18 network.
19 The rules shall be applicable for both MCO coverage
20 and fee-for-service coverage.
21 If the fee-for-service system is ultimately determined to
22 have been responsible for coverage on the date of service, the
23 Department shall provide for an extended period for claims
24 submission outside the standard timely filing requirements.
25 (g-6) MCO Performance Metrics Report.
26 (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 Public Act 100-580 ~~this amendatory Act of the 100th General Assembly~~, the Department shall post an analysis of MCO claims

1 processing and payment performance on its website every 6
2 months. Such analysis shall include a review and evaluation of
3 a representative sample of hospital claims that are rejected
4 and denied for clean and unclean claims and the top 5 reasons
5 for such actions and timeliness of claims adjudication, which
6 identifies the percentage of claims adjudicated within 30, 60,
7 90, and over 90 days, and the dollar amounts associated with
8 those claims.

9 (g-8) Dispute resolution process. The Department shall
10 maintain a provider complaint portal through which a provider
11 can submit to the Department unresolved disputes with an MCO.
12 An unresolved dispute means an MCO's decision that denies in
13 whole or in part a claim for reimbursement to a provider for
14 health care services rendered by the provider to an enrollee
15 of the MCO with which the provider disagrees. Disputes shall
16 not be submitted to the portal until the provider has availed
17 itself of the MCO's internal dispute resolution process.
18 Disputes that are submitted to the MCO internal dispute
19 resolution process may be submitted to the Department of
20 Healthcare and Family Services' complaint portal no sooner
21 than 30 days after submitting to the MCO's internal process
22 and not later than 30 days after the unsatisfactory resolution
23 of the internal MCO process or 60 days after submitting the
24 dispute to the MCO internal process. Multiple claim disputes
25 involving the same MCO may be submitted in one complaint,
26 regardless of whether the claims are for different enrollees,

1 when the specific reason for non-payment of the claims
2 involves a common question of fact or policy. Within 10
3 business days of receipt of a complaint, the Department shall
4 present such disputes to the appropriate MCO, which shall then
5 have 30 days to issue its written proposal to resolve the
6 dispute. The Department may grant one 30-day extension of this
7 time frame to one of the parties to resolve the dispute. If the
8 dispute remains unresolved at the end of this time frame or the
9 provider is not satisfied with the MCO's written proposal to
10 resolve the dispute, the provider may, within 30 days, request
11 the Department to review the dispute and make a final
12 determination. Within 30 days of the request for Department
13 review of the dispute, both the provider and the MCO shall
14 present all relevant information to the Department for
15 resolution and make individuals with knowledge of the issues
16 available to the Department for further inquiry if needed.
17 Within 30 days of receiving the relevant information on the
18 dispute, or the lapse of the period for submitting such
19 information, the Department shall issue a written decision on
20 the dispute based on contractual terms between the provider
21 and the MCO, contractual terms between the MCO and the
22 Department of Healthcare and Family Services and applicable
23 Medicaid policy. The decision of the Department shall be
24 final. By January 1, 2020, the Department shall establish by
25 rule further details of this dispute resolution process.
26 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

1 contract agreement.
2 (B) The date the provider or its representative
3 submits to the MCO the complete and accurate standardized
4 roster form for the provider in the format approved by the
5 Department.
6 (C) The provider effective date contained within the
7 Department's provider enrollment subsystem within the
8 Illinois Medicaid Program Advanced Cloud Technology
9 (IMPACT) System.
10 (2) The standardized roster form may be submitted to the
11 MCO at the same time that the provider submits an enrollment
12 application to the Department through IMPACT.
13 (3) By October 1, 2019, the Department shall require all
14 MCOs to update their provider directory with information for
15 new practitioners of existing contracted providers within 30
16 days of receipt of a complete and accurate standardized roster
17 template in the format approved by the Department provided
18 that the provider is effective in the Department's provider
19 enrollment subsystem within the IMPACT system. Such provider
20 directory shall be readily accessible for purposes of
21 selecting an approved health care provider and comply with all
22 other federal and State requirements.
23 (g-11) The Department shall work with relevant
24 stakeholders on the development of operational guidelines to
25 enhance and improve operational performance of Illinois'
26 Medicaid managed care program, including, but not limited to,

1 improving provider billing practices, reducing claim
2 rejections and inappropriate payment denials, and
3 standardizing processes, procedures, definitions, and response
4 timelines, with the goal of reducing provider and MCO
5 administrative burdens and conflict. The Department shall
6 include a report on the progress of these program improvements
7 and other topics in its Fiscal Year 2020 annual report to the
8 General Assembly.
9 (g-12) Notwithstanding any other provision of law, if the
10 Department or an MCO requires submission of a claim for
11 payment in a non-electronic format, a provider shall always be
12 afforded a period of no less than 90 business days, as a
13 correction period, following any notification of rejection by
14 either the Department or the MCO to correct errors or
15 omissions in the original submission.
16 Under no circumstances, either by an MCO or under the
17 State's fee-for-service system, shall a provider be denied
18 payment for failure to comply with any timely submission
19 requirements under this Code or under any existing contract,
20 unless the non-electronic format claim submission occurs after
21 the initial 180 days following the latest date of service on
22 the claim, or after the 90 business days correction period
23 following notification to the provider of rejection or denial
24 of payment.
25 (h) The Department shall not expand mandatory MCO
26 enrollment into new counties beyond those counties already

1 designated by the Department as of June 1, 2014 for the
2 individuals whose eligibility for medical assistance is not
3 the seniors or people with disabilities population until the
4 Department provides an opportunity for accountable care
5 entities and MCOs to participate in such newly designated
6 counties.

7 (i) The requirements of this Section apply to contracts
8 with accountable care entities and MCOs entered into, amended,
9 or renewed after June 16, 2014 (the effective date of Public
10 Act 98-651).

11 (j) Health care information released to managed care
12 organizations. A health care provider shall release to a
13 Medicaid managed care organization, upon request, and subject
14 to the Health Insurance Portability and Accountability Act of
15 1996 and any other law applicable to the release of health
16 information, the health care information of the MCO's
17 enrollee, if the enrollee has completed and signed a general
18 release form that grants to the health care provider
19 permission to release the recipient's health care information
20 to the recipient's insurance carrier.

21 (k) The Department of Healthcare and Family Services,
22 managed care organizations, a statewide organization
23 representing hospitals, and a statewide organization
24 representing safety-net hospitals shall explore ways to
25 support billing departments in safety-net hospitals.

26 (l) The requirements of this Section added by Public Act

1 102-4 ~~this amendatory Act of the 102nd General Assembly~~ shall
2 apply to services provided on or after the first day of the
3 month that begins 60 days after April 27, 2021 (the effective
4 date of Public Act 102-4) ~~this amendatory Act of the 102nd~~
5 ~~General Assembly~~.
6 (m) The Department shall be responsible for and actively
7 oversee managed care organization compliance and shall
8 immediately modify all contractual arrangements with each of
9 the managed care organizations in conflict with the provisions
10 of this Section. Failure of a managed care organization to
11 agree to all necessary amendments to its contract with the
12 State shall constitute the company's notice of withdrawal from
13 the medical assistance program.
14 The Department shall attest to each managed care
15 organization's compliance with all provisions of this Section
16 within 60 days after the effective date of this amendatory Act
17 of the 102nd General Assembly. If the Department cannot attest
18 to each managed care organization's compliance by the end of
19 the 60 days or after any of the audits required by this
20 Section, then the Department shall prohibit the managed care
21 organization from managing skilled nursing facilities patients
22 under the medical assistance managed care program. The
23 Department shall oversee the transition of all network
24 residents to managed care organizations in good standing with
25 the Department and under contract with the facility where the
26 network member resides and shall guarantee the payment of all

1 outstanding claims for services rendered to network members
2 until a managed care organization in good standing with the
3 Department has assumed responsibility for paying for Medicaid
4 covered services.
5 The Department shall perform quarterly audits of each
6 managed care organization's business practices to ensure they
7 align with the provisions of this Section.
8 The Department shall require each managed care
9 organization and its subcontractors to perform monthly audits
10 of the managed care organization's information technology
11 systems and practices to ensure that no claims are rejected or
12 denied based on programming errors.
13 Managed care organizations under contract with the State
14 must pay to each individual nursing facility no less than the
15 Medicaid fee-for-service reimbursement rate established by the
16 Department and in effect at the time the service is rendered.
17 Managed care organizations are expressly prohibited, at
18 any time and for any reason, from offering, negotiating, or
19 entering into contracts with a nursing facility for a level of
20 compensation less than the Medicaid fee-for-service rate in
21 effect at the time the service is rendered.
22 A sanction of $20,000 per incident shall be levied against
23 a managed care organization for failure to comply with this
24 Section, which shall double for each subsequent incident of
25 the same or similar violation. All fines shall be deposited
26 into the Long-Term Care Provider Fund. Use of the funds shall

1 be limited to expenditures that qualify for federal matching
2 funds and that promote quality of resident care.
3 A managed care organization's participation in the medical
4 assistance program shall be terminated for failure to make all
5 necessary changes to business practices in conflict with this
6 Section.
7 (Source: P.A. 101-209, eff. 8-5-19; 102-4, eff. 4-27-21;
8 102-43, eff. 7-6-21; 102-144, eff. 1-1-22; 102-454, eff.
9 8-20-21; revised 10-5-21.)