

SB1962



103RD GENERAL ASSEMBLY

State of Illinois

2023 and 2024

SB1962

Introduced 2/9/2023, by Sen. Ann Gillespie

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.1

Amends the Illinois Public Aid. Makes a technical change in a Section concerning managed care protections.

LRB103 30582 KTG 57019 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 ~~the~~ Department to provide services
11 where payment for medical services is made on a capitated
12 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
17 defined by Section 10 of the Managed Care Reform and
18 Patient Rights Act;

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

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

1 Act.

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

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

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

17 (1) the MCO authorized such services;

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

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

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

25 (5) the MCO and the treating provider, if the treating
26 provider is a non-affiliated provider, could not reach an

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

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

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

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

25 (3) The MCO shall have no obligation to cover medical
26 services provided on an emergency basis that are not

1 covered services under the contract.

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

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

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

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

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

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

24 (D) the enrollee is discharged.

25 (f) Network adequacy and transparency.

26 (1) The Department shall:

1 (A) ensure that an adequate provider network is in
2 place, taking into consideration health professional
3 shortage areas and medically underserved areas;

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

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

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

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

19 (F) require MCOs, including Medicaid Managed Care
20 Entities as defined in Section 5-30.2, to meet each of
21 the requirements under subsection (d-5) of Section 10
22 of the Network Adequacy and Transparency Act; with
23 necessary exceptions to the MCO's network to ensure
24 that admission and treatment with a provider or at a
25 treatment facility in accordance with the network
26 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

1 quarterly basis, each MCO's operational performance,
2 including, but not limited to, the following categories of
3 metrics:

4 (A) claims payment, including timeliness and
5 accuracy;

6 (B) prior authorizations;

7 (C) grievance and appeals;

8 (D) utilization statistics;

9 (E) provider disputes;

10 (F) provider credentialing; and

11 (G) member and provider customer service.

12 (2) The Department shall ensure that the metrics
13 report is accessible to providers online by January 1,
14 2017.

15 (3) The metrics shall be developed in consultation
16 with industry representatives of the Medicaid managed care
17 health plans and representatives of associations
18 representing the majority of providers within the
19 identified industry.

20 (4) Metrics shall be defined and incorporated into the
21 applicable Managed Care Policy Manual issued by the
22 Department.

23 (g-7) MCO claims processing and performance analysis. In
24 order to monitor MCO payments to hospital providers, pursuant
25 to Public Act 100-580, the Department shall post an analysis
26 of MCO claims processing and payment performance on its

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

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

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

1 in Section 1-30 of the Illinois Administrative Procedure Act,
2 conferring any right to an administrative hearing.

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

6 (A) Premium revenue, with appropriate adjustments.

7 (B) Benefit expense, setting forth the aggregate
8 amount spent for the following:

9 (i) Direct paid claims.

10 (ii) Subcapitation payments.

11 (iii) Other claim payments.

12 (iv) Direct reserves.

13 (v) Gross recoveries.

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

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

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

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

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

5 (C) The provider effective date contained within the
6 Department's provider enrollment subsystem within the
7 Illinois Medicaid Program Advanced Cloud Technology
8 (IMPACT) System.

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

12 (3) By October 1, 2019, the Department shall require all
13 MCOs to update their provider directory with information for
14 new practitioners of existing contracted providers within 30
15 days of receipt of a complete and accurate standardized roster
16 template in the format approved by the Department provided
17 that the provider is effective in the Department's provider
18 enrollment subsystem within the IMPACT system. Such provider
19 directory shall be readily accessible for purposes of
20 selecting an approved health care provider and comply with all
21 other federal and State requirements.

22 (g-11) The Department shall work with relevant
23 stakeholders on the development of operational guidelines to
24 enhance and improve operational performance of Illinois'
25 Medicaid managed care program, including, but not limited to,
26 improving provider billing practices, reducing claim

1 rejections and inappropriate payment denials, and
2 standardizing processes, procedures, definitions, and response
3 timelines, with the goal of reducing provider and MCO
4 administrative burdens and conflict. The Department shall
5 include a report on the progress of these program improvements
6 and other topics in its Fiscal Year 2020 annual report to the
7 General Assembly.

8 (g-12) Notwithstanding any other provision of law, if the
9 Department or an MCO requires submission of a claim for
10 payment in a non-electronic format, a provider shall always be
11 afforded a period of no less than 90 business days, as a
12 correction period, following any notification of rejection by
13 either the Department or the MCO to correct errors or
14 omissions in the original submission.

15 Under no circumstances, either by an MCO or under the
16 State's fee-for-service system, shall a provider be denied
17 payment for failure to comply with any timely submission
18 requirements under this Code or under any existing contract,
19 unless the non-electronic format claim submission occurs after
20 the initial 180 days following the latest date of service on
21 the claim, or after the 90 business days correction period
22 following notification to the provider of rejection or denial
23 of payment.

24 (h) The Department shall not expand mandatory MCO
25 enrollment into new counties beyond those counties already
26 designated by the Department as of June 1, 2014 for the

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

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

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

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

25 (l) The requirements of this Section added by Public Act
26 102-4 shall apply to services provided on or after the first

1 day of the month that begins 60 days after April 27, 2021 (the
2 effective date of Public Act 102-4).

3 (Source: P.A. 101-209, eff. 8-5-19; 102-4, eff. 4-27-21;
4 102-43, eff. 7-6-21; 102-144, eff. 1-1-22; 102-454, eff.
5 8-20-21; 102-813, eff. 5-13-22.)