



May 28, 2019

Agreement Reached on Medicaid Managed Care Reform Legislation (SB 1321)

Following weeks of negotiations with the Illinois Department of Healthcare and Family Services (HFS), the Medicaid Managed Care Organizations (MCOs) and the legislative Medicaid Working Group, IHA is pleased to announce that an agreement has been reached on a comprehensive Medicaid managed care reform package. Filed this afternoon, *Senate Bill 1321, House Amendment 1* includes several hard-fought and much needed reforms that will help ensure timely access to quality healthcare for all Medicaid beneficiaries.

As a core component of IHA's Medicaid managed care advocacy strategy, this legislation lays the foundation needed to reduce inappropriate payment denials and significantly ease administrative burden on member hospitals and health systems. Specifically, it addresses high priority, systemic issues identified by members, many of which have plagued mandatory Medicaid managed care since the program was first implemented.

Key provisions of the bill include:

- *Reimbursement for Stays beyond Medical Necessity* – HFS must implement a methodology to reimburse hospitals for inpatient stays beyond medical necessity when HFS, the MCO, and/or the hospital are unable to secure appropriate post discharge placement, beginning July 1, 2019.
- *Expedited Payments* – MCOs must expedite payments to providers identified on HFS' expedited provider list. Periodic interim payment programs, mutually agreed to by the MCO and the hospital, may be used to satisfy this requirement.
- *Timely Payment Interest Penalties* – MCOs must calculate and pay timely payment interest penalties (at least equal to the penalty required under the Insurance Code), when due, within 30 days of claim payment. MCOs may not ask providers to request or apply for such payments.
- *Dispute Resolution Process* – By January 1, 2020, HFS must implement a dispute resolution process, with specific timeframes, through which providers may challenge an MCO's determination to deny, in whole or in part, reimbursement for medically necessary services. If the MCO's proposed resolution is unsatisfactory, or the MCO fails to respond, the provider may ask HFS to review the dispute and issue a final, written decision.
- *Claims Rejection/Denial Management* – HFS will procure, if available, technology to establish a clearinghouse through which all Medicaid managed care claims must be submitted before automatically transmitting them to the MCOs. HFS having a record of all claims submitted to the MCOs will significantly enhance the Department's ability to identify and resolve the root causes of claim denials.
- *Timely Filing Extension for Eligibility Errors* – HFS must extend the standard timely filing period when there is an eligibility error and traditional Medicaid, rather than an MCO, is ultimately determined responsible for payment.
- *Provider Effective Dates* – MCOs must comply with a standard policy that sets forth the date a Medicaid-enrolled, contracted provider becomes eligible for payment of medically necessary and covered services.
- *Provider Directory Updates* – MCOs must update their provider directories within 30 days of a complete and accurate roster submitted on the HFS-approved universal roster template.
- *Operational Standardization* – HFS will work with stakeholders, including IHA, to improve the operational performance of

and standardize operations across the MCOs, with the goal of reducing both inappropriate payment denials and administrative burden.

- *Medical Loss Ratios* – On an annual basis, HFS must publically report each MCO's Medical Loss Ratio, inclusive of premium revenue and aggregate benefit expenses, defined as paid claims, sub-capitation payments, other claim payments, direct reserves, gross recoveries, and quality improvement activities.
- *Value-based Payment Models* – HFS will convene stakeholders to discuss the development of alternative value-based payment models.

In addition to reducing inappropriate denials and easing administrative burden, this bill provides a pathway for improved communication between HFS, the MCOs, and hospitals. IHA will provide a detailed technical summary once the bill is final.

We would like to thank and congratulate all of our members who, by sharing their stories, effectively demonstrated the urgent need for relief from the MCOs' most abusive practices. Through the united effort of IHA and the hospital community, we secured these critical managed care program improvements. We must now continue our collective efforts to assure their timely and effective implementation. Together, we will continue to advocate for performance improvement measures until managed Medicaid realizes the promise of enhanced care coordination, improved patient outcomes, greater efficiencies and cost savings.

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