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February 15, 2019

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Comprehensive Medicaid Managed Care Reform Legislation Will Strengthen Illinois Medicaid Program for Patients, Ensure Fairness and Accountability

Naperville and Springfield, IL – A comprehensive legislative package of Medicaid managed care reform bills strongly backed by the Illinois Health and Hospital Association (IHA) and the hospital community has been introduced in the General Assembly to hold managed care organizations (MCOs) accountable to preserve and assure access to timely, quality healthcare for all Medicaid beneficiaries.

Since the introduction of mandatory managed care in Illinois in 2015, hospitals across the state have faced an overwhelming series of unnecessary administrative burdens, claim denials and long payment delays that jeopardize access to care for low-income and vulnerable communities in urban and rural areas of the state and that undermine the financial stability of hospitals, especially Safety Net and Critical Access Hospitals. Initial claim denial rates by MCOs are still unacceptably high – 26 percent – resulting in delayed payments to hospitals in the hundreds of millions of dollars for medically necessary services that were authorized and provided to Medicaid beneficiaries. Most of the denials are based on process and paperwork, not medical necessity.

“The state’s Medicaid managed care program, which now covers more than 2.2 million Illinoisans, has failed to realize the promise of increased care coordination, improved patient outcomes, greater efficiencies and lower costs,” said A.J. Wilhelmi, President and CEO of the Illinois Health and Hospital Association. “Instead, the program has been crippled with increasing administrative burden, lack of standardization, lack of uniformity of rules, and insufficient oversight – putting extreme financial pressure on hospitals, jeopardizing Illinoisans’ access to care. MCOs must be held accountable, and we commend Senators Heather Steans, Kimberly Lightford and Don Harmon, and Representatives Robyn Gabel, Camille Lilly, and Bob Morgan for introducing legislation to do that and to support patients so they receive quality care when they need it in the appropriate setting.”

The Medicaid managed care reform legislative package includes Senate Bill 1697/House Bill 2715, concerning Medicaid managed care organization fairness and accountability; Senate Bill 1807/House Bill 2814, concerning Safety Net and Critical Access Hospital MCO reforms; and Senate Bill 1703/House Bill 2730, concerning the right to a fair review of improper Medicaid MCO denials.

The legislative package has the strong support of hospitals across Illinois.

With two-thirds of our patients relying on the Medicaid program for their healthcare, long payment delays by the MCOs present enormous challenges for Sinai Health System,” said Karen Teitelbaum, President and CEO, Sinai Health System, Chicago’s largest safety-net hospital system. “The incredibly high claim denial rates for care we have already provided mean tens of millions of dollars in

reimbursement delays, accounting for 8 percent of our net patient revenue. No hospital, especially a safety-net hospital system like ours, can financially sustain that magnitude of revenue loss.”

“Because of continuing unresolved administrative issues with MCOs, AMITA Health, which already has sophisticated and modern accounting systems and management in place, has been forced to hire additional staff to deal with those issues,” said Mark Frey, President and CEO, AMITA Health, the largest health system and one of the largest behavioral health providers in Illinois. “That unnecessarily diverts scarce resources and staff from direct patient care that we are dedicated to providing every day to meet the needs of our communities.”

“Chicago’s Austin community has some of the worst health disparities in the state. If you compare downtown Chicago to the Greater West Side of Chicago, the average life expectancy decreases by 20 years. This is an inequity,” said George N. Miller, Jr., President and CEO of The Loretto Hospital on the West side of Chicago. “We come to work every day to provide our patients quality healthcare in a safe environment, with a smile. This is our mission. This is our ministry of care. Now it is the responsibility of the MCOs to pay us in a timely manner for the services we have provided to our patients we are privileged to serve.” More than 75 percent of The Loretto Hospital’s patients are covered by Medicaid.

“The challenges we face with Medicaid managed care is not just a Chicago area issue, but one that affects all areas of the state, including patients and hospitals downstate and in rural communities across Illinois,” said Mary Starmann Harrison, President and CEO, Hospital Sisters Health System, Springfield, and chair of the IHA Board of Trustees. “It is critical that the General Assembly take action to ensure that MCOs adopt fair and common sense business practices.”

Senate Bill 1697/House Bill 2715, sponsored by Sen. Heather Steans and Rep. Robyn Gabel, includes provisions that would require:

- Uniform set of rules concerning medical necessity documentation and service authorization.
- Timely MCO requests for information to adjudicate claims (within 5 days of claim submission).
- Standard list of essential clinical information to support payment of claims.
- Timely MCO provider roster updates – and assurance of payment to providers under contract regardless of updates to roster, when medically necessary.
- Automatic calculation of timely payment interest penalty payments due.
- Regular, consistent payments to qualified expedited hospitals.
- Uniform definitions on key issues, such as claims rejections, claims payment rate adjustments, claim recoupment adjustment, claim denial and service authorization.
- Standard list of uniform codes for claim denials.
- Reasonable time extension (120 days) for providers to submit bills for payment to HFS when coverage disputes occur as a result of inaccurate eligibility data
- Post discharge care coordination placement by MCOs within 24 hours of notification of a physician’s discharge order or pay for the days beyond the physician ordered discharge date.

Senate Bill 1807/House Bill 2814, sponsored by Senator Kimberly Lightford and Representative Camille Lilly, includes provisions that would require:

- MCOs must update their rosters within seven days of all new providers being contracted.

- Providers under contract with an MCO must be reimbursed for a medically necessary service provided to an enrollee regardless of whether the MCO updated its roster.
- MCOs must pay all hospitals qualifying under expedited provider rules on a schedule as regular as that made to expedited providers under the state's fee-for-service (FFS) system.
- Reasonable time to correct errors on non-electronic claims by extending a 90-day period after notification.
- MCOs must make post discharge care coordination placement within 24 hours of notification of a physician's discharge order or pay for the days beyond the physician ordered discharge date.

Senate Bill 1703/House Bill 2730, sponsored by Senator Don Harmon and Representative Bob Morgan, would provide a fair process to review and correct improper Medicaid MCO payment denials, as follows:

- Hospitals, and other health care providers, shall have the right, after exhausting their internal appeal rights within the MCO contract, to have the final decision of an MCO that denies payment of a claim, in whole or in part, reviewed by an external independent third party.
- Multiple claims could be determined in one external independent third party review.
- An MCO's letter to a provider reflecting the final decision on its internal appeal shall include a statement that the provider is entitled to an external independent third party review and the time period and address for submitting a request for such a review.
- Either party would then be entitled to appeal a final decision of the external independent third party review through the administrative hearing process within the Department of Healthcare and Family Services (HFS), with such appeal having to be filed within 30 days of the decision on the external independent third party review. The final decision of the Director of HFS on the appeal would then be subject to judicial review.
- HFS may, by rule, establish a fee of up to \$1,000 to defray the expenses of the administrative hearing, which shall be paid by the party that does not prevail.

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About IHA

The Illinois Health and Hospital Association, with offices in Chicago, Naperville, Springfield, and Washington, D.C., advocates for Illinois' more than 200 hospitals and nearly 50 health systems as they serve their patients and communities. IHA members provide a broad range of services—not just within their walls, but across the continuum of healthcare and in their communities. Reflecting the diversity of the state, IHA members consist of nonprofit, investor-owned and public hospitals in the following categories: community, safety net, rural, critical access, specialty, and teaching hospitals, including academic medical centers. For more information, see www.team-iha.org. Like IHA on [Facebook](#). Follow IHA on [Twitter](#).