

July 6, 2021

**ILLINOIS HEALTH AND HOSPITAL ASSOCIATION  
M E M O R A N D U M**

**SUBJECT: IHA Summary: Medicaid Managed Care and Prior Authorization Reform Bills**

This memo summarizes recent state legislation to reform clinical and reimbursement policies implemented by commercial health insurance issuers and Medicaid Managed Care Organizations (MCOs) that have been identified as administratively burdensome by IHA member hospitals and health systems. IHA is pleased to report that the Prior Authorization Reform Act ([House Bill 711](#)) unanimously passed both chambers of the General Assembly and is awaiting Governor Pritzker's signature to become law. In addition, IHA worked with the Department of Healthcare and Family Services (HFS) to create transparency in state contractual and policy guidance to the MCOs and standardize MCO hospital readmissions programs.

**HB711: Prior Authorization Reform Act**

Sponsored by House Majority Leader Greg Harris and Assistant Senate Majority Leader Linda Holmes, this IHA-supported legislation establishes much-needed guardrails to ensure that patient care is not disrupted nor delayed by unnecessary or burdensome utilization review programs. Key pieces of the Prior Authorization Reform Act are summarized below.

*Applicability*

The Act applies to health insurance policies amended, delivered, issued, or renewed by state-regulated health insurance issuers, including Medicaid MCOs, on or after the date the bill is signed into law. The Act does not apply to employee or employer self-funded health plans (ERISA); healthcare provided under the Workers' Compensation Act or the Workers Occupational Diseases Act; or state employee, local government, or school district health plans.

*Disclosure Requirements*

Health insurance issuers and their contracted Utilization Review Organizations (UROs) must:

- Make a complete and detailed list of prior authorization requirements, including associated clinical review criteria, readily accessible to providers and patients on their websites;
- Update their websites and give written notice to in-network providers at least 60 days prior to implementation of any new or revised authorization requirements;
- Post to their websites statistics on the number of approved and denied authorization requests, appeal requests and decisions, and the top five reasons for adverse determinations; and
- Periodically review and remove authorization requirements for medications or procedures that are customary and properly indicated, as supported by peer-reviewed medical publications, or for patients currently managed with an established treatment regimen.

*Clinical Review Criteria*

Clinical review criteria must be based on nationally recognized, generally accepted standards and aligned with the standards of national medical accreditation entities. Criteria must also be evidence-based, sufficiently flexible to allow for case-by-case exceptions, and annually reviewed and updated.

#### *Determination Timeframes*

- For non-urgent requests, a determination must be issued as required under applicable state law, but no later than five calendar days after obtaining all “necessary information” from the provider. “Necessary information” includes the results of face-to-face clinical evaluations, second opinions, or other clinical information required by the issuer/URO.
- For urgent requests, a determination must be issued as required under applicable state law, but no later than 48 hours after receiving all requested information from the provider. Providers must have access to an issuer/URO clinician authorized to make the authorization determination.
- Healthcare services are deemed authorized if an issuer/URO fails to comply with these deadlines.

#### *Approved Requests*

Approved authorizations are valid for the lesser of six months from the date the approval is granted or the length of treatment. Approvals of recurring services or maintenance medications for treatment of a chronic or long-term condition are valid for the lesser of 12 months from the date approval is granted or the length of treatment.

#### *Denied Requests*

Adverse determinations must generally be made by a physician when the authorization request is submitted by a physician (or a representative of the physician). The issuer/URO physician issuing the denial must have experience treating and managing patients with the medical condition or disease for which authorization was requested. Enrollees and their healthcare providers must be notified of adverse determinations. The notification must include the reason for the denial, any related evidence-based criteria used in making the determination, a description of any missing or insufficient documentation, and appeal instructions.

#### *Appeals*

Appeals submitted by a physician must generally be reviewed by a physician who practices in the same or similar specialty as a doctor who typically manages the medical condition or disease or has knowledge of and experience in providing the services under appeal and was not directly involved in the initial denial. The issuer/URO physician must consider all clinical aspects of the case, including medical records and literature submitted by the provider.

#### *Payment for Authorized Services*

Issuers may conduct post-payment review of approved services, but may not:

- Deny a claim for failure to obtain authorization if the authorization requirement was not in effect on the date of service;
- Deem as incidental/deny supplies and services routinely used as part of an approved service, treatment, or procedure; or

- With limited exceptions, deny properly submitted claims where an approval is granted prior to the time of service.

### *Continuity of Care*

Issuers must honor an approved authorization granted to an enrollee from a previous health insurance policy for at least the initial 90 days of the coverage under the new policy, subject to the terms of the member's coverage agreement. The enrollee or healthcare provider must submit documentation of the prior approval.

### *Compliance*

For commercial health insurance issuers, the Department of Insurance (DOI) may issue cease and desist orders and require corrective action plans for noncompliance with the Act. DOI may impose fines up to \$250,000 for failure to submit a corrective action plan, failure to comply with the plan, or repeated violations of the Act. For MCOs, HFS is responsible for enforcement of the Act.

### *Other Changes*

The Act amends the Illinois Insurance Code to require state-regulated accident and health insurance issuers to adhere to the definitions of "emergency services prior to stabilization," "post stabilization medical services," and, for reimbursement purposes, "emergency medical condition" in the Managed Care Reform and Patient Rights Act ([215 ILCS 134](#)). It also amends the Managed Care Reform and Patient Rights Act to expand the definition of "healthcare services" to include behavioral health and mental health services and creates a new section of the Public Aid Code to require MCOs to comply with HB711, where applicable.

### **Medicaid Managed Care**

During the spring legislative session, IHA proposed a series of practical reforms designed to reduce administrative burden and red tape that serve as barriers to care for Medicaid beneficiaries enrolled in MCOs. IHA successfully advocated for greater transparency in the state's contracts with and policy guidance to the MCOs and standardization of MCOs' hospital potentially preventable readmission (PPR) programs. Due to these negotiations, HFS has agreed to:

- Post to its website a current version of its [master contract](#) with the MCOs, including amendments, and managed care [program policies](#) issued to the MCOs since the contracts were signed in 2018.
- Direct the MCOs to limit PPR payment penalties to hospital readmissions occurring at the same hospital or hospital within the same system, exclude certain conditions from readmission measures (e.g., behavioral health), and cease the practice of deeming a stay a readmission due to shared discharge planning responsibilities or poor MCO care coordination. The MCOs are in the process of updating their PPR policies, which will be implemented prospectively, in accordance with [HFS guidance](#) (May 2021).<sup>1</sup>

IHA continues to urge HFS to hold the MCOs accountable for new clinical or payment policies that have a material effect on reimbursement or add undue administrative burden. Meanwhile, IHA's Patient

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<sup>1</sup> The HFS Hospital Readmission Guidelines note that detoxification admissions within 60 days of a prior inpatient detoxification stay are not covered benefits under Illinois Medicaid. [Senate Bill 2294](#) will remove this benefit limitation if signed into law by Governor Pritzker, and the HFS policy document should be updated accordingly.

Financial Services continues to work with the MCOs and HFS to streamline billing processes and reduce systemic claim denials. Finally, in July, IHA will request MCO Performance Survey data for the first and second quarters of 2020. Survey results from the third and fourth quarters of 2019 showed a 10% full denial rate, a significant drop from 26% for the fourth quarter of 2019.

For questions or additional information, [please IHA](#).