

**TECHNICAL SUMMARY OF SENATE BILL 1321**  
**MEDICAID OMNIBUS BILL**  
**June 3, 2019**

On May 30, 2019, the Illinois General Assembly (GA) passed a Medicaid Omnibus Bill ([SB1321](#)) designed to stabilize Illinois' Medicaid managed care program and address significant issues in the state's Medicaid eligibility determination and redetermination processes. This critical legislation includes numerous reforms to improve the performance of the Medicaid Managed Care Organizations (MCOs), reduce administrative burden on providers, and resolve other high priority, systemic challenges experienced by IHA member hospitals and health systems. Below is a technical summary of and guide to the bill's contents.

**IHA-recommended Initiatives**

IHA strongly advocated for inclusion of the key initiatives listed below in the Medicaid Omnibus Bill, as identified by the Board of Trustees and various member groups. *All initiatives cited below amend the Public Aid Code (305 ILCS 5) and are effective upon enactment, unless specifically noted.*

**Pgs. 4-5**

**Centralized Claims Submission "Pipeline"**

Grants the Department of Healthcare and Family Services (HFS) expedited procurement authority to acquire, no later than August 1, 2019, technology that would create a new Medicaid managed care claims submission system for all providers. The target date for implementation of the technology is January 1, 2020 (*Illinois Procurement Code, 30 ILCS 500/20-25.1(a) new*).

**Pgs. 64-66**

Allows providers to initially submit a claim for reimbursement to the new "pipeline," which would capture all claim elements for HFS before forwarding the claim directly to the appropriate MCO for adjudication and determination of payment. HFS would have the ability to create standard front-end edits that would return an immediate HIPAA compliant response to a provider should a claim submission error occur. This timely, standard information would allow providers to quickly identify the error and submit a corrected claim. Ultimately, the pipeline would lead to greater standardization across MCOs and ease administrative burden of denials management on providers.

By having a complete record of all claim submissions, HFS would have greater oversight of the Medicaid managed care program and enhanced ability to hold the MCOs accountable for their performance. The pipeline would also allow HFS to improve the quality of its MCO encounter data, allowing for an accurate accounting of the true cost of the Illinois Medicaid program.

**While this technology is not unique, Illinois would be the first state in the nation to implement such a pipeline to improve oversight of its managed Medicaid program.**

**Pgs. 53-54**

**Timely Payment Interest/Expedited Payments**

Requires all MCOs to calculate and pay any timely payment interest penalties due to providers in accordance with the “timely payment for health care services” section of the Insurance Code (215 ILCS 5/368a). MCOs must pay an interest penalty of 9 percent per annum for each day a claim remains unpaid beyond the 30-day timely payment window. **This timely interest payment penalty is not superseded by any state delays in making capitation payments to the MCOs.**

Prohibits MCOs from requiring providers to request or apply for timely payment interest. MCOs must clearly identify and separately report timely payment interest penalty amounts from other payments for services rendered by the provider. Separate reporting on the explanation of payment/remittance advice will allow providers to distinguish between payment for services and interest penalty payments.

Requires all MCOs to adhere to HFS’ list of expedited providers, as determined under 89 Ill. Adm. Code 140.71(b), and pay these providers on a schedule that is at least as frequent as HFS’ expedited schedule. HFS is required to share its expedited provider list with all MCOs at least monthly. MCOs may satisfy the expedited payment requirement through a Periodic Interim Payment (PIP) program, if mutually agreed upon by the MCO and the expedited provider.

**Pgs. 54-56**

**FFS Timely Filing Extensions for Eligibility Errors**

Clarifies the intent of [Public Act \(PA\) 099-0751](#) (SB3080), which directed HFS to establish a process to resolve liability disputes when the state’s eligibility system provided inaccurate enrollment information at the time of service. The revised language clarifies that HFS is responsible for payment if the beneficiary was actually eligible and enrolled in traditional fee-for-service (FFS) Medicaid on the date of service. (HFS will not pay for services in cases where the patient was deemed ineligible for Medicaid on the date of service.) **If FFS Medicaid is ultimately deemed liable for coverage on the date of service, HFS must extend the timely filing period for paper claim submission.**

**Pgs. 57-59**

**Dispute Resolution Process**

By January 1, 2020, HFS must implement a dispute resolution process for providers to challenge an MCO’s decision to deny, in whole or part, reimbursement for a claim. The provider must first avail itself of the MCO’s

internal dispute resolution process and allow the MCO 30 days to resolve the issue. If the MCO's proposed resolution is unsatisfactory, or the MCO fails to respond within 30 days, the provider has 30 days from the date the MCO issues its resolution, or the end of the 30-day resolution period if the MCO fails to respond, to submit the dispute to the HFS complaint portal. Multiple claims disputes involving the same MCO, regardless of whether the claims are for different enrollees, may be submitted in one complaint when the reason for non-payment involves a common question of fact or policy. Within 10 business days of receiving the complaint, HFS must present the dispute to the MCO, which has 30 days to issue its written proposal to resolve the dispute. HFS may grant one 30-day extension of this timeframe.

If the dispute remains unresolved, the provider has 30 days to request HFS review of the dispute. The provider and MCO shall present relevant information to HFS within 30 days of the request for review. Within 30 days of receiving the relevant information or the end of the 30 day submission period, HFS must issue a written decision on the dispute based on the contractual terms between the provider and MCO, the contract between HFS and the MCO and Medicaid policy. HFS' written decision is final.

**Pgs. 59-60**

**MCO Medical Loss Ratios**

Requires HFS to annually calculate the Medical Loss Ratio (MLR) of each MCO and publically publish the results, inclusive of premium revenue and aggregate benefit expenses. The MLR calculation formula is contained within the statute. HFS must comply with federal regulations regarding a claims runout period in the calculation.

**Pgs. 60-61**

**Provider Liability Effective Date and Directory Updates**

Establishes a standard policy on the date an MCO becomes liable for payment of services rendered by a contracted network provider. For all MCOs, the "liability effective date" is the latter of the:

1. Contract date;
2. Date the provider submits a complete and accurate standard roster template to the MCO; or
3. "Provider Effective Date" contained in HFS' provider enrollment system (i.e., IMPACT).

Requires all MCOs to update their publically available provider directories within 30 days of receipt of a complete and accurate standard roster template, assuming the provider is enrolled in Illinois Medicaid and effective in the IMPACT subsystem.

- Pg. 61**                    **Stakeholder Collaboration on Performance Improvement**  
Directs HFS to work with relevant stakeholders to develop guidelines to enhance and improve the operational performance of the Medicaid managed care program, establish uniform standards across MCOs, reduce administrative burden, and improve provider-MCO relations. These efforts may take the form of unofficial Technical Advisory Groups (TAGs), as have been used in the past. HFS must report on the progress of these efforts in its fiscal year 2020 Annual Report to the General Assembly.
- Pg. 67**                    **Hospital Assessment Due Date**  
Corrects a technical drafting error in [PA100-1181](#). Changes the statutory due date for payment of the hospital assessment tax from the 14<sup>th</sup> business day of each month to the 17<sup>th</sup> business day of each month.
- Pgs. 76**                    **Stakeholder Input on Eligibility Determination Process Improvements**  
Directs HFS to explore opportunities for greater stakeholder involvement in approaches to expediting and improving eligibility determination and redetermination processes. As a result of IHA’s advocacy, the language specifically references implementation of Hospital Presumptive Eligibility as authorized under the Affordable Care Act as an approach to expediting the eligibility process.
- Clarifies HFS’ intent to explore the implementation of a real-time eligibility determination process, consistent with federal requirements, once the current eligibility system is stabilized and application backlog reduced.
- Pgs. 103-105**            **Inpatient Hospital Stays Beyond Medical Necessity**  
Directs HFS to establish a rate of reimbursement for hospital inpatient days beyond medical necessity when (1) HFS, the responsible MCO, and/or the hospital are unable to find appropriate post-discharge placement; and (2) the prevailing rate methodology provides no reimbursement. HFS may satisfy this requirement through the development of a “day outlier” payment add-on under the APR-DRG system. Days beyond medical necessity are, however, excluded from any add-on payments under the Medicaid High Volume Adjustment (MHVA) and Medicaid Percentage Adjustment (MPA) programs. The MCOs must adopt HFS’ methodology or implement an alternative methodology that pays at least as much as HFS’ methodology, unless a mutually agreed upon risk-based or other innovative payment methodology is contained within the provider contract language.
- Requires hospitals to notify the responsible MCO within 24 hours of admission as a condition of payment for days beyond medical necessity. If the hospital fails to notify the MCO within 24 hours, payment for days beyond medical necessity will be reduced by one day for each 24-hour

period beyond the initial notification period. This provision was added to limit the loss of payment to only those days where the hospital failed to comply with the notification requirement.

Requires notification to HFS of the need for post-discharge placement for patients enrolled in FFS Medicaid. Payment will only be made for days beyond medical necessity that occur after HFS has been notified. HFS will establish a notification process for FFS Medicaid patients.

By October 1, 2019, HFS must publish rules to implement a payment methodology, effective for dates of service on and after July 1, 2019.

**Pg. 105-106**

**Extension of DCFS Psychiatric Per Diem for Lock-Outs**

Extends the current requirement that the Department of Children and Family Services (DCFS) reimburse for “Lock Out” days to July 1, 2020. These days will not be eligible for the new “stays beyond medical necessity” add-on payment.

**Eligibility Determination/Redetermination Process Improvements**

In addition to IHA’s proposals, the Medicaid Omnibus Bill seeks to improve the state’s processes and enhance its resources for determining and redetermining Medicaid eligibility. Specifically, the bill amends the Children’s Health Insurance Program (CHIP) Act (215 ILCS 160/7), the Covering ALL KIDS Health Insurance Act (215 ILCS 170/7), and/or the Public Aid Code (305 ILCS 5/11) to:

- Allow HFS to extend the end of the benefit coverage date by one month for redeterminations;
- Simplify the proof of income process by allowing verification of one month’s income from one paystub;
- Allow HFS to use applications for other non-medical benefits in the annual eligibility redetermination process;
- Allow eligibility redeterminations only on an annual basis for some or all Medicaid categories; and
- Require quarterly progress reports on implementation of improvements to eligibility determination processes.

SB1321 also amends the Illinois Procurement Code to allow for expedited procurement of a vendor to assess and monitor the performance of the Department of Human Services’ (DHS) Integrated Eligibility System (IES) until it is stabilized (*30 ILCS 500/20-25.1(b) new*).

**Other Medicaid Reforms**

- Allows rather than requires prior approval for physical, occupational and speech therapy;
- Eliminates a mandatory requirement to maximize co-payments as part of efforts to achieve greater compliance with federal standards;

- Removes language that allowed licensed dietician nutritionist and certified diabetes educators to provide in-home services;
- Requires HFS to engage in stakeholder meetings on the topic of Value-based purchasing;
- Removes a requirement for HFS to contract with a back-end third party liability (TPL) vendor; and
- Requires healthcare providers to release to an MCO, in compliance with all HIPAA standards, an enrollee's health records if the patient has signed a general release. **Due to IHA's advocacy on this issue, the bill does not require hospitals to grant MCOs direct access to electronic medical records (EMRs), as proposed by the MCOs.** Provision of records may be satisfied on a case-by-case basis through the release of records via paper copies or other secure method.

### **MCO Minority and Women-owned Business Reporting**

- Beginning March 1, 2020, each MCO must annually submit a report to HFS that details:
  - Administrative expenses paid to the MCO;
  - Expenses paid by the MCO to Business Enterprise Program (BEP) certified businesses;
  - Expenses paid by the MCO to minority- and women-owned businesses certified by other state agencies or private organizations;
  - Expenses paid by the MCO to not-for-profit community-based organizations serving predominantly minority communities;
  - The proportion of minorities, people with disabilities, and women who are employed by the MCO;
  - Recommendations to increase expenditures with minority and women-owned businesses;
  - A list of service types for which the MCO is contemplating adding new vendors;
  - Certifications the MCO accepts for minority and women-owned businesses; and
  - The MCOs point of contact for vendors seeking to do business with the MCO.
- HFS will be required to:
  - Publish each MCOs report on its website and maintain copies for five years; and
  - Beginning May 2020, and every May thereafter, hold two annual public workshops for potential vendors to network with the MCOs about opportunities to submit plans. (Workshops must be held in Chicago and Springfield.)

### **Questions**

For questions regarding the legislation or the technical summary, please contact IHA's Health Policy and Finance team.