Illinois Health and Hospital Association

December 30, 2024

Elizabeth Whitehorn
Director
Illinois Department of Healthcare and Family Services
401 South Clinton Street
Chicago, IL 60607

Dear Director Whitehorn,

On behalf of our more than 200 member hospitals and nearly 40 health systems, the Illinois Health and Hospital Association (IHA) appreciates the opportunity to provide comments on the state of Illinois' HealthChoice Illinois Medicaid Managed Care Organization (MCO) request for proposal. As the state begins to re-bid these contracts, it is vital to remain focused on our shared goals and ongoing efforts to improve health outcomes, reduce health disparities, increase oversight of Medicaid MCOs and expand access to high-quality care for the state's most underserved residents. It is equally important that the process used to select the MCOs is both a thorough and transparent endeavor that considers the performance of current MCOs as well as member and provider feedback.

As you know, there have been positive steps the Illinois General Assembly and Administration have taken in recent years to advance our shared goals. For example, Public Act (P.A.) 103-0102 established the first general revenue fund Medicaid rate increase for hospitals in 28 years. In addition, P.A. 103-0593 establishes meaningful Medicaid MCO prior authorization reforms including utilization review standardization and transparency guidelines, a service authorization performance (Gold Card) program, and an inpatient stabilization period (72 Hour Rule). However, these efforts alone may not ensure the success of our larger shared goals.

With that said, in addition to the changes enacted through P.A. 103-0102 and P.A. 103-0593, we believe it is crucial for the Department to ensure that the new MCO model contract is aligned with the following priorities:

Adequate Reimbursement Rates

Medicaid patients have complex health needs, and it is essential that MCOs offer reimbursement rates that are adequate to support the quality of care required. Without adequate reimbursement, patient access to care may be impacted as hospital finances continue to be challenged by dramatically higher labor and supply chain costs compounded by inflation. While it has been the standard practice for MCOs to nominally reimburse hospitals with at least the fee-for-service ("FFS") rates, MCOs employ various contract-based practices that are intended to directly or indirectly dilute those rates. In

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order to ensure MCOs are not the unintended beneficiaries of P.A. 103-0102 or other rate increases, we recommend HFS address these practices in the following ways:

Unilateral Contract Changes

Contracts are negotiated agreements that establish mutual obligations and expectations, however, due to their bargaining power, MCOs frequently reserve the right to make unilateral changes. These changes are not limited to security programs or other internal administration of the MCO but are instead material changes impacting hospital reimbursement including, but not limited to, clinical or coding policies (e.g., claims editing, pre-pay audits, post-pay audits, and service authorization). This effectively allows MCOs to unilaterally alter previously negotiated terms to their advantage with little or no hospital recourse. IHA recommends the new MCO model contract restricts an MCO's ability to implement unilateral contract changes.

Audit/Manual Reviews

The MCOs, along with their vendors, consistently implement audit/manual review practices that result in a reduction in reimbursement. In some cases, a single MCO may have multiple manual reviews and audits being conducted at the same time. We recommend that the contract set reasonable limits on claims that can be audited/manually reviewed by MCOs and their vendors who are acting on their behalf.

Institutional Claims and Encounters

Complete encounter data is vital to hospital reimbursement as it impacts both Medicaid inpatient utilization rates and hospital payments in the Hospital Assessment Program. Although capturing 100 percent of encounter data is ideal, it is often not realized. We are generally encouraged by HFS' efforts to enforce more complete reporting of encounter data through sanctions. In addition to those efforts, we recommend the percentage of completeness of hospital encounter data be published quarterly for each MCO, separated by inpatient and outpatient claims. This transparency will support stakeholder confidence in a process that has significant financial implications for the hospital community.

Medicaid Provider Contractual Rate Setting Disclosure

MCOs and hospitals may mutually agree to risk-based contracting or other variable rate arrangements in which it is obvious to both MCOs and hospitals that the reimbursement may result in less or more than the expected reimbursement under FFS rates. However, some MCOs employ obscure language that results in state-based rate increases benefiting MCOs rather than providers who were the intended beneficiaries. For example, the language of some MCO contracts provides for reimbursement *at the lesser of* FFS or their billed charges. In operation, small and rural hospitals' billed charges are lower than FFS to accommodate their uninsured or underinsured patients. MCOs are aware that hospitals will avoid increasing charges on the uninsured and underinsured in their communities, and they may not be aware of the consequences of the "at the

lesser of" language. Therefore, we recommend that MCOs be affirmatively obligated to disclose prominently in their contracts with hospitals that the proposed reimbursement may fall below Medicaid FFS rates.

Administrative Burden

MCOs often impose a significant administrative burden on hospitals through complex billing requirements, frequent claims denials, and prospective and retrospective itemized bill reviews. Service authorizations add another layer of complexity to the administrative burden MCOs place on hospitals, delaying care and forcing hospitals to dedicate their resources to paperwork rather than patient outcomes. These practices not only strain hospital administrative capacities but also divert resources from direct patient care, undermining the overall efficiency of healthcare delivery. Denials of claims further exacerbate these challenges, requiring time-intensive appeals and resubmissions. Recognizing that hospitals must navigate unique rules across multiple MCOs, we offer the following recommendations related to easing a hospital's administrative burden and allowing them to focus more time on caring for their patients:

2024 Medicaid MCO Prior Authorization Reforms (P.A. 103-0593).

We appreciated the opportunity to partner with the Department earlier this year on meaningful Medicaid MCO prior authorization legislation. Given the breadth and scope of that legislation and the overwhelming support it received from the Illinois General Assembly, Medicaid MCO compliance with the new law is paramount. Therefore, we recommend that the model contract clearly outline sanctions for non-compliance as well as how MCOs will be assessed for meeting the requirements of the new law. As a corollary, the reforms in P.A. 103-0593 should be added as an affirmative requirement in the new MCO model contract by reference to statute and its rules.

Furthermore, to target compliance with the anticipated reforms (and underscore their importance), HFS should consider adding a subsection of sanctions in the new MCO model contract to include failure to comply with the anticipated reforms. At a minimum, the subsection of sanction for failure to substantially comply with "any State or federal laws affecting [the MCO's] conduct not otherwise specifically enunciated" should be expanded to include the rules promulgated under those State or federal laws.

Alignment

P.A. 103-0593 is a step toward reducing inefficiencies and increased costs, however, all things considered equal, the ever-evolving rules of the MCOs outside of the subject matter of P.A. 103-0593 should be incentivized to converge towards standardization. We recommend the new MCO model contract require standardization among all appropriate facets of the managed care program, including utilization management and claims adjudication policies, such as itemized bill requirement thresholds. The Claims and Clinical Accountability Workgroups have resulted in resolution for countless issues between MCOs and hospital providers, and we strongly encourage these workgroups to continue their efforts to resolve various issues in the managed care program. If full

standardization is not required, we recommend the Claims and Clinical Accountability Workgroups address standardization in the managed care program to advance the goal of standardizing as many areas as possible. We recommend HFS formalize the Claims and Clinical Accountability Workgroups and require MCOs to participate in these workgroups in the new MCO model contract.

Provider Enrollment

The failure of an MCO to update its provider information should not be cause for hospitals to expend staff time to dispute a claim denial. The new MCO model contract should prohibit MCOs from front-end rejection of claims based on provider enrollment status. Additionally, MCOs should be required to accept and process all claims regardless of provider enrollment status and re-process all claims that it previously denied due to a provider's enrollment status from the date such a provider is enrolled, regardless of when its provider records were updated and regardless of whether such a claim has been formally disputed by the provider.

Additionally, the new MCO model contract should shorten the timeframe requirement that MCOs update its provider records from within thirty (30) days to ten (10) business days of receiving a notice from HFS indicating that the provider has been updated in either the IMPACT Provider Enrollment System or the Legacy Provider Enrollment System. We recommend adding a subsection of sanctions in the new MCO model contract for failure to comply with this requirement.

The Scope of an MCO's Internal Dispute Resolution Process

P.A. 101-0209 required the creation of the Managed Care Provider Resolution Portal ("Portal"), and the service authorization dispute resolution language in the current MCO model contract was intended to encompass all service authorization denials including administrative denials and medical necessity denials. However, the language has been interpreted by some MCOs to apply to only service authorizations that were denied for administrative reasons. This self-serving interpretation forecloses legitimate disputes being adjudicated directly between the hospital and MCO and prevents a hospital from bringing its dispute to HFS, as Portal submissions require the provider to first attempt resolution through the MCO's internal dispute resolution process. The new MCO model contract should include language that clarifies the required dispute resolution process applies to all service authorization denials (including both administrative and medical necessity reasons).

Medical Necessity Disputes

In cases where a hospital provider has exhausted all avenues for contesting a service authorization denial, and the clinicians at the hospital and the MCO remain in disagreement as to whether a service or level of care is medically necessary, the provider's only recourse is to submit a complaint to the Portal. While the current MCO contract contains language that allows for member appeals to be reviewed by an independent external quality review organization, that "independent" organization is a vendor of the MCO, which inserts inherent bias into a process where subjectivity of clinical opinion is applied or, at the least, creates the appearance of a conflict of interest. Medical

necessity provider complaints submitted to the Portal should be reviewed by HFS' EQRO vendor for a truly independent determination, ensuring a final decision by a neutral third-party clinician.

Provider Manuals

An MCO's provider manual is an essential tool for hospitals and despite the current MCO model contract requiring it be available online, it is not available on all of the MCOs' public-facing websites. We recommend the new MCO model contract specifically require publication of an MCO's provider manual on its public-facing website in an area that is intuitive and easy to navigate, no more than two clicks from the homepage, and without the requirement to login to a special segregated area to view or obtain it. We also recommend the provider manual be easily located based on entering "provider manual" into the website's search function.

Care Coordination and Communication

Effective care coordination between MCOs and hospital providers is critical to improving patient outcomes, particularly for those with chronic conditions or complex medical needs. Ensuring the new MCO model contract contains strong care coordination requirements, paired with continuous oversight by HFS, is vital to create a robust system of collaboration and ensure continuity of care and better health outcomes for Medicaid beneficiaries.

Enforcement of Care Coordination Requirements

The State moved to a Medicaid program with most beneficiaries covered by managed care in order to provide care coordination and case management to improve quality of care, expand coverage and access, and improve the health and outcomes of Medicaid beneficiaries. The current MCO model contract requires MCOs to complete a health-risk screening or health risk assessment within a specified time frame, however, based on the available MCO Performance Metric Dashboard Summaries, no MCO completed more than 73% of these assessments within the required timeframes.

The current MCO model contract also requires MCOs to develop a comprehensive, person-centered individualized plan of care for enrollees in specified risk categories within a specified time frame. Based on the available MCO Performance Metric Dashboard Summaries, no MCO completed more than 83% of plans of care. While MCOs have not been able to achieve contractually required care coordination, hospitals continually provide care coordination services, beyond any reimbursement from the Medicaid program. IHA recommends the new MCO model contract include a subsection of sanctions for failing to achieve the care coordination and case management requirements.

Enhancement of Care Coordination Requirements

When hospitals seek placement for a complex patient at a Skilled Nursing Facilities (SNF), the hospital will turn to the patient's MCO for assistance and, in return, are provided a list of SNFs contracted with or in the network of the patient's MCO. While care coordination between MCOs

and hospitals for any particular patient can come in many forms and must vary by context to best address a patient's needs, simply providing a list of SNFs is far from care coordination.

We recommend the requirements for care coordination in the new MCO model contract be intensified, especially for patients discharging from the hospital. For example, the new MCO model contract could require in-person contact (without audio only or virtual exemptions) for not only the required situations in the current MCO model contract, but also for beneficiaries discharging from hospitals who are transferring to Long-Term Acute Care Hospitals, SNFs, and home with the support of home health. In addition, any time a hospital requests payment of long-term care days (administrative days), MCOs could be required to assign a care coordinator if the patient does not already have one, and that care coordinator must have a face-to-face visit with that patient within 3 calendar days. Although patient needs may vary, the new MCO model contract must require the MCOs to coordinate care, helping ensure that those patients who clearly need care coordination receive it.

Readmissions

Not all readmissions should be presumed to be preventable. For example, on the one hand, a hospital may plan a readmission (e.g., for repetitive treatments, a procedural admission following diagnostic admission, or a same-day admission to a different hospital unit). On the other hand, a readmission may be due to factors outside of the hospital's control (e.g., admission based on an unrelated condition, a patient leaving against medical advice or refusing to comply with post-discharge plants, or an MCO's failure to authorize post-discharge services). The new MCO model contract should prohibit MCOs from classifying a readmission as preventable if it was planned by the hospital or outside of the hospital's ability to affect, based on the hospital's documentation.

Mental Health (MH) and Substance Use Disorder (SUD) Parity Requirements

A January 2023 analysis jointly published by the Illinois Department of Insurance and HFS indicated that prior authorization denial rates submitted by MCOs were presented in aggregate rather than by classifications of care, making it difficult to compare denial rates within these benefits and identify plan compliance with parity laws. We recommend that MCOs are specifically required to submit non-quantitative treatment limitations by classification of care under the new MCO model contract to determine parity between MH/SUD and medical and surgical benefits moving forward in compliance with P.A. 100-1024. For comparative analyses between the two types of benefits, requiring submission of non-quantitative treatment limitations like medical management standards and prior authorization requirements under the six classifications of care for Medicaid plans (inpatient in or out-of-network, outpatient in or out-of-network, prescription and emergency) would support compliance.

Conclusion

We look forward to the opportunity to continue collaborating with both the Department and the MCOs in a way that supports the best interests of Medicaid beneficiaries.

It is important to recognize the disproportionate impact that inadequate reimbursement rates, highly administratively burdensome processes, and insufficient care coordination have on at-risk and marginalized communities served by MCOs. These systemic issues exacerbate existing health inequities by limiting access to timely, high-quality care and straining the resources of hospitals that serve as safety nets for these vulnerable populations. Addressing these barriers is essential to improving health outcomes and fostering a more equitable healthcare system for all Medicaid members.

We appreciate your consideration of these concerns and respectfully request that HFS address them as part of the RFP process. We look forward to working with you to ensure that the state's Medicaid Managed Care arrangements are effective, equitable, and ultimately beneficial to the individuals and communities we serve.

Sincerely,

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