Illinois Health and Hospital Association

MEDICAID MANAGED CARE:
Common sense business practices need to be established in law

Hospitals face an overwhelming array of challenges working with the six Medicaid Managed Care Organizations (MCOs) charged with serving more than two million Illinois Medicaid beneficiaries. Hospitals have been working with the MCOs both on an individual basis and collectively through the IHA, but we need statutory assurances that MCOs will adhere to increased transparency and improved business practices. IHA has identified priority areas where enhanced oversight of MCO operational performance, coupled with requiring the MCOs to immediately implement proven, common sense business practices, would lead to improved outcomes for patients and providers. We need the General Assembly to put these provisions in law so that hospitals know with certainty that MCO performance will improve and hospitals can count on a reduction in the administrative burden that hinders the provision of medical care. The following are the priority problems that need to be addressed permanently by legislation. Please support SB1697, SB1807, SB1703, and HB1654.

Problem	**Hospitalization beyond medical necessity, resulting from lack of post discharge care coordination placement.** Hospitals are increasingly being required to retain Medicaid enrollees in the hospital, beyond the date when the enrollee has been deemed ready for discharge by their attending physician. These "Beyond Medical Necessity" stays typically do not receive reimbursement resulting in additional hospital expenses that are not reimbursed. MCOs are required to coordinate placement or transfer to the appropriate setting of care post discharge but currently do not have an incentive to do so in a timely manner when the patient can remain in the hospital at no cost to the MCO.
Proposed Remedy	MCOs should be required to fulfill their obligations to arrange placement or transfer to the proper setting of care in a timely fashion, once notified by the hospital of a physician's discharge order. Placement or transfer should occur within 24 hours, or the MCO should reimburse the hospital at a rate equal to the per day rate (per diem) for the associated stay, including any and all add-ons, such as Medicaid High Volume Adjustments (MHVA), Medicaid Percentage Adjustment (MPA) and Safety Net Hospital adjustments. These stays often result in unreimbursed cost for the most financially vulnerable hospitals, such as Safety Net and Critical Access Hospitals.
Problem	**Untimely MCO provider roster updates**, resulting in denial of payment for services rendered while a contracted provider waits to be added to the publically viewable roster. Although HFS has centralized the credentialing process, the MCOs continue to deny claims due to untimely MCO updating of provider rosters once the provider has been placed under contract with the MCO. Frequently, MCOs will reject a claim submitted by a provider not contained on the MCOs publically available roster, despite the provider having a valid in-network contract. Additionally, the delay in loading rosters with updated information creates an access to care issue for hospitals wishing to notify their regular patients that a new physician has become available under the associated MCO. This results in a period of time when the physician is in limbo and unable to bill and receive reimbursement from the MCO.

Proposed Remedy	Any provider under contract with an MCO on the date services are provided to a covered enrollee should be reimbursed for medically necessary services, regardless of the provider being identified on the MCO's roster. Because the MCOs currently have little incentive to load physicians timely, the MCOs should be required to update their rosters within seven days of all newly contracted providers.
Problem	**Providers need to have the option of bringing payment disputes to an independent arbitrator** much like how individuals can do so when appealing a coverage denial. Attempts to resolve payment denial disputes take too long and, after months of haggling, hospitals are given an offer to settle the disputed claim at a substantial discount. MCOs should be held accountable for improper denials.
Proposed Remedy	Providers should 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, to be reviewed by an external independent third party.
Problem	**Medical necessity documentation and service authorization uniform guidelines.** Hospitals have noted wide ranging rules related to medical necessity and service authorization requests. Often MCO rules change with little or no notice. MCOs vary in how they confirm receipt of service authorizations, and many require a non-electronic, cumbersome system of faxing that is prone to error. Hospitals may not know if their requests were ever received. MCOs will often conduct audits after services are provided and take back payments without giving providers sufficient notice or a rationale for why the funds are being recouped. All these obstacles ultimately result in significant administrative burden and cost on the hospitals, barriers to receiving payment, and delays in providing medically necessary care.
Proposed Remedy	A comprehensive and uniform set of common sense business practices related to service authorization process: • MCOs must maintain and make available to providers an electronic tracking system of all service authorization requests, including a tracking number and identification of services being requested. • MCOs must respond within four days, or 48 hours for urgent cases, and if the MCO does not respond within these timeframes, the service is deemed authorized. • Once an MCO has approved a service, no further clinical information should be requested to determine if the provider will be paid, unless the services billed are substantially different than those approved by the MCO. • Once a service is approved, the MCO should not be allowed to downgrade the service. • MCOs should follow standard post-payment audit rules and give providers sufficient notice and identify the reason for the recovery when MCOs seek to take money back from providers. • MCOs should be penalized when they deny payment for a service that

	was authorized by the MCO prior to delivery, but claim that service authorization was not obtained. • MCOs should be penalized for claims that are denied due to insufficient documentation when it can be shown that the original submission contained all necessary information.
Problem	**MCOs are not adhering to the same payment timelines as the state's FFS expedited provider list**. The Illinois Pubic Aid code identifies providers who are financially vulnerable and who require regular payment of claims submitted. These providers are identified as expedited providers and are given priority for payment at the Illinois Comptroller's office and are largely paid on a weekly basis. MCOs have been encouraged by HFS to make accommodations to pay these providers timely, but it is not currently required.
Proposed Remedy	MCOs should be required to pay all hospitals qualifying under the expedited provider rules on a schedule at least as regular as the state FFS system pays the expedited provider list. MCOs may meet this requirement by entering into a Periodic Interim Payment (PIP) program. The parameters of a PIP program must be mutually agreed to and documented between the MCO and provider and must be voluntary. The program must assure that the hospital provider is paid on a regular basis, consistent with the FFS system. The program should allow for a reconciliation provision for any overpayments or advances.
Problem	**Timely Interest Payment Penalty** MCOs often fail to identify the penalty on a payment voucher, making it nearly impossible to attribute the penalty to the correct claim. By not clearly identifying the applicable case due the penalty, the provider cannot determine if the payment is compliant with the statue. Furthermore, not all MCOs automatically calculate and pay the penalty, instead requiring the provider to separately request these payments. Also, MCOs are able to avoid paying the penalty by requesting additional information in an untimely manner. Often, hospitals receive a request for additional clinical information long after a claim has been submitted. The request for additional information has been deemed by the MCOs as justification that the timely payment provision of the Illinois Insurance Code does not apply once the request has been issued. Often, hospitals receive the request near the end of the 30-day required payment period, essentially delaying payment for a service and avoid paying the timely payment interest penalty.
Proposed Remedy	Providers need to be paid timely interest penalties in a transparent manner. MCOs should be required to automatically calculate timely payment interest penalties in accordance with the Illinois Insurance Code and separately identify payments for services from payment of interest. MCOs should request any additional information necessary to adjudicate a claim within five days of receiving the claim. MCOs should not require the submission of additional information for a claim which the MCO previously approved. The request for additional information may only suspend the 30 day payment requirement under the timely payment provisions of the insurance code. The mere presence of a request for additional information should not remove the claims from a clean claim status in perpetuity. Once the additional information has been

	supplied by the hospital, the clock should begin on the balance of the 30 days. This will incentivize the MCOs to respond in a timely manner.
Problem	**MCO amounts spent on medical care remain unverified.** MCOs are required to report on the amounts they spend on medical care and administrative expenses to show that they are meeting minimum requirements. Although the state is already required to verify the payout ratios of the MCOs, the Illinois Auditor General found that this has not occurred so there is no independent verification that MCOs are meeting minimum medical spending requirements.
Proposed Remedy	To inform the General Assembly on the extent that the MCOs are in compliance with their contracts with the state regarding payout ratios, the state should calculate the payout ratios reported by MCOs no less frequently than annually and post these calculations to its website. For an MCO not meeting the 85 percent payout threshold, the MCO should pay a refund to the state. MCOs that do not pay the refund should be excluded from the Medicaid program.
Problem	**Lack of uniformity of key definitions** related to MCO claims adjudication and service authorization terms. The MCOs use some terms interchangeably (e.g., rejection/denial), leading to confusion regarding how to appropriately resolve payment and authorization disputes.
Proposed Remedy	MCOs should use uniform clear definitions for the following regularly misunderstood terms: *Claims Rejections, Claims Payment Rate Adjustments, Claim Recoupment Adjustment, Claim Denial, and Service Authorization*.
Problem	**Non-uniform list of essential clinical information requested by MCOs to adjudicate and pay an otherwise clean claim.** Each of the six MCOs have their own, unique list of clinical or other documentation, outside of the standard information reported on a claim, that may be required to support payment. Moreover, these lists change constantly, with little or no warning given to hospitals. Navigating these ever-changing payment rules increases the administrative burden on hospitals and diverts resources from patient care.
Proposed Remedy	Require the MCOs to use a single, standard list of essential clinical information or other documentation to support payment of claims. To provide stability, this standard list would be developed by HFS, posted on the agency's website and only updated annually.
Problem	**Non uniform claim coding and messaging**. Each MCO has a proprietary list of codes that identify the reason a claim has been paid or not paid and any action that must be taken to change the claim from unacceptable to acceptable. The code descriptions often lack the detail needed for the hospital to determine why the MCO has reduced or refused payment, requiring staff to conduct substantial manual research to determine the real reason for the denial and whether the issue can be corrected. Adhering to six different sets of insufficiently defined instructions unnecessarily increases the administrative cost of seeking payment for services.
Proposed Remedy	The MCOs should adhere to a single, standard list of payment determination codes that are cross-referenced with the national standard codes. This would

provide uniformity and consistency to help providers bill correctly and effectively manage denials, and significantly mitigate the rising administrative costs being passed on to the provider community.