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

TO: Chief Executive Officers, Member Hospitals and Health Systems
Chief Financial Officers
Government Relations Personnel
Patient Financial Services Staff

FROM: A.J. Wilhelmi, President and CEO
David Gross, Senior Vice President, Government Relations
Patrick Gallagher, Senior Vice President, Health Policy and Finance
Helena Lefkow, Senior Director, Revenue Cycle & Managed Care

SUBJECT: IHA's Medicaid Managed Care Legislation & Advocacy Strategy

Today, a comprehensive legislative package of Medicaid managed care reform bills developed and strongly backed by IHA was introduced in the Illinois General Assembly designed to hold managed care organizations (MCOs) accountable for their performance in order to preserve and assure access to timely, quality healthcare for all Medicaid patients.

The Legislative Package

The legislation is designed to bring rationality to a harmful and irrational process that requires hospitals to redirect healthcare resources to manage unnecessary administrative burdens associated with unclear and disparate MCO billing and reimbursement processes, extraordinary claims denial rates and reimbursement delays.

Components of the legislation are aimed at addressing hospital concerns with crippling MCO payment denials by requiring common sense clarifications and standardization of processes, instituting accountability for MCO performance and providing avenues for independent third party reviews to resolve disputes.

Illinois hospitals proudly serve as the backbone of the Medicaid program and should be fairly reimbursed in a timely fashion for care provided to Medicaid patients in good faith in partnership with the State of Illinois.

IHA has been working on behalf of Illinois hospitals to identify, analyze and attempt to resolve the causes of Medicaid MCO reimbursement denials and delays. This work has been an important and necessary part of the strategy to address these issues by:

- Working to gather information about the causes of the denials and delays so that thoughtful solutions to these problems could be crafted.
- Educating legislators and policymakers about the problems created by the rapid expansion of Medicaid managed care, our efforts to resolve those issues and the negative impact this inefficient system is having on patient care and access to care.
- Performing our due diligence and making a strong show of good faith to attempt to resolve issues with the MCOs and the Illinois Department of Healthcare and Family Services (HFS). Illinois hospitals are now able to reasonably contend that all avenues to resolve these issues outside of the legislative process have been exhausted and a legislative solution is required to adequately fix a broken system.

Having put forth that good faith effort to resolve issues with the MCOs and seeing incremental, but unacceptable, progress to date, IHA is now well positioned to take our case to the General Assembly. The Medicaid managed care reform legislative package includes the following bills:

- [**Senate Bill 1697/House Bill 2715**](#), sponsored by Senator Heather Steans and Representative Robyn Gabel, includes provisions to establish a comprehensive approach on needed managed care reforms. Requirements include: a uniform set of rules on 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 automatic calculation of timely payment interest penalty payments due. (See [**IHA fact sheet**](#))
- [**Senate Bill 1807/House Bill 2814**](#), sponsored by Senator Kimberly Lightford and Representative Camille Lilly, includes provisions to address key managed care issues for hospitals, especially Safety Net and Critical Access hospitals. Requirements include: 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; and 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. (See [**IHA fact sheet**](#))
- [**Senate Bill 1703/House Bill 2730**](#), sponsored by Senator Don Harmon and Representative Bob Morgan, includes provisions to provide a fair process to review and correct improper Medicaid MCO payment denials. Hospitals and other healthcare providers will 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. ([See IHA fact sheet](#))

Ongoing IHA Efforts to Address MCO Issues

Even as we pursue the legislative package, addressing and resolving members' concerns with Illinois' Medicaid managed care program will continue to be a top priority for IHA in our ongoing work with our members, HFS and the MCOs. We greatly appreciate the work and support of IHA's CFO Forum in helping IHA develop our advocacy strategy and prioritize the most relevant issues to address with HFS and the MCOs.

The remainder of this memorandum provides an overview of IHA's parallel advocacy strategy outside of the MCO reform legislation to improve HFS' oversight of the MCOs and to ensure HFS holds the MCOs accountable for their operational performance, particularly with respect to ongoing payment denials for medically necessary care rendered in good faith.

To that end, IHA continues to:

- Share with HFS data from its quarterly MCO Administrative Performance Survey, the results of which demonstrate an initial average denial rate of 26 percent for encounters submitted in state fiscal year (SFY) 2018 to the MCOs by a representative sample of member hospitals; and
- Work with HFS and the MCOs to ease the administrative burden on members by enhancing and standardizing operational processes across health plans, including development of comprehensive uniform billing instructions and clear discharge planning procedures. We are pleased to report that the hospital outpatient services section of the comprehensive *MCO Provider Billing Manual*, which was developed through the HFS/IHA/Illinois Association of Medicaid Health Plans (IAMHP) MCO Billing Guidelines Joint Workgroup, will be posted on IAMHP's [website](#). The hospital inpatient services section will be released in the near future. These sections and related billing examples were developed with extensive input from representatives of IHA's Patient Financial Services Committee. IHA hopes that having billing guidelines, for the first time, will help reduce inappropriate denials.

Background

In recent years, IHA has had success in achieving legislative reforms to improve the Medicaid managed care program. In 2017, IHA worked to enact legislation establishing a process for hospitals to receive payment due to eligibility data errors (SB3080). In 2018, IHA worked to enact legislation to increase HFS transparency of, and MCO accountability for, claims processing performance. This legislation (SB1573/Public Act 100-0580) was a companion to the assessment redesign legislation, requiring HFS to publicly report an analysis of MCO claims processing and payment performance on its website every six months. This report is in addition to the claims data report that HFS collects from the MCOs and publicly publishes on a quarterly basis.

IHA also supported a House Resolution directing the Auditor General to conduct an audit of the MCOs. The [audit report](#) (January 2018) was critical of HFS oversight of the mandatory managed care program, concluding that HFS did not maintain complete and accurate information needed to adequately monitor payments made to and by the MCOs during SFY2016. The auditors made a number of recommendations for HFS to improve financial oversight of the MCOs, including ensuring compliance with all contract provisions.

MCO Administrative Performance Survey

IHA recently completed its fourth quarterly MCO Administrative Performance Survey, which collects member-reported data on MCO initial denial rates, the top reasons for these denials, and MCO timeliness in resolving denials. With the most recent survey, IHA has now provided HFS with MCO-specific data on more than 2 million encounters submitted by a static, representative sample of members for a full State Fiscal Year (July 1, 2017 to June 30, 2018). Of the encounters submitted in SFY 2018, the average initial denial rate was **26 percent**. The median denial rate was 21 percent, which means half of the hospitals reported denial rates of more than 21 percent and half had denial rates below 21 percent.

For the 691,754 encounters submitted by 81 member hospitals to the MCOs during the last quarter of SFY 2018 (April 1, 2018 to June 30, 2018):

- The average initial denial rate across all MCOs was 25 percent, down from 29 percent in IHA's first quarterly survey;
- The median initial denial rate for all MCOs was 13 percent, down from 23 percent in the first survey; and
- The median rate of encounters that remained unresolved as of the most recent reporting period (September 30, 2018) was 13 percent, compared to 17 percent reported in the first survey.

While the quarterly surveys have shown a measured decline in denials, the results have helped IHA successfully demonstrate to HFS that denial rates remain unacceptably high four years after implementation of Medicaid managed care in Illinois. HFS has been using the data in discussions with the MCOs and is monitoring MCO efforts to identify and address the root causes of these denials.

For SFY 2019, IHA plans to revise the survey to more closely align with the denial metrics used by HFS in its semiannual MCO claims processing and payment performance reports, for which IHA advocated in SB1573/Public Act 100-0580. The survey will also be revised to differentiate between denials that may be related to a provider billing error versus inappropriate determinations of nonpayment by an MCO, as well as to support efforts to improve MCO reporting to hospitals of the rationale behind the denials.

Operational Standardization Efforts

Over the past year, IHA, in conjunction with HFS and IAMHP, has achieved standardization in two priority areas for members: a centralized credentialing process through HFS' Illinois Medicaid Program Advanced Cloud Technology system; and a universal provider roster template to submit data required by the MCOs for claims payment, care coordination, and provider directory purposes. In 2019, IHA, HFS, and IAMHP will continue to participate in two HFS-led workgroups to standardize MCO billing guidelines and develop best practices for a collaborative discharge planning process.

Standardized Credentialing Process

HFS has completed one of the highest priorities for hospitals: centralizing the credentialing process. Previously, the MCOs each had their own credentialing process with separate requirements and administrative processes, which led to delays in approving providers and payment denials.

Standardized Provider Roster Template

HFS expects that providers are now using the standardized provider roster template, created by HFS, IHA and IAMHP, to submit data required for claims payment, care coordination, and provider directories to the MCOs. IHA, in conjunction with IAMHP and the MCOs, completed a series of well-received webinars in July on how to complete and submit the standardized provider roster template to the MCOs. IHA continues to urge HFS to closely monitor MCO compliance with the Model Contract, which requires MCOs to load the data within 30 days of receipt of updated information. Adherence to this timeframe will improve patient access to in-network providers and allow hospitals to submit claims for covered services. However, if the MCOs do not load physician templates in a timely manner, the efforts to centralize credentialing and standardize the rosters will have no effect on reducing denials. IHA is also working with IAMHP to minimize any MCO-specific deviations from the standard template.

Billing Guidelines Joint Workgroup

Through the Billing Guidelines Joint Workgroup, IHA has successfully demonstrated to HFS how the lack of transparency and consistency in billing instructions across the MCOs has contributed to the high denial rate. As a result, HFS instructed the MCOs to develop, in writing, comprehensive billing instructions for all provider types, beginning with hospital services. HFS also recognized that some MCOs have been inappropriately recouping certain claim payments, sometimes years after the date(s) of service. These recoupments are related to rejections the MCOs receive when submitting paid claim data to the state. Effective July 12, 2018, HFS directed the MCOs to discontinue any recoupment of payments from a provider due to encounter-related rejections that could have been prevented by implementing front-end edits to their claims processing systems. Through the Billing Workgroup, IHA will continue to collaborate with IAMHP and the MCOs to refine the hospital-specific guidelines and to identify and address the root causes of payment denials.

Discharge Planning Joint Workgroup

Hospitals have identified the lack of proactive MCO involvement in securing post-acute placement of patients as a longstanding problem. To address this issue, members of the Discharge Planning Joint Workgroup, which includes representatives from the PFS Subcommittee on Utilization Review/Case Management, have initiated various pilot programs under which MCO care coordinators are either embedded at a hospital or provide telephonic care coordination. Each pilot program will select, track, and report outcomes on a variety of metrics, including avoidable days. The goal of these pilots is to develop discharge planning best practices to ensure active MCO involvement in post-acute care placement. This effort corresponds with a recent evaluation of the MCOs conducted by Health Services Advisory Group (HSAG) that identified transition of care as one of the most critical areas for improvement with Medicaid MCOs.

IHA has also used this forum to highlight member concerns regarding MCO responsiveness to initial requests for discharge planning assistance. IHA requested that the MCOs provide a comprehensive resource document identifying key discharge planning contacts and escalation points for hospitals. IHA is pleased to report that IAMHP, in conjunction with the MCOs, has developed a *Discharge Planning Resource Guide* to help hospitals make initial contact with the MCOs for discharge planning assistance and to identify the appropriate escalation hierarchy if no response is received to the initial request. IAMHP has assured IHA that it will make regular updates to this document.

Continuing to Work with HFS

Working cooperatively with HFS still holds the greatest promise for success in areas such as quicker MCO response time when requiring additional claim information, greater standardization across MCOs in explaining why a claim is not being paid, providing education on billing guidelines, and improving the MCOs' discharge planning processes. There is, however, still a need for advancing a legislative strategy to address these and other member concerns, including easing administrative burden.

Looking ahead, IHA will continue to advocate for improving the performance of the MCOs by refining its member surveys on denials and working with HFS and the MCOs to standardize administrative processes.

If you have any questions, please contact Patrick Gallagher at pgallagher@team-iha.org or 630-276-5496 or Helena Lefkow at hlefkow@team-iha.org or 312-906-6008.