State Position Paper

Illinois Health and Hospital Association
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Support the Right to a Fair Review of Improper Medicaid MCO Denials
Senate Bill 1703/House Bill 2730
Sponsors: Senator Don Harmon and Representative Bob Morgan

Issue: Illinois rapidly expanded Medicaid managed care over the past several years, so that 2.2 million Medicaid beneficiaries (two-thirds of the total) are now enrolled in a Medicaid Managed Care Organization (MCO). Unfortunately, Medicaid managed care has failed to realize the promise of increased care coordination, improved patient outcomes, greater efficiencies and cost savings.

Instead, hospitals struggle with excessive MCO initial claim denial rates (26 percent – well above the single digit rates for private insurance/non-Medicaid claims). Attempts by hospitals to resolve the payment denial disputes within the MCO's internal dispute resolution process are typically met with delays, unreasonable requests for additional information and a general lack of responsiveness. After months of haggling, hospitals are often given an offer to settle the disputed claim at a substantial discount.

IHA Position: To assure access to care for Medicaid beneficiaries, health care providers must be paid for the medically necessary services they deliver in good faith. Improper payment denials by MCOs jeopardize access to care by threatening the financial viability of some providers and discouraging others from expanding services to Medicaid managed care enrollees. To preserve and enhance access to care, there must be a meaningful process for providers to hold MCOs accountable for improper denials. An independent third party review process will incentivize hospitals and MCOs to resolve billing questions in an agreeable fashion, reducing the time and resources spent on billing disputes.

Solution: Senate Bill 1703/House Bill 2730 will help assure access to care for Medicaid beneficiaries by providing a fair process to review and correct improper Medicaid MCO payment denials, as follows:

- Hospitals, and other health care providers, shall 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.
- Multiple claims could be determined in one external independent third party review.
- An MCO's letter to a provider reflecting the final decision on its internal appeal shall include a statement that the provider is entitled to an external independent third party review and the time period and address for submitting a request for such a review.
- Either party would then be entitled to appeal a final decision of the external independent third party review through the administrative hearing process within the Department of Healthcare and Family Services (HFS), with such appeal having to be filed within 30 days of the decision on the external independent third party review. The final decision of the Director of HFS on the appeal would then be subject to judicial review.
- HFS may, by rule, establish a fee of up to $1000 to defray the expenses of the administrative hearing, which shall be paid by the party that does not prevail.

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