

SB2331



99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

SB2331

Introduced 1/27/2016, by Sen. Daniel Biss

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30

Amends the Illinois Public Aid Code. Makes a technical change in a Section concerning care coordination.

LRB099 19286 KTG 43678 b

A BILL FOR

1 AN ACT concerning public aid.

2 **Be it enacted by the People of the State of Illinois,**
3 **represented in the General Assembly:**

4 Section 5. The Illinois Public Aid Code is amended by
5 changing Section 5-30 as follows:

6 (305 ILCS 5/5-30)

7 Sec. 5-30. Care coordination.

8 (a) At least 50% of recipients eligible for ~~for~~
9 comprehensive medical benefits in all medical assistance
10 programs or other health benefit programs administered by the
11 Department, including the Children's Health Insurance Program
12 Act and the Covering ALL KIDS Health Insurance Act, shall be
13 enrolled in a care coordination program by no later than
14 January 1, 2015. For purposes of this Section, "coordinated
15 care" or "care coordination" means delivery systems where
16 recipients will receive their care from providers who
17 participate under contract in integrated delivery systems that
18 are responsible for providing or arranging the majority of
19 care, including primary care physician services, referrals
20 from primary care physicians, diagnostic and treatment
21 services, behavioral health services, in-patient and
22 outpatient hospital services, dental services, and
23 rehabilitation and long-term care services. The Department

1 shall designate or contract for such integrated delivery
2 systems (i) to ensure enrollees have a choice of systems and of
3 primary care providers within such systems; (ii) to ensure that
4 enrollees receive quality care in a culturally and
5 linguistically appropriate manner; and (iii) to ensure that
6 coordinated care programs meet the diverse needs of enrollees
7 with developmental, mental health, physical, and age-related
8 disabilities.

9 (b) Payment for such coordinated care shall be based on
10 arrangements where the State pays for performance related to
11 health care outcomes, the use of evidence-based practices, the
12 use of primary care delivered through comprehensive medical
13 homes, the use of electronic medical records, and the
14 appropriate exchange of health information electronically made
15 either on a capitated basis in which a fixed monthly premium
16 per recipient is paid and full financial risk is assumed for
17 the delivery of services, or through other risk-based payment
18 arrangements.

19 (c) To qualify for compliance with this Section, the 50%
20 goal shall be achieved by enrolling medical assistance
21 enrollees from each medical assistance enrollment category,
22 including parents, children, seniors, and people with
23 disabilities to the extent that current State Medicaid payment
24 laws would not limit federal matching funds for recipients in
25 care coordination programs. In addition, services must be more
26 comprehensively defined and more risk shall be assumed than in

1 the Department's primary care case management program as of
2 January 25, 2011 (the effective date of Public Act 96-1501)
3 ~~this amendatory Act of the 96th General Assembly.~~

4 (d) The Department shall report to the General Assembly in
5 a separate part of its annual medical assistance program
6 report, beginning April, 2012 until April, 2016, on the
7 progress and implementation of the care coordination program
8 initiatives established by the provisions of Public Act 96-1501
9 ~~this amendatory Act of the 96th General Assembly.~~ The
10 Department shall include in its April 2011 report a full
11 analysis of federal laws or regulations regarding upper payment
12 limitations to providers and the necessary revisions or
13 adjustments in rate methodologies and payments to providers
14 under this Code that would be necessary to implement
15 coordinated care with full financial risk by a party other than
16 the Department.

17 (e) Integrated Care Program for individuals with chronic
18 mental health conditions.

19 (1) The Integrated Care Program shall encompass
20 services administered to recipients of medical assistance
21 under this Article to prevent exacerbations and
22 complications using cost-effective, evidence-based
23 practice guidelines and mental health management
24 strategies.

25 (2) The Department may utilize and expand upon existing
26 contractual arrangements with integrated care plans under

1 the Integrated Care Program for providing the coordinated
2 care provisions of this Section.

3 (3) Payment for such coordinated care shall be based on
4 arrangements where the State pays for performance related
5 to mental health outcomes on a capitated basis in which a
6 fixed monthly premium per recipient is paid and full
7 financial risk is assumed for the delivery of services, or
8 through other risk-based payment arrangements such as
9 provider-based care coordination.

10 (4) The Department shall examine whether chronic
11 mental health management programs and services for
12 recipients with specific chronic mental health conditions
13 do any or all of the following:

14 (A) Improve the patient's overall mental health in
15 a more expeditious and cost-effective manner.

16 (B) Lower costs in other aspects of the medical
17 assistance program, such as hospital admissions,
18 emergency room visits, or more frequent and
19 inappropriate psychotropic drug use.

20 (5) The Department shall work with the facilities and
21 any integrated care plan participating in the program to
22 identify and correct barriers to the successful
23 implementation of this subsection (e) prior to and during
24 the implementation to best facilitate the goals and
25 objectives of this subsection (e).

26 (f) A hospital that is located in a county of the State in

1 which the Department mandates some or all of the beneficiaries
2 of the Medical Assistance Program residing in the county to
3 enroll in a Care Coordination Program, as set forth in Section
4 5-30 of this Code, shall not be eligible for any non-claims
5 based payments not mandated by Article V-A of this Code for
6 which it would otherwise be qualified to receive, unless the
7 hospital is a Coordinated Care Participating Hospital no later
8 than 60 days after June 14, 2012 (the effective date of Public
9 Act 97-689) ~~this amendatory Act of the 97th General Assembly~~ or
10 60 days after the first mandatory enrollment of a beneficiary
11 in a Coordinated Care program. For purposes of this subsection,
12 "Coordinated Care Participating Hospital" means a hospital
13 that meets one of the following criteria:

14 (1) The hospital has entered into a contract to provide
15 hospital services with one or more MCOs to enrollees of the
16 care coordination program.

17 (2) The hospital has not been offered a contract by a
18 care coordination plan that the Department has determined
19 to be a good faith offer and that pays at least as much as
20 the Department would pay, on a fee-for-service basis, not
21 including disproportionate share hospital adjustment
22 payments or any other supplemental adjustment or add-on
23 payment to the base fee-for-service rate, except to the
24 extent such adjustments or add-on payments are
25 incorporated into the development of the applicable MCO
26 capitated rates.

1 As used in this subsection (f), "MCO" means any entity
2 which contracts with the Department to provide services where
3 payment for medical services is made on a capitated basis.

4 (g) No later than August 1, 2013, the Department shall
5 issue a purchase of care solicitation for Accountable Care
6 Entities (ACE) to serve any children and parents or caretaker
7 relatives of children eligible for medical assistance under
8 this Article. An ACE may be a single corporate structure or a
9 network of providers organized through contractual
10 relationships with a single corporate entity. The solicitation
11 shall require that:

12 (1) An ACE operating in Cook County be capable of
13 serving at least 40,000 eligible individuals in that
14 county; an ACE operating in Lake, Kane, DuPage, or Will
15 Counties be capable of serving at least 20,000 eligible
16 individuals in those counties and an ACE operating in other
17 regions of the State be capable of serving at least 10,000
18 eligible individuals in the region in which it operates.
19 During initial periods of mandatory enrollment, the
20 Department shall require its enrollment services
21 contractor to use a default assignment algorithm that
22 ensures if possible an ACE reaches the minimum enrollment
23 levels set forth in this paragraph.

24 (2) An ACE must include at a minimum the following
25 types of providers: primary care, specialty care,
26 hospitals, and behavioral healthcare.

1 (3) An ACE shall have a governance structure that
2 includes the major components of the health care delivery
3 system, including one representative from each of the
4 groups listed in paragraph (2).

5 (4) An ACE must be an integrated delivery system,
6 including a network able to provide the full range of
7 services needed by Medicaid beneficiaries and system
8 capacity to securely pass clinical information across
9 participating entities and to aggregate and analyze that
10 data in order to coordinate care.

11 (5) An ACE must be capable of providing both care
12 coordination and complex case management, as necessary, to
13 beneficiaries. To be responsive to the solicitation, a
14 potential ACE must outline its care coordination and
15 complex case management model and plan to reduce the cost
16 of care.

17 (6) In the first 18 months of operation, unless the ACE
18 selects a shorter period, an ACE shall be paid care
19 coordination fees on a per member per month basis that are
20 projected to be cost neutral to the State during the term
21 of their payment and, subject to federal approval, be
22 eligible to share in additional savings generated by their
23 care coordination.

24 (7) In months 19 through 36 of operation, unless the
25 ACE selects a shorter period, an ACE shall be paid on a
26 pre-paid capitation basis for all medical assistance

1 covered services, under contract terms similar to Managed
2 Care Organizations (MCO), with the Department sharing the
3 risk through either stop-loss insurance for extremely high
4 cost individuals or corridors of shared risk based on the
5 overall cost of the total enrollment in the ACE. The ACE
6 shall be responsible for claims processing, encounter data
7 submission, utilization control, and quality assurance.

8 (8) In the fourth and subsequent years of operation, an
9 ACE shall convert to a Managed Care Community Network
10 (MCCN), as defined in this Article, or Health Maintenance
11 Organization pursuant to the Illinois Insurance Code,
12 accepting full-risk capitation payments.

13 The Department shall allow potential ACE entities 5 months
14 from the date of the posting of the solicitation to submit
15 proposals. After the solicitation is released, in addition to
16 the MCO rate development data available on the Department's
17 website, subject to federal and State confidentiality and
18 privacy laws and regulations, the Department shall provide 2
19 years of de-identified summary service data on the targeted
20 population, split between children and adults, showing the
21 historical type and volume of services received and the cost of
22 those services to those potential bidders that sign a data use
23 agreement. The Department may add up to 2 non-state government
24 employees with expertise in creating integrated delivery
25 systems to its review team for the purchase of care
26 solicitation described in this subsection. Any such

1 individuals must sign a no-conflict disclosure and
2 confidentiality agreement and agree to act in accordance with
3 all applicable State laws.

4 During the first 2 years of an ACE's operation, the
5 Department shall provide claims data to the ACE on its
6 enrollees on a periodic basis no less frequently than monthly.

7 Nothing in this subsection shall be construed to limit the
8 Department's mandate to enroll 50% of its beneficiaries into
9 care coordination systems by January 1, 2015, using all
10 available care coordination delivery systems, including Care
11 Coordination Entities (CCE), MCCNs, or MCOs, nor be construed
12 to affect the current CCEs, MCCNs, and MCOs selected to serve
13 seniors and persons with disabilities prior to that date.

14 Nothing in this subsection precludes the Department from
15 considering future proposals for new ACEs or expansion of
16 existing ACEs at the discretion of the Department.

17 (h) Department contracts with MCOs and other entities
18 reimbursed by risk based capitation shall have a minimum
19 medical loss ratio of 85%, shall require the entity to
20 establish an appeals and grievances process for consumers and
21 providers, and shall require the entity to provide a quality
22 assurance and utilization review program. Entities contracted
23 with the Department to coordinate healthcare regardless of risk
24 shall be measured utilizing the same quality metrics. The
25 quality metrics may be population specific. Any contracted
26 entity serving at least 5,000 seniors or people with

1 disabilities or 15,000 individuals in other populations
2 covered by the Medical Assistance Program that has been
3 receiving full-risk capitation for a year shall be accredited
4 by a national accreditation organization authorized by the
5 Department within 2 years after the date it is eligible to
6 become accredited. The requirements of this subsection shall
7 apply to contracts with MCOs entered into or renewed or
8 extended after June 1, 2013.

9 (h-5) The Department shall monitor and enforce compliance
10 by MCOs with agreements they have entered into with providers
11 on issues that include, but are not limited to, timeliness of
12 payment, payment rates, and processes for obtaining prior
13 approval. The Department may impose sanctions on MCOs for
14 violating provisions of those agreements that include, but are
15 not limited to, financial penalties, suspension of enrollment
16 of new enrollees, and termination of the MCO's contract with
17 the Department. As used in this subsection (h-5), "MCO" has the
18 meaning ascribed to that term in Section 5-30.1 of this Code.

19 (i) Unless otherwise required by federal law, Medicaid
20 Managed Care Entities shall not divulge, directly or
21 indirectly, including by sending a bill or explanation of
22 benefits, information concerning the sensitive health services
23 received by enrollees of the Medicaid Managed Care Entity to
24 any person other than providers and care coordinators caring
25 for the enrollee and employees of the entity in the course of
26 the entity's internal operations. The Medicaid Managed Care

1 Entity may divulge information concerning the sensitive health
2 services if the enrollee who received the sensitive health
3 services requests the information from the Medicaid Managed
4 Care Entity and authorized the sending of a bill or explanation
5 of benefits. Communications including, but not limited to,
6 statements of care received or appointment reminders either
7 directly or indirectly to the enrollee from the health care
8 provider, health care professional, and care coordinators,
9 remain permissible.

10 For the purposes of this subsection, the term "Medicaid
11 Managed Care Entity" includes Care Coordination Entities,
12 Accountable Care Entities, Managed Care Organizations, and
13 Managed Care Community Networks.

14 For purposes of this subsection, the term "sensitive health
15 services" means mental health services, substance abuse
16 treatment services, reproductive health services, family
17 planning services, services for sexually transmitted
18 infections and sexually transmitted diseases, and services for
19 sexual assault or domestic abuse. Services include prevention,
20 screening, consultation, examination, treatment, or follow-up.

21 Nothing in this subsection shall be construed to relieve a
22 Medicaid Managed Care Entity or the Department of any duty to
23 report incidents of sexually transmitted infections to the
24 Department of Public Health or to the local board of health in
25 accordance with regulations adopted under a statute or
26 ordinance or to report incidents of sexually transmitted

1 infections as necessary to comply with the requirements under
2 Section 5 of the Abused and Neglected Child Reporting Act or as
3 otherwise required by State or federal law.

4 The Department shall create policy in order to implement
5 the requirements in this subsection.

6 (j) ~~(i)~~ Managed Care Entities (MCEs), including MCOs and
7 all other care coordination organizations, shall develop and
8 maintain a written language access policy that sets forth the
9 standards, guidelines, and operational plan to ensure language
10 appropriate services and that is consistent with the standard
11 of meaningful access for populations with limited English
12 proficiency. The language access policy shall describe how the
13 MCEs will provide all of the following required services:

14 (1) Translation (the written replacement of text from
15 one language into another) of all vital documents and forms
16 as identified by the Department.

17 (2) Qualified interpreter services (the oral
18 communication of a message from one language into another
19 by a qualified interpreter).

20 (3) Staff training on the language access policy,
21 including how to identify language needs, access and
22 provide language assistance services, work with
23 interpreters, request translations, and track the use of
24 language assistance services.

25 (4) Data tracking that identifies the language need.

26 (5) Notification to participants on the availability

1 of language access services and on how to access such
2 services.

3 (Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14;
4 99-106, eff. 1-1-16; 99-181, eff. 7-29-15; revised 10-26-15.)