



100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB5433

by Rep. Fred Crespo

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services to calculate the payout ratios reported by managed care organizations no less frequently than annually and to post these calculations on its website. Provides that the minimum payout ratio shall be 85% and that a managed care organization not meeting the 85% threshold must refund to the State, for each coverage year, an amount equal to the difference between the calculated payout ratio and 85% multiplied by coverage year revenue for that managed care organization. Defines "payment ratio". Requires the Department to exclusively use paid claims data submitted by managed care organizations in establishing managed care capitation rates. Provides that managed care organizations shall not be reimbursed by the State for any costs associated with health insurance fees.

LRB100 19504 KTG 34770 b

FISCAL NOTE ACT
MAY APPLY

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

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

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

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

1 January 25, 2011 (the effective date of Public Act 96-1501).

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

14 (e) Integrated Care Program for individuals with chronic
15 mental health conditions.

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

22 (2) The Department may utilize and expand upon existing
23 contractual arrangements with integrated care plans under
24 the Integrated Care Program for providing the coordinated
25 care provisions of this Section.

26 (3) Payment for such coordinated care shall be based on

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

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

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

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

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

23 (f) A hospital that is located in a county of the State in
24 which the Department mandates some or all of the beneficiaries
25 of the Medical Assistance Program residing in the county to
26 enroll in a Care Coordination Program, as set forth in Section

1 5-30 of this Code, shall not be eligible for any non-claims
2 based payments not mandated by Article V-A of this Code for
3 which it would otherwise be qualified to receive, unless the
4 hospital is a Coordinated Care Participating Hospital no later
5 than 60 days after June 14, 2012 (the effective date of Public
6 Act 97-689) or 60 days after the first mandatory enrollment of
7 a beneficiary in a Coordinated Care program. For purposes of
8 this subsection, "Coordinated Care Participating Hospital"
9 means a hospital that meets one of the following criteria:

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

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

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

26 (g) No later than August 1, 2013, the Department shall

1 issue a purchase of care solicitation for Accountable Care
2 Entities (ACE) to serve any children and parents or caretaker
3 relatives of children eligible for medical assistance under
4 this Article. An ACE may be a single corporate structure or a
5 network of providers organized through contractual
6 relationships with a single corporate entity. The solicitation
7 shall require that:

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

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

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

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

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

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

20 (7) In months 19 through 36 of operation, unless the
21 ACE selects a shorter period, an ACE shall be paid on a
22 pre-paid capitation basis for all medical assistance
23 covered services, under contract terms similar to Managed
24 Care Organizations (MCO), with the Department sharing the
25 risk through either stop-loss insurance for extremely high
26 cost individuals or corridors of shared risk based on the

1 overall cost of the total enrollment in the ACE. The ACE
2 shall be responsible for claims processing, encounter data
3 submission, utilization control, and quality assurance.

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

9 The Department shall allow potential ACE entities 5 months
10 from the date of the posting of the solicitation to submit
11 proposals. After the solicitation is released, in addition to
12 the MCO rate development data available on the Department's
13 website, subject to federal and State confidentiality and
14 privacy laws and regulations, the Department shall provide 2
15 years of de-identified summary service data on the targeted
16 population, split between children and adults, showing the
17 historical type and volume of services received and the cost of
18 those services to those potential bidders that sign a data use
19 agreement. The Department may add up to 2 non-state government
20 employees with expertise in creating integrated delivery
21 systems to its review team for the purchase of care
22 solicitation described in this subsection. Any such
23 individuals must sign a no-conflict disclosure and
24 confidentiality agreement and agree to act in accordance with
25 all applicable State laws.

26 During the first 2 years of an ACE's operation, the

1 Department shall provide claims data to the ACE on its
2 enrollees on a periodic basis no less frequently than monthly.

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

10 Nothing in this subsection precludes the Department from
11 considering future proposals for new ACEs or expansion of
12 existing ACEs at the discretion of the Department.

13 (h) Department contracts with MCOs and other entities
14 reimbursed by risk based capitation shall have a minimum
15 medical loss ratio of 85%, shall require the entity to
16 establish an appeals and grievances process for consumers and
17 providers, and shall require the entity to provide a quality
18 assurance and utilization review program. Entities contracted
19 with the Department to coordinate healthcare regardless of risk
20 shall be measured utilizing the same quality metrics. The
21 quality metrics may be population specific. Any contracted
22 entity serving at least 5,000 seniors or people with
23 disabilities or 15,000 individuals in other populations
24 covered by the Medical Assistance Program that has been
25 receiving full-risk capitation for a year shall be accredited
26 by a national accreditation organization authorized by the

1 Department within 2 years after the date it is eligible to
2 become accredited. The requirements of this subsection shall
3 apply to contracts with MCOs entered into or renewed or
4 extended after June 1, 2013.

5 (h-2) The Department must calculate the payout ratios
6 reported by MCOs no less frequently than annually and post
7 these calculations on its website. The minimum payout ratio
8 shall be 85%. For an MCO not meeting the 85% threshold, the MCO
9 must refund to the State, for each coverage year, an amount
10 equal to the difference between the calculated payout ratio and
11 85% multiplied by coverage year revenue for that MCO. As used
12 in this subsection, "payout ratio" means the total amount of
13 paid claims to medical providers by an MCO as reported to the
14 Department divided by total capitation payments made by the
15 Department to the MCO for any given period of time.

16 (h-3) Beginning with capitation rates for calendar year
17 2019, the Department must exclusively use paid claims data
18 submitted by MCOs in establishing managed care capitation
19 rates.

20 (h-4) MCOs shall not be reimbursed by the State for any
21 costs associated with health insurance fees.

22 (h-5) The Department shall monitor and enforce compliance
23 by MCOs with agreements they have entered into with providers
24 on issues that include, but are not limited to, timeliness of
25 payment, payment rates, and processes for obtaining prior
26 approval. The Department may impose sanctions on MCOs for

1 violating provisions of those agreements that include, but are
2 not limited to, financial penalties, suspension of enrollment
3 of new enrollees, and termination of the MCO's contract with
4 the Department. As used in this subsection (h-5), "MCO" has the
5 meaning ascribed to that term in Section 5-30.1 of this Code.

6 (i) Unless otherwise required by federal law, Medicaid
7 Managed Care Entities and their respective business associates
8 shall not disclose, directly or indirectly, including by
9 sending a bill or explanation of benefits, information
10 concerning the sensitive health services received by enrollees
11 of the Medicaid Managed Care Entity to any person other than
12 covered entities and business associates, which may receive,
13 use, and further disclose such information solely for the
14 purposes permitted under applicable federal and State laws and
15 regulations if such use and further disclosure satisfies all
16 applicable requirements of such laws and regulations. The
17 Medicaid Managed Care Entity or its respective business
18 associates may disclose information concerning the sensitive
19 health services if the enrollee who received the sensitive
20 health services requests the information from the Medicaid
21 Managed Care Entity or its respective business associates and
22 authorized the sending of a bill or explanation of benefits.
23 Communications including, but not limited to, statements of
24 care received or appointment reminders either directly or
25 indirectly to the enrollee from the health care provider,
26 health care professional, and care coordinators, remain

1 permissible. Medicaid Managed Care Entities or their
2 respective business associates may communicate directly with
3 their enrollees regarding care coordination activities for
4 those enrollees.

5 For the purposes of this subsection, the term "Medicaid
6 Managed Care Entity" includes Care Coordination Entities,
7 Accountable Care Entities, Managed Care Organizations, and
8 Managed Care Community Networks.

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

16 For purposes of this subsection, "business associate",
17 "covered entity", "disclosure", and "use" have the meanings
18 ascribed to those terms in 45 CFR 160.103.

19 Nothing in this subsection shall be construed to relieve a
20 Medicaid Managed Care Entity or the Department of any duty to
21 report incidents of sexually transmitted infections to the
22 Department of Public Health or to the local board of health in
23 accordance with regulations adopted under a statute or
24 ordinance or to report incidents of sexually transmitted
25 infections as necessary to comply with the requirements under
26 Section 5 of the Abused and Neglected Child Reporting Act or as

1 otherwise required by State or federal law.

2 The Department shall create policy in order to implement
3 the requirements in this subsection.

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

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

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

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

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

24 (5) Notification to participants on the availability
25 of language access services and on how to access such
26 services.

1 (Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14;
2 99-106, eff. 1-1-16; 99-181, eff. 7-29-15; 99-566, eff. 1-1-17;
3 99-642, eff. 7-28-16.)