



Sen. Heather A. Steans

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1 AMENDMENT TO SENATE BILL 343

2 AMENDMENT NO. _____. Amend Senate Bill 343 by replacing
3 everything after the enacting clause with the following:

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

1 contract in integrated delivery systems that are responsible
2 for providing or arranging the majority of care, including
3 primary care physician services, referrals from primary care
4 physicians, diagnostic and treatment services, behavioral
5 health services, in-patient and outpatient hospital services,
6 dental services, and rehabilitation and long-term care
7 services. The Department shall designate or contract for such
8 integrated delivery systems (i) to ensure enrollees have a
9 choice of systems and of primary care providers within such
10 systems; (ii) to ensure that enrollees receive quality care in
11 a culturally and linguistically appropriate manner; and (iii)
12 to ensure that coordinated care programs meet the diverse needs
13 of enrollees with developmental, mental health, physical, and
14 age-related disabilities.

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

25 (c) To qualify for compliance with this Section, the 50%
26 goal shall be achieved by enrolling medical assistance

1 enrollees from each medical assistance enrollment category,
2 including parents, children, seniors, and people with
3 disabilities to the extent that current State Medicaid payment
4 laws would not limit federal matching funds for recipients in
5 care coordination programs. In addition, services must be more
6 comprehensively defined and more risk shall be assumed than in
7 the Department's primary care case management program as of the
8 effective date of this amendatory Act of the 96th General
9 Assembly.

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

22 (e) Integrated Care Program for individuals with chronic
23 mental health conditions.

24 (1) The Integrated Care Program shall encompass
25 services administered to recipients of medical assistance
26 under this Article to prevent exacerbations and

1 complications using cost-effective, evidence-based
2 practice guidelines and mental health management
3 strategies.

4 (2) The Department may utilize and expand upon existing
5 contractual arrangements with integrated care plans under
6 the Integrated Care Program for providing the coordinated
7 care provisions of this Section.

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

15 (4) The Department shall examine whether chronic
16 mental health management programs and services for
17 recipients with specific chronic mental health conditions
18 do any or all of the following:

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

21 (B) Lower costs in other aspects of the medical
22 assistance program, such as hospital admissions,
23 emergency room visits, or more frequent and
24 inappropriate psychotropic drug use.

25 (5) The Department shall work with the facilities and
26 any integrated care plan participating in the program to

1 identify and correct barriers to the successful
2 implementation of this subsection (e) prior to and during
3 the implementation to best facilitate the goals and
4 objectives of this subsection (e).

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

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

22 (2) The hospital has not been offered a contract by a
23 care coordination plan that the Department has determined
24 to be a good faith offer and that pays at least as much as
25 the Department would pay, on a fee-for-service basis, not
26 including disproportionate share hospital adjustment

1 payments or any other supplemental adjustment or add-on
2 payment to the base fee-for-service rate, except to the
3 extent such adjustments or add-on payments are
4 incorporated into the development of the applicable MCO
5 capitated rates.

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

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

17 (1) An ACE operating in Cook County be capable of
18 serving at least 40,000 eligible individuals in that
19 county; an ACE operating in Lake, Kane, DuPage, or Will
20 Counties be capable of serving at least 20,000 eligible
21 individuals in those counties and an ACE operating in other
22 regions of the State be capable of serving at least 10,000
23 eligible individuals in the region in which it operates.
24 During initial periods of mandatory enrollment, the
25 Department shall require its enrollment services
26 contractor to use a default assignment algorithm that

1 ensures if possible an ACE reaches the minimum enrollment
2 levels set forth in this paragraph.

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

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

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

16 (5) An ACE must be capable of providing both care
17 coordination and complex case management, as necessary, to
18 beneficiaries. To be responsive to the solicitation, a
19 potential ACE must outline its care coordination and
20 complex case management model and plan to reduce the cost
21 of care.

22 (6) In the first 18 months of operation, unless the ACE
23 selects a shorter period, an ACE shall be paid care
24 coordination fees on a per member per month basis that are
25 projected to be cost neutral to the State during the term
26 of their payment and, subject to federal approval, be

1 eligible to share in additional savings generated by their
2 care coordination.

3 (7) In months 19 through 36 of operation, unless the
4 ACE selects a shorter period, an ACE shall be paid on a
5 pre-paid capitation basis for all medical assistance
6 covered services, under contract terms similar to Managed
7 Care Organizations (MCO), with the Department sharing the
8 risk through either stop-loss insurance for extremely high
9 cost individuals or corridors of shared risk based on the
10 overall cost of the total enrollment in the ACE. The ACE
11 shall be responsible for claims processing, encounter data
12 submission, utilization control, and quality assurance.

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

18 The Department shall allow potential ACE entities 5 months
19 from the date of the posting of the solicitation to submit
20 proposals. After the solicitation is released, in addition to
21 the MCO rate development data available on the Department's
22 website, subject to federal and State confidentiality and
23 privacy laws and regulations, the Department shall provide 2
24 years of de-identified summary service data on the targeted
25 population, split between children and adults, showing the
26 historical type and volume of services received and the cost of

1 those services to those potential bidders that sign a data use
2 agreement. The Department may add up to 2 non-state government
3 employees with expertise in creating integrated delivery
4 systems to its review team for the purchase of care
5 solicitation described in this subsection. Any such
6 individuals must sign a no-conflict disclosure and
7 confidentiality agreement and agree to act in accordance with
8 all applicable State laws.

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

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

19 Nothing in this subsection precludes the Department from
20 considering future proposals for new ACEs or expansion of
21 existing ACEs at the discretion of the Department.

22 (h) Department contracts with MCOs and other entities
23 reimbursed by risk based capitation shall have a minimum
24 medical loss ratio of 85%, shall require the entity to
25 establish an appeals and grievances process for consumers and
26 providers, and shall require the entity to provide a quality

1 assurance and utilization review program. Entities contracted
2 with the Department to coordinate healthcare regardless of risk
3 shall be measured utilizing the same quality metrics. The
4 quality metrics may be population specific. Any contracted
5 entity serving at least 5,000 seniors or people with
6 disabilities or 15,000 individuals in other populations
7 covered by the Medical Assistance Program that has been
8 receiving full-risk capitation for a year shall be accredited
9 by a national accreditation organization authorized by the
10 Department within 2 years after the date it is eligible to
11 become accredited. The requirements of this subsection shall
12 apply to contracts with MCOs entered into or renewed or
13 extended after June 1, 2013.

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

24 (i) As used in this subsection:

25 "Care coordination entity" means a collaboration of
26 providers and community agencies, governed by a lead entity,

1 which receives a care coordination payment with a portion of
2 the payment at risk for meeting quality outcome targets, in
3 order to provide care coordination services for its enrollees.

4 "Children with complex medical needs" means persons under
5 21 years of age who are clients of medical assistance programs
6 or other health benefit programs administered by the Department
7 through the use of the 3M™ Clinical Risk Grouping Software
8 (CRG) as Status 6.1 and above, through a clinical screening
9 tool, or those who do not have sufficient claims data in order
10 to be identified by the Department through the CRG software.

11 The Department shall offer children with complex medical
12 needs the choice of enrollment in a coordinated care entity
13 (CCE) to provide services to the children, where available.
14 This choice shall be in addition to otherwise available health
15 maintenance organizations (HMOs), managed care community
16 networks (MCCNs), and accountable care entities (ACEs).

17 Children with complex medical needs under 18 years of age
18 shall be eligible to enroll in the CCE as long as such children
19 continue to maintain eligibility for medical assistance
20 programs or other health benefit programs administered by the
21 Department. The Department may choose to extend enrollment to
22 individuals under 21 years of age for initial enrollment.
23 Individuals may also be excluded if they are:

24 (1) enrolled in the Medically Fragile Technology
25 Dependent Waiver;

26 (2) receiving private duty nursing;

1 (3) eligible for high third party liability coverage as
2 defined by the Department;

3 (4) residing in institutions including pediatric
4 skilled nursing facilities;

5 (5) enrolled in the DSCC Core Program; or

6 (6) placed in foster care with the Department of
7 Children and Family Services.

8 The Department shall ensure that the parents of all
9 eligible enrollees that are children with complex medical needs
10 shall receive notification of their eligibility and an
11 explanation of how to elect the CCE option. The Department
12 shall ensure that any third party enrollment broker is briefed
13 on such CCE option and that the broker shall ensure that all
14 enrollment options are presented to the parents of children
15 with complex medical needs.

16 (Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13;
17 98-651, eff. 6-16-14.)

18 Section 99. Effective date. This Act takes effect upon
19 becoming law."