

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 the

1 effective date of this amendatory Act of the 96th General
2 Assembly.

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

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

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

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

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

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

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

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

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

24 (f) A hospital that is located in a county of the State in
25 which the Department mandates some or all of the beneficiaries
26 of the Medical Assistance Program residing in the county to

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

12 (1) The hospital has entered into a contract to provide
13 hospital services to enrollees of the care coordination
14 program.

15 (2) The hospital has not been offered a contract by a
16 care coordination plan that pays at least as much as the
17 Department would pay, on a fee-for-service basis, not
18 including disproportionate share hospital adjustment
19 payments or any other supplemental adjustment or add-on
20 payment to the base fee-for-service rate.

21 (g) No later than August 1, 2013, the Department shall
22 issue a purchase of care solicitation for Accountable Care
23 Entities (ACE) to serve any children and parents or caretaker
24 relatives of children eligible for medical assistance under
25 this Article. An ACE may be a single corporate structure or a
26 network of providers organized through contractual

1 relationships with a single corporate entity. The solicitation
2 shall require that:

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

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

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

22 (4) An ACE must be an integrated delivery system,
23 including a network able to provide the full range of
24 services needed by Medicaid beneficiaries and system
25 capacity to securely pass clinical information across
26 participating entities and to aggregate and analyze that

1 data in order to coordinate care.

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

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

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

25 (8) In the fourth and subsequent years of operation, an
26 ACE shall convert to a Managed Care Community Network

1 (MCCN), as defined in this Article, or Health Maintenance
2 Organization pursuant to the Illinois Insurance Code,
3 accepting full-risk capitation payments.

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

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

24 Nothing in this subsection shall be construed to limit the
25 Department's mandate to enroll 50% of its beneficiaries into
26 care coordination systems by January 1, 2015, using all

1 available care coordination delivery systems, including Care
2 Coordination Entities (CCE), MCCNs, or MCOs, nor be construed
3 to affect the current CCEs, MCCNs, and MCOs selected to serve
4 seniors and persons with disabilities prior to that date.

5 (h) Department contracts with MCOs and other entities
6 reimbursed by risk based capitation shall have a minimum
7 medical loss ratio of 85%, shall require the MCO or other
8 entity to pay claims within 30 days of receiving a bill that
9 contains all the essential information needed to adjudicate the
10 bill, and shall require the entity to pay a penalty that is at
11 least equal to the penalty imposed under the Illinois Insurance
12 Code for any claims not paid within this time period. The
13 requirements of this subsection shall apply to contracts with
14 MCOs entered into or renewed or extended after June 1, 2013.

15 (i) Managed Care Entities (MCEs), including MCOs and all
16 other care coordination organizations, serving individuals
17 enrolled in the medical assistance program under this Article V
18 shall develop and maintain a written Language Access Policy
19 that sets forth standards, guidelines, and an operational plan
20 to ensure language-appropriate services and that is consistent
21 with the standard of meaningful access for Limited English
22 Proficiency (LEP) populations. The Language Access Policy
23 shall describe how the MCEs will provide the following required
24 services:

25 (1) Translation (the written replacement of text from
26 one language into another) of all vital documents and

1 forms, as identified by the Department.

2 (2) Qualified Interpreter Services (the oral
3 communication of a message from one language into another
4 by a qualified interpreter).

5 (3) Staff Training on the Language Access Policy,
6 including how to identify language needs, how to access and
7 provide language assistance services, how to work with
8 interpreters, how to request translations, and how to track
9 the use of language assistance services.

10 (4) Data Tracking that identifies the language need.

11 (5) Notification to participants stating that language
12 access services are available and describing how to obtain
13 them.

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