# SB2563

# 103RD GENERAL ASSEMBLY

# State of Illinois

# 2023 and 2024

## SB2563

Introduced 4/19/2023, by Sen. Julie A. Morrison - Dave Syverson

## SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30

Amends the Medical Assistance Article of the Illinois Public Aid Code. In provisions concerning care coordination, provides that the Department of Healthcare and Family Services may not impose and a provider shall not be required to pay any assessment, tax or fee, the proceeds of which will fund any authorized coordinated care program.

LRB103 31823 KTG 60447 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 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.
14 For 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
6 needs of enrollees with developmental, mental health,
7 physical, and 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

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

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

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

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

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

(3) Payment for such coordinated care shall be based

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) An ACE shall have a governance structure that includes the major components of the health care delivery system, including one representative from each of the 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
14 ACE 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

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

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

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

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
20 risk 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-5) The Department shall monitor and enforce compliance
6 by MCOs with agreements they have entered into with providers
7 on issues that include, but are not limited to, timeliness of
8 payment, payment rates, and processes for obtaining prior
9 approval. The Department may impose sanctions on MCOs for
10 violating provisions of those agreements that include, but are
11 not limited to, financial penalties, suspension of enrollment
12 of new enrollees, and termination of the MCO's contract with
13 the Department. As used in this subsection (h-5), "MCO" has
14 the meaning ascribed to that term in Section 5-30.1 of this
15 Code.
16 (i) Unless otherwise required by federal law, Medicaid
17 Managed Care Entities and their respective business associates
18 shall not disclose, directly or indirectly, including by
19 sending a bill or explanation of benefits, information
20 concerning the sensitive health services received by enrollees
21 of the Medicaid Managed Care Entity to any person other than
22 covered entities and business associates, which may receive,
23 use, and further disclose such information solely for the
24 purposes permitted under applicable federal and State laws and
25 regulations if such use and further disclosure satisfies all
26 applicable requirements of such laws and regulations. The

1 Medicaid Managed Care Entity or its respective business
2 associates may disclose information concerning the sensitive
3 health services if the enrollee who received the sensitive
4 health services requests the information from the Medicaid
5 Managed Care Entity or its respective business associates and
6 authorized the sending of a bill or explanation of benefits.
7 Communications including, but not limited to, statements of
8 care received or appointment reminders either directly or
9 indirectly to the enrollee from the health care provider,
10 health care professional, and care coordinators, remain
11 permissible. Medicaid Managed Care Entities or their
12 respective business associates may communicate directly with
13 their enrollees regarding care coordination activities for
14 those enrollees.

15 For the purposes of this subsection, the term "Medicaid
16 Managed Care Entity" includes Care Coordination Entities,
17 Accountable Care Entities, Managed Care Organizations, and
18 Managed Care Community Networks.

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

26 For purposes of this subsection, "business associate",

1 "covered entity", "disclosure", and "use" have the meanings
2 ascribed to those terms in 45 CFR 160.103.
3 Nothing in this subsection shall be construed to relieve a
4 Medicaid Managed Care Entity or the Department of any duty to
5 report incidents of sexually transmitted infections to the
6 Department of Public Health or to the local board of health in
7 accordance with regulations adopted under a statute or
8 ordinance or to report incidents of sexually transmitted
9 infections as necessary to comply with the requirements under
10 Section 5 of the Abused and Neglected Child Reporting Act or as
11 otherwise required by State or federal law.
12 The Department shall create policy in order to implement
13 the requirements in this subsection.
14 (j) Managed Care Entities (MCEs), including MCOs and all
15 other care coordination organizations, shall develop and
16 maintain a written language access policy that sets forth the
17 standards, guidelines, and operational plan to ensure language
18 appropriate services and that is consistent with the standard
19 of meaningful access for populations with limited English
20 proficiency. The language access policy shall describe how the
21 MCEs will provide all of the following required services:
22 (1) Translation (the written replacement of text from
23 one language into another) of all vital documents and
24 forms as identified by the Department.
25 (2) Qualified interpreter services (the oral
26 communication of a message from one language into another

by a qualified interpreter).

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

(4) Data tracking that identifies the language need.

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

(k) The Department shall actively monitor the contractual relationship between Managed Care Organizations (MCOs) and any dental administrator contracted by an MCO to provide dental services. The Department shall adopt appropriate dental Healthcare Effectiveness Data and Information Set (HEDIS) measures and shall include the Annual Dental Visit (ADV) HEDIS measure in its Health Plan Comparison Tool and Illinois Medicaid Plan Report Card that is available on the Department's website for enrolled individuals.

The Department shall collect from each MCO specific information about the types of contracted, broad-based care coordination occurring between the MCO and any dental administrator, including, but not limited to, pregnant women and diabetic patients in need of oral care.

(l) Notwithstanding any other provision of this Code, the Department may not impose and a provider shall not be required

1 to pay any assessment, tax or fee, the proceeds of which will
2 fund any coordinated care program authorized by this Section.
3 (Source: P.A. 99-106, eff. 1-1-16; 99-181, eff. 7-29-15;
4 99-566, eff. 1-1-17; 99-642, eff. 7-28-16; 100-587, eff.
5 6-4-18.)