SB3020

LRB094 18935 DRJ 54383 b

94TH GENERAL ASSEMBLY

State of Illinois

2005 and 2006

SB3020

Introduced 1/20/2006, by Sen. Dale A. Righter - Christine Radogno - Larry K. Bomke - Gary G. Dahl - Cheryl Axley, et al.

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-16 from Ch. 23, par. 5-16

Amends the Illinois Public Aid Code. Provides that in State fiscal year 2007, the Department of Healthcare and Family Services shall implement a pilot mandatory managed care program requiring recipients to enroll with a managed care organization under contract with the Department. Provides that the program shall be implemented in at least 4 contiguous counties determined suitable for a managed care organization-based managed care system using objective criteria. Sets forth features that the program must include, including criteria for evaluating potential managed care organization contractors. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

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

Section 5. The Illinois Public Aid Code is amended by changing Section 5-16 as follows:

(305 ILCS 5/5-16) (from Ch. 23, par. 5-16)

Sec. 5-16. Managed Care. The Illinois Department may develop and implement a Primary Care Sponsor System consistent with the provisions of this Section. The purpose of this managed care delivery system shall be to contain the costs of providing medical care to Medicaid recipients by having one provider responsible for managing all aspects of a recipient's medical care. This managed care system shall have the following characteristics:

(a) The Department, by rule, shall establish criteria to determine which clients must participate in this program;

(b) Providers participating in the program may be paid an amount per patient per month, to be set by the Illinois Department, for managing each recipient's medical care;

(c) Providers eligible to participate in the program shall be physicians licensed to practice medicine in all its branches, and the Illinois Department may terminate a provider's participation if the provider is determined to have failed to comply with any applicable program standard or procedure established by the Illinois Department;

(d) Each recipient required to participate in the program must select from a panel of primary care providers or networks established by the Department in their communities;

(e) A recipient may change his designated primary care provider:

(1) when the designated source becomes unavailable, as the Illinois Department shall determine by rule; or

(2) when the designated primary care provider notifies the Illinois Department that it wishes to withdraw from any obligation as primary care provider; or

(3) in other situations, as the Illinois Department shall provide by rule;

(f) The Illinois Department shall, by rule, establish procedures for providing medical services when the designated source becomes unavailable or wishes to withdraw from any obligation as primary care provider taking into consideration the need for emergency or temporary medical assistance and ensuring that the recipient has continuous and unrestricted access to medical care from the date on which such unavailability or withdrawal becomes effective until such time as the recipient designates a primary care source;

(g) Only medical care services authorized by a recipient's designated provider, except for emergency services, services performed by a provider that is owned or operated by a county and that provides non-emergency services without regard to ability to pay and such other services as provided by the Illinois Department, shall be subject to payment by the Illinois Department. The Illinois Department shall enter into an intergovernmental agreement with each county that owns or operates such a provider to develop and implement policies to minimize the provision of medical care services provided by county owned or operated providers pursuant to the foregoing exception.

The Illinois Department shall seek and obtain necessary authorization provided under federal law to implement such a program including the waiver of any federal regulations.

The Illinois Department may implement the amendatory changes to this Section made by this amendatory Act of 1991

through the use of emergency rules in accordance with the provisions of Section 5.02 of the Illinois Administrative Procedure Act. For purposes of the Illinois Administrative Procedure Act, the adoption of rules to implement the amendatory changes to this Section made by this amendatory Act of 1991 shall be deemed an emergency and necessary for the public interest, safety and welfare.

The Illinois Department may establish a managed care system demonstration program, on a limited basis, as described in this Section. The demonstration program shall terminate on June 30, 1997. Within 30 days after the end of each year of the demonstration program's operation, the Illinois Department shall report to the Governor and the General Assembly concerning the operation of the demonstration program.

In order to determine the potential for savings and improved quality of care in the Medicaid program, in State fiscal year 2007, the Department shall implement a pilot mandatory managed care program requiring recipients to enroll with a managed care organization under contract with the Department. The program shall be implemented in at least 4 contiguous counties determined suitable for a managed care organization-based managed care system using objective criteria. The program shall have the following features:

(A) All recipients in the selected counties who do not have eligibility through the spend-down program and who are not excluded from State-plan-based mandatory managed care by the federal Balanced Budget Act of 1997 shall be enrolled in the program.

(B) Only the following services shall be excluded from the program and shall be delivered to eligible recipients through the fee-for-service system: nursing home and assisted living long-term care services and services provided through waivers granted pursuant to Sections 1115 and 1915 of the Social Security Act.

(C) Three managed care organizations shall be selected for the program following a competitive procurement. The

competitive procurement shall evaluate potential managed care organization contractors on the following criteria: (i) network adequacy ensuring availability and access to care, (ii) provider payment levels, (iii) quality assurance plans, (iv) past performance on quality outcome measures (for example, HEDIS), (v) plan for care management, (vi) data system adequacy for member enrollment and communication, and (vii) any other criteria that the Department determines to be appropriate.

(D) The Department shall competitively procure the services of an enrollment broker to facilitate enrollment in the selected plans in a manner that maximizes consumer choice and continuity of care. The Department shall develop a default assignment algorithm for recipients in the selected counties who do not choose a managed care organization.

(Source: P.A. 87-14; 88-490.)

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