HB1628

LRB095 09974 MJR 30187 b

95TH GENERAL ASSEMBLY

State of Illinois

2007 and 2008

HB1628

Introduced 2/22/2007, by Rep. Frank J. Mautino

SYNOPSIS AS INTRODUCED:

215 ILCS 170/40
215 ILCS 170/47 new
215 ILCS 170/50
215 ILCS 170/52 new
215 ILCS 170/53 new

Amends the Covering ALL KIDS Health Insurance Act. Provides that there shall be no co-payment or coinsurance required for any services under the Covering ALL KIDS Health Insurance Program (now, children enrolled in the Program are not required to provide a co-payment or coinsurance for well-baby or well-child health care, including, but not limited to, age-appropriate immunizations as required under State or federal law). Requires the Department to report to the General Assembly no later than September 1 of each year beginning in 2007 on the number of professionals serving in the primary care case management program and the number of individuals enrolled in the Program according to certain demographics. Requires the Department to ensure adequate access to specialty physician care for Program participants allowing referrals to be accomplished without undue delay. Provides Program standards for disease management programs and performance measures implemented by the Department and requires the Department to adopt variance procedures for the application of any disease management program or any performance measures to an individual enrollee. Makes other changes.

LRB095 09974 MJR 30187 b

FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning regulation.

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

Section 5. The Covering ALL KIDS Health Insurance Act is amended by changing Sections 40 and 50 and by adding Sections 47, 52, and 53 as follows:

(215 ILCS 170/40)

(Section scheduled to be repealed on July 1, 2011)

Sec. 40. Cost-sharing.

(a) Children enrolled in the Program under subsection (a) of Section 35 are subject to the following cost-sharing requirements:

(1) The Department, by rule, shall set forth requirements concerning ~~co-payments and coinsurance for health care services and~~ monthly premiums. This cost-sharing shall be on a sliding scale based on family income. The Department may periodically modify such cost-sharing.

(2) There ~~Notwithstanding paragraph (1), there~~ shall be no co-payment or coinsurance required for any services under the Program ~~well-baby or well-child health care, including, but not limited to, age-appropriate immunizations as required under State or federal law~~.

(b) Children enrolled in a privately sponsored health insurance plan under subsection (b) of Section 35 are subject to the cost-sharing provisions stated in the privately sponsored health insurance plan.

(c) Notwithstanding any other provision of law, rates paid by the Department shall not be used in any way to determine the usual and customary or reasonable charge, which is the charge for health care that is consistent with the average rate or charge for similar services furnished by similar providers in a certain geographic area.

(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/47 new)

Sec. 47. Program Information. The Department shall report to the General Assembly no later than September 1 of each year beginning in 2007, all of the following information:

(a) The number of professionals serving in the primary care case management program, by licensed profession and by county, and, for counties with a population of 100,000 or greater, by geo zip code.

(b) The number of non-primary care providers accepting referrals, by specialty designation, by licensed profession and by county, and, for counties with a population of 100,000 or greater, by geo zip code.

(c) The number of individuals enrolled in the Covering ALL KIDS Health Insurance Program by income or premium level and by

county, and, for counties with a population of 100,000 or greater, by geo zip code.

(215 ILCS 170/50)

(Section scheduled to be repealed on July 1, 2011)

Sec. 50. Consultation with stakeholders. The Department shall present details regarding implementation of the Program to the Medicaid Advisory Committee, and the Committee shall serve as the forum for healthcare providers, advocates, consumers, and other interested parties to advise the Department with respect to the Program. The Department shall consult with stakeholders on the rules for healthcare professional participation in the Program pursuant to Sections 52 and 53 of this Act.

(Source: P.A. 94-693, eff. 7-1-06.)

(215 ILCS 170/52 new)

Sec. 52. Adequate access to specialty care.

(a) The Department shall ensure adequate access to specialty physician care for Program participants by allowing referrals to be accomplished without undue delay.

(b) The Department shall allow a primary care provider to make appropriate referrals to specialist physicians or other healthcare providers for an enrollee who has a condition that requires care from a specialist physician or other healthcare provider. A referral shall be effective for the period

necessary to provide the referred services or one year, whichever is less. A primary care provider may renew and re-renew a referral.

(c) The enrollee's primary care provider shall remain responsible for coordinating the care of an enrollee who has received a standing referral to a specialist physician or other healthcare provider. If a secondary referral is necessary, the specialist physician or other healthcare provider shall advise the primary care physician. The specialist physician shall be responsible for making the secondary referral. In addition, the Department shall require the specialist physician or other healthcare provider to provide regular updates to the enrollee's primary care provider.

(215 ILCS 170/53 new)

Sec. 53. Program standards.

(a) Any disease management program implemented by the Department must be or must have been developed in consultation with physician organizations, such as State, national, and specialty medical societies, and any available standards or guidelines of these organizations. These programs must be based on evidence-based, scientifically sound principles that are accepted by the medical community. An enrollee must be excused from participation in a disease management program if the enrollee's physician licensed to practice medicine in all its branches, in his or her professional judgment, determines that

participation is not beneficial to the enrollee.

(b) Any performance measures, such as primary care provider monitoring, implemented by the Department must be or must have been developed on consultation with physician organizations, such as State, national, and specialty medical societies, and any available standards or guidelines of these organizations. These measures must be based on evidence-based, scientifically sound principles that are accepted by the medical community.

(c) The Department shall adopt variance procedures for the application of any disease management program or any performance measures to an individual enrollee.