



97TH GENERAL ASSEMBLY

State of Illinois

2011 and 2012

HB5909

Introduced 2/16/2012, by Rep. Patricia R. Bellock

SYNOPSIS AS INTRODUCED:

215 ILCS 106/23
215 ILCS 170/56
305 ILCS 5/5-30

Amends the Children's Health Insurance Program Act, the Covering ALL KIDS Health Insurance Act, and the Medical Assistance Article of the Illinois Public Aid Code. Provides that prior to the Department of Healthcare and Family Services enrolling individuals under the expanded coverage provisions mandated by the federal Patient Protection and Affordable Care Act of 2010 which require a minimum eligibility level of 133% of the federal poverty level for legal residents, the Department shall first meet the care coordination enrolling requirements mandated by Public Act 96-1501. Effective immediately.

LRB097 17029 KTG 62225 b

FISCAL NOTE ACT
MAY APPLY

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 Children's Health Insurance Program Act is
5 amended by changing Section 23 as follows:

6 (215 ILCS 106/23)

7 Sec. 23. 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 This requirement shall be met prior to enrolling individuals
15 under the expanded coverage provisions mandated by the federal
16 Patient Protection and Affordable Care Act of 2010 which
17 require a minimum eligibility level of 133% of the federal
18 poverty level for legal residents. For purposes of this
19 Section, "coordinated care" or "care coordination" means
20 delivery systems where recipients will receive their care from
21 providers who participate under contract in integrated
22 delivery systems that are responsible for providing or
23 arranging the majority of care, including primary care

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

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

23 (c) To qualify for compliance with this Section, the 50%
24 goal shall be achieved by enrolling medical assistance
25 enrollees from each medical assistance enrollment category,
26 including parents, children, seniors, and people with

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

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

20 (Source: P.A. 96-1501, eff. 1-25-11.)

21 Section 10. The Covering ALL KIDS Health Insurance Act is
22 amended by changing Section 56 as follows:

23 (215 ILCS 170/56)

24 (Section scheduled to be repealed on July 1, 2016)

1 Sec. 56. Care coordination.

2 (a) At least 50% of recipients eligible for comprehensive
3 medical benefits in all medical assistance programs or other
4 health benefit programs administered by the Department,
5 including the Children's Health Insurance Program Act and the
6 Covering ALL KIDS Health Insurance Act, shall be enrolled in a
7 care coordination program by no later than January 1, 2015.
8 This requirement shall be met prior to enrolling individuals
9 under the expanded coverage provisions mandated by the federal
10 Patient Protection and Affordable Care Act of 2010 which
11 require a minimum eligibility level of 133% of the federal
12 poverty level for legal residents. For purposes of this
13 Section, "coordinated care" or "care coordination" means
14 delivery systems where recipients will receive their care from
15 providers who participate under contract in integrated
16 delivery systems that are responsible for providing or
17 arranging the majority of care, including primary care
18 physician services, referrals from primary care physicians,
19 diagnostic and treatment services, behavioral health services,
20 in-patient and outpatient hospital services, dental services,
21 and rehabilitation and long-term care services. The Department
22 shall designate or contract for such integrated delivery
23 systems (i) to ensure enrollees have a choice of systems and of
24 primary care providers within such systems; (ii) to ensure that
25 enrollees receive quality care in a culturally and
26 linguistically appropriate manner; and (iii) to ensure that

1 coordinated care programs meet the diverse needs of enrollees
2 with developmental, mental health, physical, and age-related
3 disabilities.

4 (b) Payment for such coordinated care shall be based on
5 arrangements where the State pays for performance related to
6 health care outcomes, the use of evidence-based practices, the
7 use of primary care delivered through comprehensive medical
8 homes, the use of electronic medical records, and the
9 appropriate exchange of health information electronically made
10 either on a capitated basis in which a fixed monthly premium
11 per recipient is paid and full financial risk is assumed for
12 the delivery of services, or through other risk-based payment
13 arrangements.

14 (c) To qualify for compliance with this Section, the 50%
15 goal shall be achieved by enrolling medical assistance
16 enrollees from each medical assistance enrollment category,
17 including parents, children, seniors, and people with
18 disabilities to the extent that current State Medicaid payment
19 laws would not limit federal matching funds for recipients in
20 care coordination programs. In addition, services must be more
21 comprehensively defined and more risk shall be assumed than in
22 the Department's primary care case management program as of the
23 effective date of this amendatory Act of the 96th General
24 Assembly.

25 (d) The Department shall report to the General Assembly in
26 a separate part of its annual medical assistance program

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

11 (Source: P.A. 96-1501, eff. 1-25-11.)

12 Section 15. The Illinois Public Aid Code is amended by
13 changing Section 5-30 as follows:

14 (305 ILCS 5/5-30)

15 Sec. 5-30. Care coordination.

16 (a) At least 50% of recipients eligible for comprehensive
17 medical benefits in all medical assistance programs or other
18 health benefit programs administered by the Department,
19 including the Children's Health Insurance Program Act and the
20 Covering ALL KIDS Health Insurance Act, shall be enrolled in a
21 care coordination program by no later than January 1, 2015.
22 This requirement shall be met prior to enrolling individuals
23 under the expanded coverage provisions mandated by the federal
24 Patient Protection and Affordable Care Act of 2010 which

1 require a minimum eligibility level of 133% of the federal
2 poverty level for legal residents. For purposes of this
3 Section, "coordinated care" or "care coordination" means
4 delivery systems where recipients will receive their care from
5 providers who participate under contract in integrated
6 delivery systems that are responsible for providing or
7 arranging the majority of care, including primary care
8 physician services, referrals from primary care physicians,
9 diagnostic and treatment services, behavioral health services,
10 in-patient and outpatient hospital services, dental services,
11 and rehabilitation and long-term care services. The Department
12 shall designate or contract for such integrated delivery
13 systems (i) to ensure enrollees have a choice of systems and of
14 primary care providers within such systems; (ii) to ensure that
15 enrollees receive quality care in a culturally and
16 linguistically appropriate manner; and (iii) to ensure that
17 coordinated care programs meet the diverse needs of enrollees
18 with developmental, mental health, physical, and age-related
19 disabilities.

20 (b) Payment for such coordinated care shall be based on
21 arrangements where the State pays for performance related to
22 health care outcomes, the use of evidence-based practices, the
23 use of primary care delivered through comprehensive medical
24 homes, the use of electronic medical records, and the
25 appropriate exchange of health information electronically made
26 either on a capitated basis in which a fixed monthly premium

1 per recipient is paid and full financial risk is assumed for
2 the delivery of services, or through other risk-based payment
3 arrangements.

4 (c) To qualify for compliance with this Section, the 50%
5 goal shall be achieved by enrolling medical assistance
6 enrollees from each medical assistance enrollment category,
7 including parents, children, seniors, and people with
8 disabilities to the extent that current State Medicaid payment
9 laws would not limit federal matching funds for recipients in
10 care coordination programs. In addition, services must be more
11 comprehensively defined and more risk shall be assumed than in
12 the Department's primary care case management program as of the
13 effective date of this amendatory Act of the 96th General
14 Assembly.

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

1 (Source: P.A. 96-1501, eff. 1-25-11.)

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