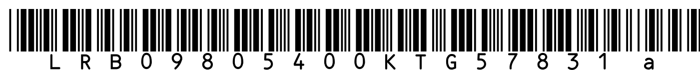

Sen. Iris Y. Martinez

Filed: 3/28/2014

1 AMENDMENT TO SENATE BILL 221

2 AMENDMENT NO. ______. Amend Senate Bill 221 by replacing
3 everything after the enacting clause with the following:

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

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

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

25 (c) To qualify for compliance with this Section, the 50%
26 goal shall be achieved by enrolling medical assistance

1 enrollees from each medical assistance enrollment category,
2 including parents, children, seniors, and people with
3 disabilities to the extent that current State Medicaid payment
4 laws would not limit federal matching funds for recipients in
5 care coordination programs. In addition, services must be more
6 comprehensively defined and more risk shall be assumed than in
7 the Department's primary care case management program as of the
8 effective date of this amendatory Act of the 96th General
9 Assembly.
10 (d) The Department shall report to the General Assembly in
11 a separate part of its annual medical assistance program
12 report, beginning April, 2012 until April, 2016, on the
13 progress and implementation of the care coordination program
14 initiatives established by the provisions of this amendatory
15 Act of the 96th General Assembly. The Department shall include
16 in its April 2011 report a full analysis of federal laws or
17 regulations regarding upper payment limitations to providers
18 and the necessary revisions or adjustments in rate
19 methodologies and payments to providers under this Code that
20 would be necessary to implement coordinated care with full
21 financial risk by a party other than the Department.
22 (e) Integrated Care Program for individuals with chronic
23 mental health conditions.
24 (1) The Integrated Care Program shall encompass
25 services administered to recipients of medical assistance
26 under this Article to prevent exacerbations and

1 complications using cost-effective, evidence-based
2 practice guidelines and mental health management
3 strategies.
4 (2) The Department may utilize and expand upon existing
5 contractual arrangements with integrated care plans under
6 the Integrated Care Program for providing the coordinated
7 care provisions of this Section.
8 (3) Payment for such coordinated care shall be based on
9 arrangements where the State pays for performance related
10 to mental health outcomes on a capitated basis in which a
11 fixed monthly premium per recipient is paid and full
12 financial risk is assumed for the delivery of services, or
13 through other risk-based payment arrangements such as
14 provider-based care coordination.
15 (4) The Department shall examine whether chronic
16 mental health management programs and services for
17 recipients with specific chronic mental health conditions
18 do any or all of the following:
19 (A) Improve the patient's overall mental health in
20 a more expeditious and cost-effective manner.
21 (B) Lower costs in other aspects of the medical
22 assistance program, such as hospital admissions,
23 emergency room visits, or more frequent and
24 inappropriate psychotropic drug use.
25 (5) The Department shall work with the facilities and
26 any integrated care plan participating in the program to

1 identify and correct barriers to the successful
2 implementation of this subsection (e) prior to and during
3 the implementation to best facilitate the goals and
4 objectives of this subsection (e).
5 (f) A hospital that is located in a county of the State in
6 which the Department mandates some or all of the beneficiaries
7 of the Medical Assistance Program residing in the county to
8 enroll in a Care Coordination Program, as set forth in Section
9 5-30 of this Code, shall not be eligible for any non-claims
10 based payments not mandated by Article V-A of this Code for
11 which it would otherwise be qualified to receive, unless the
12 hospital is a Coordinated Care Participating Hospital no later
13 than 60 days after the effective date of this amendatory Act of
14 the 97th General Assembly or 60 days after the first mandatory
15 enrollment of a beneficiary in a Coordinated Care program. For
16 purposes of this subsection, "Coordinated Care Participating
17 Hospital" means a hospital that meets one of the following
18 criteria:
19 (1) The hospital has entered into a contract to provide
20 hospital services to enrollees of the care coordination
21 program.
22 (2) The hospital has not been offered a contract by a
23 care coordination plan that pays at least as much as the
24 Department would pay, on a fee-for-service basis, not
25 including disproportionate share hospital adjustment
26 payments or any other supplemental adjustment or add-on

1 payment to the base fee-for-service rate.
2 (g) No later than August 1, 2013, the Department shall
3 issue a purchase of care solicitation for Accountable Care
4 Entities (ACE) to serve any children and parents or caretaker
5 relatives of children eligible for medical assistance under
6 this Article. An ACE may be a single corporate structure or a
7 network of providers organized through contractual
8 relationships with a single corporate entity. The solicitation
9 shall require that:
10 (1) An ACE operating in Cook County be capable of
11 serving at least 40,000 eligible individuals in that
12 county; an ACE operating in Lake, Kane, DuPage, or Will
13 Counties be capable of serving at least 20,000 eligible
14 individuals in those counties and an ACE operating in other
15 regions of the State be capable of serving at least 10,000
16 eligible individuals in the region in which it operates.
17 During initial periods of mandatory enrollment, the
18 Department shall require its enrollment services
19 contractor to use a default assignment algorithm that
20 ensures if possible an ACE reaches the minimum enrollment
21 levels set forth in this paragraph.
22 (2) An ACE must include at a minimum the following
23 types of providers: primary care, specialty care,
24 hospitals, and behavioral healthcare.
25 (3) An ACE shall have a governance structure that
26 includes the major components of the health care delivery

system, including one representative from each of the groups listed in paragraph (2).

(4) An ACE must be an integrated delivery system, including a network able to provide the full range of services needed by Medicaid beneficiaries and system capacity to securely pass clinical information across participating entities and to aggregate and analyze that data in order to coordinate care.

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

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

(7) In months 19 through 36 of operation, unless the ACE selects a shorter period, an ACE shall be paid on a pre-paid capitation basis for all medical assistance covered services, under contract terms similar to Managed Care Organizations (MCO), with the Department sharing the

1 risk through either stop-loss insurance for extremely high
2 cost individuals or corridors of shared risk based on the
3 overall cost of the total enrollment in the ACE. The ACE
4 shall be responsible for claims processing, encounter data
5 submission, utilization control, and quality assurance.
6 (8) In the fourth and subsequent years of operation, an
7 ACE shall convert to a Managed Care Community Network
8 (MCCN), as defined in this Article, or Health Maintenance
9 Organization pursuant to the Illinois Insurance Code,
10 accepting full-risk capitation payments.
11 The Department shall allow potential ACE entities 5 months
12 from the date of the posting of the solicitation to submit
13 proposals. After the solicitation is released, in addition to
14 the MCO rate development data available on the Department's
15 website, subject to federal and State confidentiality and
16 privacy laws and regulations, the Department shall provide 2
17 years of de-identified summary service data on the targeted
18 population, split between children and adults, showing the
19 historical type and volume of services received and the cost of
20 those services to those potential bidders that sign a data use
21 agreement. The Department may add up to 2 non-state government
22 employees with expertise in creating integrated delivery
23 systems to its review team for the purchase of care
24 solicitation described in this subsection. Any such
25 individuals must sign a no-conflict disclosure and
26 confidentiality agreement and agree to act in accordance with

1 all applicable State laws.
2 During the first 2 years of an ACE's operation, the
3 Department shall provide claims data to the ACE on its
4 enrollees on a periodic basis no less frequently than monthly.
5 Nothing in this subsection shall be construed to limit the
6 Department's mandate to enroll 50% of its beneficiaries into
7 care coordination systems by January 1, 2015, using all
8 available care coordination delivery systems, including Care
9 Coordination Entities (CCE), MCCNs, or MCOs, nor be construed
10 to affect the current CCEs, MCCNs, and MCOs selected to serve
11 seniors and persons with disabilities prior to that date.
12 (h) Department contracts with MCOs and other entities
13 reimbursed by risk based capitation shall have a minimum
14 medical loss ratio of 85%, shall require the MCO or other
15 entity to pay claims within 30 days of receiving a bill that
16 contains all the essential information needed to adjudicate the
17 bill, and shall require the entity to pay a penalty that is at
18 least equal to the penalty imposed under the Illinois Insurance
19 Code for any claims not paid within this time period. The
20 requirements of this subsection shall apply to contracts with
21 MCOs entered into or renewed or extended after June 1, 2013.
22 (i) Managed Care Entities (MCEs), including MCOs and all
23 other care coordination organizations, shall develop and
24 maintain a written language access policy that sets forth the
25 standards, guidelines, and operational plan to ensure language
26 appropriate services and that is consistent with the standard

1 of meaningful access for populations with limited English
2 proficiency. The language access policy shall describe how the
3 MCEs will provide all of the following required services:
4 (1) Translation (the written replacement of text from
5 one language into another) of all vital documents and forms
6 as identified by the Department.
7 (2) Qualified interpreter services (the oral
8 communication of a message from one language into another
9 by a qualified interpreter).
10 (3) Staff training on the language access policy,
11 including how to identify language needs, access and
12 provide language assistance services, work with
13 interpreters, request translations, and track the use of
14 language assistance services.
15 (4) Data tracking that identifies the language need.
16 (5) Notification to participants on the availability
17 of language access services and on how to access such
18 services.
19 (Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13.)".