HB2596

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB2596

by Rep. Greg Harris

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-11 from Ch. 23, par. 5-11
305 ILCS 5/5-30

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services, in conjunction with the Department of Insurance, to by rule adopt standards for assessing the solvency and financial soundness of each managed care community network. Provides that any solvency and financial standards adopted for managed care community networks shall be identical to (rather than no more restrictive than) the solvency and financial standards required under Article II of the Health Maintenance Organization Act (rather than the solvency and financial standards adopted under the Social Security Act for provider-sponsored organizations). In provisions concerning entities contracted with the Department of Healthcare and Family Services to coordinate healthcare for medical assistance recipients, provides that the Department shall treat all contracted entities identically in relation to care coordination ratios. Provides that Managed Care Entities are authorized to hire community healthcare workers to meet the mandated care coordination ratios; and that the Department shall define by policy the term "community healthcare workers" no later than January 1, 2016. Requires the Department to treat all contracted entities receiving risk-based capitation payments identically with regards to network adequacy and medical loss ratios. Provides that in conjunction with the Department of Insurance, the Department of Healthcare and Family Services shall ensure that all contracted entities receiving risk-based capitation payments are treated identically with regards to protections against financial insolvency.

LRB099 09440 KTG 29647 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 Illinois Public Aid Code is amended by
5 changing Sections 5-30 and 5-11 as follows:

6 (305 ILCS 5/5-11) (from Ch. 23, par. 5-11)
7 Sec. 5-11. Co-operative arrangements; contracts with other
8 State agencies, health care and rehabilitation organizations,
9 and fiscal intermediaries.
10 (a) The Illinois Department may enter into co-operative
11 arrangements with State agencies responsible for administering
12 or supervising the administration of health services and
13 vocational rehabilitation services to the end that there may be
14 maximum utilization of such services in the provision of
15 medical assistance.
16 The Illinois Department shall, not later than June 30,
17 1993, enter into one or more co-operative arrangements with the
18 Department of Mental Health and Developmental Disabilities
19 providing that the Department of Mental Health and
20 Developmental Disabilities will be responsible for
21 administering or supervising all programs for services to
22 persons in community care facilities for persons with
23 developmental disabilities, including but not limited to

1 intermediate care facilities, that are supported by State funds
2 or by funding under Title XIX of the federal Social Security
3 Act. The responsibilities of the Department of Mental Health
4 and Developmental Disabilities under these agreements are
5 transferred to the Department of Human Services as provided in
6 the Department of Human Services Act.

7 The Department may also contract with such State health and
8 rehabilitation agencies and other public or private health care
9 and rehabilitation organizations to act for it in supplying
10 designated medical services to persons eligible therefor under
11 this Article. Any contracts with health services or health
12 maintenance organizations shall be restricted to organizations
13 which have been certified as being in compliance with standards
14 promulgated pursuant to the laws of this State governing the
15 establishment and operation of health services or health
16 maintenance organizations. The Department shall renegotiate
17 the contracts with health maintenance organizations and
18 managed care community networks that took effect August 1,
19 2003, so as to produce $70,000,000 savings to the Department
20 net of resulting increases to the fee-for-service program for
21 State fiscal year 2006. The Department may also contract with
22 insurance companies or other corporate entities serving as
23 fiscal intermediaries in this State for the Federal Government
24 in respect to Medicare payments under Title XVIII of the
25 Federal Social Security Act to act for the Department in paying
26 medical care suppliers. The provisions of Section 9 of "An Act

1 in relation to State finance", approved June 10, 1919, as
2 amended, notwithstanding, such contracts with State agencies,
3 other health care and rehabilitation organizations, or fiscal
4 intermediaries may provide for advance payments.

5 (b) For purposes of this subsection (b), "managed care
6 community network" means an entity, other than a health
7 maintenance organization, that is owned, operated, or governed
8 by providers of health care services within this State and that
9 provides or arranges primary, secondary, and tertiary managed
10 health care services under contract with the Illinois
11 Department exclusively to persons participating in programs
12 administered by the Illinois Department.

13 The Illinois Department may certify managed care community
14 networks, including managed care community networks owned,
15 operated, managed, or governed by State-funded medical
16 schools, as risk-bearing entities eligible to contract with the
17 Illinois Department as Medicaid managed care organizations.
18 The Illinois Department may contract with those managed care
19 community networks to furnish health care services to or
20 arrange those services for individuals participating in
21 programs administered by the Illinois Department. The rates for
22 those provider-sponsored organizations may be determined on a
23 prepaid, capitated basis. A managed care community network may
24 choose to contract with the Illinois Department to provide only
25 pediatric health care services. The Illinois Department shall
26 by rule adopt the criteria, standards, and procedures by which

1 a managed care community network may be permitted to contract
2 with the Illinois Department and shall consult with the
3 Department of Insurance in adopting these rules.
4 A county provider as defined in Section 15-1 of this Code
5 may contract with the Illinois Department to provide primary,
6 secondary, or tertiary managed health care services as a
7 managed care community network without the need to establish a
8 separate entity and shall be deemed a managed care community
9 network for purposes of this Code only to the extent it
10 provides services to participating individuals. A county
11 provider is entitled to contract with the Illinois Department
12 with respect to any contracting region located in whole or in
13 part within the county. A county provider is not required to
14 accept enrollees who do not reside within the county.
15 In order to (i) accelerate and facilitate the development
16 of integrated health care in contracting areas outside counties
17 with populations in excess of 3,000,000 and counties adjacent
18 to those counties and (ii) maintain and sustain the high
19 quality of education and residency programs coordinated and
20 associated with local area hospitals, the Illinois Department
21 may develop and implement a demonstration program from managed
22 care community networks owned, operated, managed, or governed
23 by State-funded medical schools. The Illinois Department shall
24 prescribe by rule the criteria, standards, and procedures for
25 effecting this demonstration program.
26 A managed care community network that contracts with the

1 Illinois Department to furnish health care services to or
2 arrange those services for enrollees participating in programs
3 administered by the Illinois Department shall do all of the
4 following:
5 (1) Provide that any provider affiliated with the
6 managed care community network may also provide services on
7 a fee-for-service basis to Illinois Department clients not
8 enrolled in such managed care entities.
9 (2) Provide client education services as determined
10 and approved by the Illinois Department, including but not
11 limited to (i) education regarding appropriate utilization
12 of health care services in a managed care system, (ii)
13 written disclosure of treatment policies and restrictions
14 or limitations on health services, including, but not
15 limited to, physical services, clinical laboratory tests,
16 hospital and surgical procedures, prescription drugs and
17 biologics, and radiological examinations, and (iii)
18 written notice that the enrollee may receive from another
19 provider those covered services that are not provided by
20 the managed care community network.
21 (3) Provide that enrollees within the system may choose
22 the site for provision of services and the panel of health
23 care providers.
24 (4) Not discriminate in enrollment or disenrollment
25 practices among recipients of medical services or
26 enrollees based on health status.

1 (5) Provide a quality assurance and utilization review
2 program that meets the requirements established by the
3 Illinois Department in rules that incorporate those
4 standards set forth in the Health Maintenance Organization
5 Act.
6 (6) Issue a managed care community network
7 identification card to each enrollee upon enrollment. The
8 card must contain all of the following:
9 (A) The enrollee's health plan.
10 (B) The name and telephone number of the enrollee's
11 primary care physician or the site for receiving
12 primary care services.
13 (C) A telephone number to be used to confirm
14 eligibility for benefits and authorization for
15 services that is available 24 hours per day, 7 days per
16 week.
17 (7) Ensure that every primary care physician and
18 pharmacy in the managed care community network meets the
19 standards established by the Illinois Department for
20 accessibility and quality of care. The Illinois Department
21 shall arrange for and oversee an evaluation of the
22 standards established under this paragraph (7) and may
23 recommend any necessary changes to these standards.
24 (8) Provide a procedure for handling complaints that
25 meets the requirements established by the Illinois
26 Department in rules that incorporate those standards set

forth in the Health Maintenance Organization Act.

(9) Maintain, retain, and make available to the Illinois Department records, data, and information, in a uniform manner determined by the Illinois Department, sufficient for the Illinois Department to monitor utilization, accessibility, and quality of care.

(10) (Blank).

The Illinois Department shall contract with an entity or entities to provide external peer-based quality assurance review for the managed health care programs administered by the Illinois Department. The entity shall meet all federal requirements for an external quality review organization.

Each managed care community network must demonstrate its ability to bear the financial risk of serving individuals under this program. The Illinois Department, in conjunction with the Department of Insurance, shall by rule adopt standards for assessing the solvency and financial soundness of each managed care community network. Any solvency and financial standards adopted for managed care community networks shall be identical to ~~no more restrictive than~~ the solvency and financial standards required under Article II of the Health Maintenance Organization Act ~~adopted under Section 1856(a) of the Social Security Act for provider-sponsored organizations under Part C of Title XVIII of the Social Security Act~~.

The Illinois Department may implement the amendatory changes to this Code made by this amendatory Act of 1998

1 through the use of emergency rules in accordance with Section
2 5-45 of the Illinois Administrative Procedure Act. For purposes
3 of that Act, the adoption of rules to implement these changes
4 is deemed an emergency and necessary for the public interest,
5 safety, and welfare.

6 (c) Not later than June 30, 1996, the Illinois Department
7 shall enter into one or more cooperative arrangements with the
8 Department of Public Health for the purpose of developing a
9 single survey for nursing facilities, including but not limited
10 to facilities funded under Title XVIII or Title XIX of the
11 federal Social Security Act or both, which shall be
12 administered and conducted solely by the Department of Public
13 Health. The Departments shall test the single survey process on
14 a pilot basis, with both the Departments of Public Aid and
15 Public Health represented on the consolidated survey team. The
16 pilot will sunset June 30, 1997. After June 30, 1997, unless
17 otherwise determined by the Governor, a single survey shall be
18 implemented by the Department of Public Health which would not
19 preclude staff from the Department of Healthcare and Family
20 Services (formerly Department of Public Aid) from going on-site
21 to nursing facilities to perform necessary audits and reviews
22 which shall not replicate the single State agency survey
23 required by this Act. This Section shall not apply to community
24 or intermediate care facilities for persons with developmental
25 disabilities.

26 (d) Nothing in this Code in any way limits or otherwise

1 impairs the authority or power of the Illinois Department to
2 enter into a negotiated contract pursuant to this Section with
3 a managed care community network or a health maintenance
4 organization, as defined in the Health Maintenance
5 Organization Act, that provides for termination or nonrenewal
6 of the contract without cause, upon notice as provided in the
7 contract, and without a hearing.
8 (Source: P.A. 95-331, eff. 8-21-07; 96-1501, eff. 1-25-11.)

9 (305 ILCS 5/5-30)
10 Sec. 5-30. Care coordination.
11 (a) At least 50% of recipients eligible for comprehensive
12 medical benefits in all medical assistance programs or other
13 health benefit programs administered by the Department,
14 including the Children's Health Insurance Program Act and the
15 Covering ALL KIDS Health Insurance Act, shall be enrolled in a
16 care coordination program by no later than January 1, 2015. For
17 purposes of this Section, "coordinated care" or "care
18 coordination" means delivery systems where recipients will
19 receive their care from providers who participate under
20 contract in integrated delivery systems that are responsible
21 for providing or arranging the majority of care, including
22 primary care physician services, referrals from primary care
23 physicians, diagnostic and treatment services, behavioral
24 health services, in-patient and outpatient hospital services,
25 dental services, and rehabilitation and long-term care

1 services. The Department shall designate or contract for such
2 integrated delivery systems (i) to ensure enrollees have a
3 choice of systems and of primary care providers within such
4 systems; (ii) to ensure that enrollees receive quality care in
5 a culturally and linguistically appropriate manner; and (iii)
6 to ensure that coordinated care programs meet the diverse needs
7 of enrollees with developmental, mental health, physical, and
8 age-related disabilities.
9 (b) Payment for such coordinated care shall be based on
10 arrangements where the State pays for performance related to
11 health care outcomes, the use of evidence-based practices, the
12 use of primary care delivered through comprehensive medical
13 homes, the use of electronic medical records, and the
14 appropriate exchange of health information electronically made
15 either on a capitated basis in which a fixed monthly premium
16 per recipient is paid and full financial risk is assumed for
17 the delivery of services, or through other risk-based payment
18 arrangements.
19 (c) To qualify for compliance with this Section, the 50%
20 goal shall be achieved by enrolling medical assistance
21 enrollees from each medical assistance enrollment category,
22 including parents, children, seniors, and people with
23 disabilities to the extent that current State Medicaid payment
24 laws would not limit federal matching funds for recipients in
25 care coordination programs. In addition, services must be more
26 comprehensively defined and more risk shall be assumed than in

1 the Department's primary care case management program as of the
2 effective date of this amendatory Act of the 96th General
3 Assembly.
4 (d) The Department shall report to the General Assembly in
5 a separate part of its annual medical assistance program
6 report, beginning April, 2012 until April, 2016, on the
7 progress and implementation of the care coordination program
8 initiatives established by the provisions of this amendatory
9 Act of the 96th General Assembly. The Department shall include
10 in its April 2011 report a full analysis of federal laws or
11 regulations regarding upper payment limitations to providers
12 and the necessary revisions or adjustments in rate
13 methodologies and payments to providers under this Code that
14 would be necessary to implement coordinated care with full
15 financial risk by a party other than the Department.
16 (e) Integrated Care Program for individuals with chronic
17 mental health conditions.
18 (1) The Integrated Care Program shall encompass
19 services administered to recipients of medical assistance
20 under this Article to prevent exacerbations and
21 complications using cost-effective, evidence-based
22 practice guidelines and mental health management
23 strategies.
24 (2) The Department may utilize and expand upon existing
25 contractual arrangements with integrated care plans under
26 the Integrated Care Program for providing the coordinated

1 care provisions of this Section.
2 (3) Payment for such coordinated care shall be based on
3 arrangements where the State pays for performance related
4 to mental health outcomes on a capitated basis in which a
5 fixed monthly premium per recipient is paid and full
6 financial risk is assumed for the delivery of services, or
7 through other risk-based payment arrangements such as
8 provider-based care coordination.
9 (4) The Department shall examine whether chronic
10 mental health management programs and services for
11 recipients with specific chronic mental health conditions
12 do any or all of the following:
13 (A) Improve the patient's overall mental health in
14 a more expeditious and cost-effective manner.
15 (B) Lower costs in other aspects of the medical
16 assistance program, such as hospital admissions,
17 emergency room visits, or more frequent and
18 inappropriate psychotropic drug use.
19 (5) The Department shall work with the facilities and
20 any integrated care plan participating in the program to
21 identify and correct barriers to the successful
22 implementation of this subsection (e) prior to and during
23 the implementation to best facilitate the goals and
24 objectives of this subsection (e).
25 (f) A hospital that is located in a county of the State in
26 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 the effective date of this amendatory Act of the 97th General Assembly 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

1 includes the major components of the health care delivery
2 system, including one representative from each of the
3 groups listed in paragraph (2).
4 (4) An ACE must be an integrated delivery system,
5 including a network able to provide the full range of
6 services needed by Medicaid beneficiaries and system
7 capacity to securely pass clinical information across
8 participating entities and to aggregate and analyze that
9 data in order to coordinate care.
10 (5) An ACE must be capable of providing both care
11 coordination and complex case management, as necessary, to
12 beneficiaries. To be responsive to the solicitation, a
13 potential ACE must outline its care coordination and
14 complex case management model and plan to reduce the cost
15 of care.
16 (6) In the first 18 months of operation, unless the ACE
17 selects a shorter period, an ACE shall be paid care
18 coordination fees on a per member per month basis that are
19 projected to be cost neutral to the State during the term
20 of their payment and, subject to federal approval, be
21 eligible to share in additional savings generated by their
22 care coordination.
23 (7) In months 19 through 36 of operation, unless the
24 ACE selects a shorter period, an ACE shall be paid on a
25 pre-paid capitation basis for all medical assistance
26 covered services, under contract terms similar to Managed

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

Nothing in this subsection shall be construed to limit the Department's mandate to enroll 50% of its beneficiaries into care coordination systems by January 1, 2015, using all available care coordination delivery systems, including Care Coordination Entities (CCE), MCCNs, or MCOs, nor be construed to affect the current CCEs, MCCNs, and MCOs selected to serve seniors and persons with disabilities prior to that date.

Nothing in this subsection precludes the Department from considering future proposals for new ACEs or expansion of existing ACEs at the discretion of the Department.

(h) Department contracts with MCOs and other entities reimbursed by risk based capitation shall have a minimum medical loss ratio of 85%, shall require the entity to establish an appeals and grievances process for consumers and providers, and shall require the entity to provide a quality assurance and utilization review program. Entities contracted with the Department to coordinate healthcare regardless of risk shall be measured utilizing the same quality metrics. The quality metrics may be population specific. Any contracted entity serving at least 5,000 seniors or people with disabilities or 15,000 individuals in other populations

1 covered by the Medical Assistance Program that has been
2 receiving full-risk capitation for a year shall be accredited
3 by a national accreditation organization authorized by the
4 Department within 2 years after the date it is eligible to
5 become accredited. The requirements of this subsection shall
6 apply to contracts with MCOs entered into or renewed or
7 extended after June 1, 2013.

8 (h-5) The Department shall monitor and enforce compliance
9 by MCOs with agreements they have entered into with providers
10 on issues that include, but are not limited to, timeliness of
11 payment, payment rates, and processes for obtaining prior
12 approval. The Department may impose sanctions on MCOs for
13 violating provisions of those agreements that include, but are
14 not limited to, financial penalties, suspension of enrollment
15 of new enrollees, and termination of the MCO's contract with
16 the Department. As used in this subsection (h-5), "MCO" has the
17 meaning ascribed to that term in Section 5-30.1 of this Code.

18 (i) The Department shall treat all contracted entities
19 under this Section identically in relation to care coordination
20 ratios. Managed Care Entities are authorized to hire community
21 healthcare workers to meet the mandated care coordination
22 ratios. The Department shall define by policy the term
23 "community healthcare workers" no later than January 1, 2016.

24 (j) The Department shall treat all contracted entities
25 receiving risk-based capitation payments identically with
26 regards to network adequacy and medical loss ratios.

1 (k) In conjunction with the Department of Insurance, the
2 Department shall ensure that all contracted entities receiving
3 risk-based capitation payments are treated identically with
4 regards to protections against financial insolvency.
5 (Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13;
6 98-651, eff. 6-16-14.)