HB3306

LRB09909530KTG29738b

99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB3306

by Rep. Jim Durkin - Patricia R. Bellock

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30

Amends the Medical Assistance Article of the Illinois Public Aid Code. In a provision requiring the Department of Healthcare and Family Services to report to the General Assembly on the progress and implementation of the care coordination program initiatives established under the Code, provides that the Department shall submit such information beginning April, 2012 (rather than beginning April, 2012 until April, 2016). Provides that the progress reports shall include, but need not be limited to, certain data and information, including: (i) the total number of individuals covered under the medical assistance program; (ii) the total number of individuals enrolled in coordinated care; (iii) a breakdown of the individuals enrolled in coordinated care by medical assistance enrollment category; and (iv) a breakdown of the number of individuals enrolled in coordinated care by the type of coordinated care model.

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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 5-30 as follows:

(305 ILCS 5/5-30)

Sec. 5-30. Care coordination.

(a) At least 50% of recipients eligible for comprehensive medical benefits in all medical assistance programs or other health benefit programs administered by the Department, including the Children's Health Insurance Program Act and the Covering ALL KIDS Health Insurance Act, shall be enrolled in a care coordination program by no later than January 1, 2015. For purposes of this Section, "coordinated care" or "care coordination" means delivery systems where recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care, including primary care physician services, referrals from primary care physicians, diagnostic and treatment services, behavioral health services, in-patient and outpatient hospital services, dental services, and rehabilitation and long-term care services. The Department shall designate or contract for such

integrated delivery systems (i) to ensure enrollees have a choice of systems and of primary care providers within such systems; (ii) to ensure that enrollees receive quality care in a culturally and linguistically appropriate manner; and (iii) to ensure that coordinated care programs meet the diverse needs of enrollees with developmental, mental health, physical, and age-related disabilities.

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

(c) To qualify for compliance with this Section, the 50% goal shall be achieved by enrolling medical assistance enrollees from each medical assistance enrollment category, including parents, children, seniors, and people with disabilities to the extent that current State Medicaid payment laws would not limit federal matching funds for recipients in care coordination programs. In addition, services must be more comprehensively defined and more risk shall be assumed than in the Department's primary care case management program as of the

effective date of this amendatory Act of the 96th General Assembly.

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

The progress reports required under this subsection shall include, but need not be limited to, the following data and information:

(1) The total number of individuals covered under the medical assistance program.

(2) The total number of individuals enrolled in coordinated care.

(3) A breakdown of the individuals enrolled in coordinated care by medical assistance enrollment category, including parents, adults eligible for medical assistance pursuant to the Patient Protection and Affordable Care Act, children, seniors, and people with

disabilities.

(4) A breakdown of the number of individuals enrolled in coordinated care by the type of coordinated care model, including individuals enrolled in Care Coordination Entities (CCEs), Managed Care Community Networks (MCCNs), Managed Care Organizations (MCOs), and Accountable Care Entities (ACEs).

(5) The number of individuals enrolled in coordinated care who are enrolled under an entity that is paid through a fully capitated payment arrangement.

(6) Information showing migratory behavior between different coordinated care delivery systems and also between the fee-for-service system and the coordinated care delivery systems, including the extent to which individuals auto-enrolled into a coordinated care delivery system opt out of coverage through the assigned entity.

(e) Integrated Care Program for individuals with chronic mental health conditions.

(1) The Integrated Care Program shall encompass services administered to recipients of medical assistance under this Article to prevent exacerbations and complications using cost-effective, evidence-based practice guidelines and mental health management strategies.

(2) The Department may utilize and expand upon existing contractual arrangements with integrated care plans under

the Integrated Care Program for providing the coordinated care provisions of this Section.

(3) Payment for such coordinated care shall be based on arrangements where the State pays for performance related to mental health outcomes on a capitated basis in which a fixed monthly premium per recipient is paid and full financial risk is assumed for the delivery of services, or through other risk-based payment arrangements such as provider-based care coordination.

(4) The Department shall examine whether chronic mental health management programs and services for recipients with specific chronic mental health conditions do any or all of the following:

(A) Improve the patient's overall mental health in a more expeditious and cost-effective manner.

(B) Lower costs in other aspects of the medical assistance program, such as hospital admissions, emergency room visits, or more frequent and inappropriate psychotropic drug use.

(5) The Department shall work with the facilities and any integrated care plan participating in the program to identify and correct barriers to the successful implementation of this subsection (e) prior to and during the implementation to best facilitate the goals and objectives of this subsection (e).

(f) A hospital that is located in a county of the State in

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 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 risk through either stop-loss insurance for extremely high cost individuals or corridors of shared risk based on the overall cost of the total enrollment in the ACE. The ACE shall be responsible for claims processing, encounter data submission, utilization control, and quality assurance.

(8) In the fourth and subsequent years of operation, an ACE shall convert to a Managed Care Community Network (MCCN), as defined in this Article, or Health Maintenance Organization pursuant to the Illinois Insurance Code, accepting full-risk capitation payments.

The Department shall allow potential ACE entities 5 months from the date of the posting of the solicitation to submit proposals. After the solicitation is released, in addition to the MCO rate development data available on the Department's website, subject to federal and State confidentiality and privacy laws and regulations, the Department shall provide 2 years of de-identified summary service data on the targeted population, split between children and adults, showing the historical type and volume of services received and the cost of those services to those potential bidders that sign a data use agreement. The Department may add up to 2 non-state government employees with expertise in creating integrated delivery systems to its review team for the purchase of care solicitation described in this subsection. Any such

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

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

(Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13; 98-651, eff. 6-16-14.)