



99TH GENERAL ASSEMBLY

State of Illinois

2015 and 2016

HB5524

by Rep. Greg Harris

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that, beginning July 1, 2018, Accountable Care Entities, Managed Care Community Networks, and Managed Care Organizations shall report annually on HIV viral load suppression as a quality measure related to HIV/AIDS disease management. Requires implementation of reporting on the HIV quality measure to be done in consultation with the Department of Healthcare and Family Services, the Department of Public Health, health care providers and community-based organizations with expertise in HIV/AIDS care, impacted MCOs, and other interested parties and to be based on nationally-recognized quality measurement standards.

LRB099 18688 KTG 43071 b

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 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
17 contract in integrated delivery systems that are responsible
18 for providing or arranging the majority of care, including
19 primary care physician services, referrals from primary care
20 physicians, diagnostic and treatment services, behavioral
21 health services, in-patient and outpatient hospital services,
22 dental services, and rehabilitation and long-term care
23 services. The Department shall designate or contract for such

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

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

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

1 January 25, 2011 (the effective date of Public Act 96-1501)
2 ~~this amendatory Act of the 96th General Assembly.~~

3 (d) The Department shall report to the General Assembly in
4 a separate part of its annual medical assistance program
5 report, beginning April, 2012 until April, 2016, on the
6 progress and implementation of the care coordination program
7 initiatives established by the provisions of Public Act 96-1501
8 ~~this amendatory Act of the 96th General Assembly.~~ The
9 Department shall include in its April 2011 report a full
10 analysis of federal laws or regulations regarding upper payment
11 limitations to providers and the necessary revisions or
12 adjustments in rate methodologies and payments to providers
13 under this Code that would be necessary to implement
14 coordinated care with full financial risk by a party other than
15 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

1 of the Medical Assistance Program residing in the county to
2 enroll in a Care Coordination Program, as set forth in Section
3 5-30 of this Code, shall not be eligible for any non-claims
4 based payments not mandated by Article V-A of this Code for
5 which it would otherwise be qualified to receive, unless the
6 hospital is a Coordinated Care Participating Hospital no later
7 than 60 days after June 14, 2012 (the effective date of Public
8 Act 97-689) ~~this amendatory Act of the 97th General Assembly~~ or
9 60 days after the first mandatory enrollment of a beneficiary
10 in a Coordinated Care program. For purposes of this subsection,
11 "Coordinated Care Participating Hospital" means a hospital
12 that meets one of the following criteria:

13 (1) The hospital has entered into a contract to provide
14 hospital services with one or more MCOs to enrollees of the
15 care coordination program.

16 (2) The hospital has not been offered a contract by a
17 care coordination plan that the Department has determined
18 to be a good faith offer and that pays at least as much as
19 the Department would pay, on a fee-for-service basis, not
20 including disproportionate share hospital adjustment
21 payments or any other supplemental adjustment or add-on
22 payment to the base fee-for-service rate, except to the
23 extent such adjustments or add-on payments are
24 incorporated into the development of the applicable MCO
25 capitated rates.

26 As used in this subsection (f), "MCO" means any entity

1 which contracts with the Department to provide services where
2 payment for medical services is made on a capitated basis.

3 (g) No later than August 1, 2013, the Department shall
4 issue a purchase of care solicitation for Accountable Care
5 Entities (ACE) to serve any children and parents or caretaker
6 relatives of children eligible for medical assistance under
7 this Article. An ACE may be a single corporate structure or a
8 network of providers organized through contractual
9 relationships with a single corporate entity. The solicitation
10 shall require that:

11 (1) An ACE operating in Cook County be capable of
12 serving at least 40,000 eligible individuals in that
13 county; an ACE operating in Lake, Kane, DuPage, or Will
14 Counties be capable of serving at least 20,000 eligible
15 individuals in those counties and an ACE operating in other
16 regions of the State be capable of serving at least 10,000
17 eligible individuals in the region in which it operates.
18 During initial periods of mandatory enrollment, the
19 Department shall require its enrollment services
20 contractor to use a default assignment algorithm that
21 ensures if possible an ACE reaches the minimum enrollment
22 levels set forth in this paragraph.

23 (2) An ACE must include at a minimum the following
24 types of providers: primary care, specialty care,
25 hospitals, and behavioral healthcare.

26 (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

1 confidentiality agreement and agree to act in accordance with
2 all applicable State laws.

3 During the first 2 years of an ACE's operation, the
4 Department shall provide claims data to the ACE on its
5 enrollees on a periodic basis no less frequently than monthly.

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

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

16 (h) Department contracts with MCOs and other entities
17 reimbursed by risk based capitation shall have a minimum
18 medical loss ratio of 85%, shall require the entity to
19 establish an appeals and grievances process for consumers and
20 providers, and shall require the entity to provide a quality
21 assurance and utilization review program. Entities contracted
22 with the Department to coordinate healthcare regardless of risk
23 shall be measured utilizing the same quality metrics. The
24 quality metrics may be population specific. Any contracted
25 entity serving at least 5,000 seniors or people with
26 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) Unless otherwise required by federal law, Medicaid
19 Managed Care Entities shall not divulge, directly or
20 indirectly, including by sending a bill or explanation of
21 benefits, information concerning the sensitive health services
22 received by enrollees of the Medicaid Managed Care Entity to
23 any person other than providers and care coordinators caring
24 for the enrollee and employees of the entity in the course of
25 the entity's internal operations. The Medicaid Managed Care
26 Entity may divulge information concerning the sensitive health

1 services if the enrollee who received the sensitive health
2 services requests the information from the Medicaid Managed
3 Care Entity and authorized the sending of a bill or explanation
4 of benefits. Communications including, but not limited to,
5 statements of care received or appointment reminders either
6 directly or indirectly to the enrollee from the health care
7 provider, health care professional, and care coordinators,
8 remain permissible.

9 For the purposes of this subsection, the term "Medicaid
10 Managed Care Entity" includes Care Coordination Entities,
11 Accountable Care Entities, Managed Care Organizations, and
12 Managed Care Community Networks.

13 For purposes of this subsection, the term "sensitive health
14 services" means mental health services, substance abuse
15 treatment services, reproductive health services, family
16 planning services, services for sexually transmitted
17 infections and sexually transmitted diseases, and services for
18 sexual assault or domestic abuse. Services include prevention,
19 screening, consultation, examination, treatment, or follow-up.

20 Nothing in this subsection shall be construed to relieve a
21 Medicaid Managed Care Entity or the Department of any duty to
22 report incidents of sexually transmitted infections to the
23 Department of Public Health or to the local board of health in
24 accordance with regulations adopted under a statute or
25 ordinance or to report incidents of sexually transmitted
26 infections as necessary to comply with the requirements under

1 Section 5 of the Abused and Neglected Child Reporting Act or as
2 otherwise required by State or federal law.

3 The Department shall create policy in order to implement
4 the requirements in this subsection.

5 (j) ~~(i)~~ Managed Care Entities (MCEs), including MCOs and
6 all other care coordination organizations, shall develop and
7 maintain a written language access policy that sets forth the
8 standards, guidelines, and operational plan to ensure language
9 appropriate services and that is consistent with the standard
10 of meaningful access for populations with limited English
11 proficiency. The language access policy shall describe how the
12 MCEs will provide all of the following required services:

13 (1) Translation (the written replacement of text from
14 one language into another) of all vital documents and forms
15 as identified by the Department.

16 (2) Qualified interpreter services (the oral
17 communication of a message from one language into another
18 by a qualified interpreter).

19 (3) Staff training on the language access policy,
20 including how to identify language needs, access and
21 provide language assistance services, work with
22 interpreters, request translations, and track the use of
23 language assistance services.

24 (4) Data tracking that identifies the language need.

25 (5) Notification to participants on the availability
26 of language access services and on how to access such

1 services.

2 (k) Beginning July 1, 2018, ACEs, MCCNs, and MCOs shall
3 report annually on HIV viral load suppression as a quality
4 measure related to HIV/AIDS disease management. Implementation
5 of reporting on the HIV quality measure shall be done in
6 consultation with the Department, the Department of Public
7 Health, health care providers and community-based
8 organizations with expertise in HIV/AIDS care, impacted MCOs,
9 and other interested parties and shall be based on
10 nationally-recognized quality measurement standards. As used
11 in this subsection, "MCO" has the meaning ascribed to that term
12 in Section 5-30.1 of this Code.

13 (Source: P.A. 98-104, eff. 7-22-13; 98-651, eff. 6-16-14;
14 99-106, eff. 1-1-16; 99-181, eff. 7-29-15; revised 10-26-15.)