SB1379

LRB10008706SMS18842b

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

SB1379

Introduced 2/9/2017, by Sen. David Koehler - Kyle McCarter

SYNOPSIS AS INTRODUCED:

215 ILCS 106/23

Amends the Children's Health Insurance Program Act. In a provision concerning care coordination, provides that mandatory assignments into managed care organizations must not occur when 50% of persons eligible for selecting a managed care service are covered through an integrated care program until the Department of Healthcare and Family Services demonstrates that the net per-recipient cost paid by non-federal, State revenue sources in those contracts, adjusted for age and gender, is less than the non-federal, net State per-recipient cost in fee-for-service for fiscal year 2014 and the health outcome goals required in contracts have been achieved. Requires that all per-recipient cost calculations be performed between like eligibility categories. Excludes Hospital Assessment Program payments from these calculations. Requires the Department to annually calculate and publish on its website a report on the per-recipient cost calculations and certain other information.

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A BILL FOR

AN ACT concerning regulation.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

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

(215 ILCS 106/23)

Sec. 23. 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. However, mandatory assignments into managed care organizations must not occur when 50% of persons eligible for selecting a managed care service are covered through an integrated care program until the Department demonstrates that the net per-recipient cost paid by non-federal, State revenue sources in those contracts, adjusted for age and gender, is less than the non-federal, net State per-recipient cost in fee-for-service for fiscal year 2014 and the health outcome goals required in those contracts have been achieved. All per-recipient cost calculations shall be performed between

like eligibility categories. Hospital Assessment Program payments are excluded from these calculations. The Department shall annually calculate and publish the results on the Department's website. The report shall include the details of the data included, data excluded, any adjustments made, and detailed justifications for such adjustments. 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.

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