



Sen. Don Harmon

**Filed: 3/23/2012**

09700SB3326sam001

LRB097 17848 KTG 67773 a

1 AMENDMENT TO SENATE BILL 3326

2 AMENDMENT NO. \_\_\_\_\_. Amend Senate Bill 3326 by replacing  
3 everything after the enacting clause with the following:

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

6 (215 ILCS 106/23)

7 Sec. 23. Care coordination.

8 (a) At least 70% ~~50%~~ of recipients eligible for  
9 comprehensive medical benefits in all medical assistance  
10 programs or other health benefit programs administered by the  
11 Department, including the Children's Health Insurance Program  
12 Act and the Covering ALL KIDS Health Insurance Act, shall be  
13 enrolled in a care coordination program by no later than  
14 January 1, 2015. For purposes of this Section, "coordinated  
15 care" or "care coordination" means delivery systems where  
16 recipients will receive their care from providers who

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

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

26 (c) To qualify for compliance with this Section, the 70%

1 ~~50%~~ goal shall be achieved by enrolling medical assistance  
2 enrollees from each medical assistance enrollment category,  
3 including parents, children, seniors, and people with  
4 disabilities to the extent that current State Medicaid payment  
5 laws would not limit federal matching funds for recipients in  
6 care coordination programs. In addition, services must be more  
7 comprehensively defined and more risk shall be assumed than in  
8 the Department's primary care case management program as of the  
9 effective date of this amendatory Act of the 96th General  
10 Assembly.

11 (c-5) An enhanced primary care case management program that  
12 includes collaboration between primary care providers,  
13 hospitals, and behavioral health providers with protocols for  
14 coordination, electronic exchange of health information, and  
15 fees at risk based on performance and outcomes qualifies as  
16 care coordination under this Section.

17 (d) The Department shall report to the General Assembly in  
18 a separate part of its annual medical assistance program  
19 report, beginning April, 2012 until April, 2016, on the  
20 progress and implementation of the care coordination program  
21 initiatives established by the provisions of this amendatory  
22 Act of the 96th General Assembly. The Department shall include  
23 in its April 2011 report a full analysis of federal laws or  
24 regulations regarding upper payment limitations to providers  
25 and the necessary revisions or adjustments in rate  
26 methodologies and payments to providers under this Code that

1 would be necessary to implement coordinated care with full  
2 financial risk by a party other than the Department.

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

4 Section 10. The Covering ALL KIDS Health Insurance Act is  
5 amended by changing Section 56 as follows:

6 (215 ILCS 170/56)

7 (Section scheduled to be repealed on July 1, 2016)

8 Sec. 56. Care coordination.

9 (a) At least 70% ~~50%~~ of recipients eligible for  
10 comprehensive medical benefits in all medical assistance  
11 programs or other health benefit programs administered by the  
12 Department, including the Children's Health Insurance Program  
13 Act and the Covering ALL KIDS Health Insurance Act, shall be  
14 enrolled in a care coordination program by no later than  
15 January 1, 2015. For purposes of this Section, "coordinated  
16 care" or "care coordination" means delivery systems where  
17 recipients will receive their care from providers who  
18 participate under contract in integrated delivery systems that  
19 are responsible for providing or arranging the majority of  
20 care, including primary care physician services, referrals  
21 from primary care physicians, diagnostic and treatment  
22 services, behavioral health services, in-patient and  
23 outpatient hospital services, dental services, and  
24 rehabilitation and long-term care services. The Department

1 shall designate or contract for such integrated delivery  
2 systems (i) to ensure enrollees have a choice of systems and of  
3 primary care providers within such systems; (ii) to ensure that  
4 enrollees receive quality care in a culturally and  
5 linguistically appropriate manner; and (iii) to ensure that  
6 coordinated care programs meet the diverse needs of enrollees  
7 with developmental, mental health, physical, and age-related  
8 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 70%  
20 ~~50%~~ 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 (c-5) An enhanced primary care case management program that  
5 includes collaboration between primary care providers,  
6 hospitals, and behavioral health providers with protocols for  
7 coordination, electronic exchange of health information, and  
8 fees at risk based on performance and outcomes qualifies as  
9 care coordination under this Section.

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

23 Section 15. The Illinois Public Aid Code is amended by  
24 changing Section 5-30 as follows:

1 (305 ILCS 5/5-30)

2 Sec. 5-30. Care coordination.

3 (a) At least 70% ~~50%~~ of recipients eligible for  
4 comprehensive medical benefits in all medical assistance  
5 programs or other health benefit programs administered by the  
6 Department, including the Children's Health Insurance Program  
7 Act and the Covering ALL KIDS Health Insurance Act, shall be  
8 enrolled in a care coordination program by no later than  
9 January 1, 2015. For purposes of this Section, "coordinated  
10 care" or "care coordination" means delivery systems where  
11 recipients will receive their care from providers who  
12 participate under contract in integrated delivery systems that  
13 are responsible for providing or arranging the majority of  
14 care, including primary care physician services, referrals  
15 from primary care physicians, diagnostic and treatment  
16 services, behavioral health services, in-patient and  
17 outpatient hospital services, dental services, and  
18 rehabilitation and long-term care services. The Department  
19 shall designate or contract for such integrated delivery  
20 systems (i) to ensure enrollees have a choice of systems and of  
21 primary care providers within such systems; (ii) to ensure that  
22 enrollees receive quality care in a culturally and  
23 linguistically appropriate manner; and (iii) to ensure that  
24 coordinated care programs meet the diverse needs of enrollees  
25 with developmental, mental health, physical, and age-related  
26 disabilities.

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

11 (c) To qualify for compliance with this Section, the 70%  
12 ~~50%~~ goal shall be achieved by enrolling medical assistance  
13 enrollees from each medical assistance enrollment category,  
14 including parents, children, seniors, and people with  
15 disabilities to the extent that current State Medicaid payment  
16 laws would not limit federal matching funds for recipients in  
17 care coordination programs. In addition, services must be more  
18 comprehensively defined and more risk shall be assumed than in  
19 the Department's primary care case management program as of the  
20 effective date of this amendatory Act of the 96th General  
21 Assembly.

22 (c-5) An enhanced primary care case management program that  
23 includes collaboration between primary care providers,  
24 hospitals, and behavioral health providers with protocols for  
25 coordination, electronic exchange of health information, and  
26 fees at risk based on performance and outcomes qualifies as



1 care coordination under this Section.

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

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

15 Section 99. Effective date. This Act takes effect upon  
16 becoming law.".