

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 the

1 effective date of this amendatory Act of the 96th General
2 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 this amendatory
8 Act of the 96th General Assembly. The Department shall include
9 in its April 2011 report a full analysis of federal laws or
10 regulations regarding upper payment limitations to providers
11 and the necessary revisions or adjustments in rate
12 methodologies and payments to providers under this Code that
13 would be necessary to implement coordinated care with full
14 financial risk by a party other than the Department.

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

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

23 (2) The Department may utilize and expand upon existing
24 contractual arrangements with integrated care plans under
25 the Integrated Care Program for providing the coordinated
26 care provisions of this Section.

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

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

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

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

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

24 (f) A hospital that is located in a county of the State in
25 which the Department mandates some or all of the beneficiaries
26 of the Medical Assistance Program residing in the county to

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

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

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

25 As used in this subsection (f), "MCO" means any entity
26 which contracts with the Department to provide services where

1 payment for medical services is made on a capitated basis.

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

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

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

25 (3) An ACE shall have a governance structure that
26 includes the major components of the health care delivery

1 system, including one representative from each of the
2 groups listed in paragraph (2).

3 (4) An ACE must be an integrated delivery system,
4 including a network able to provide the full range of
5 services needed by Medicaid beneficiaries and system
6 capacity to securely pass clinical information across
7 participating entities and to aggregate and analyze that
8 data in order to coordinate care.

9 (5) An ACE must be capable of providing both care
10 coordination and complex case management, as necessary, to
11 beneficiaries. To be responsive to the solicitation, a
12 potential ACE must outline its care coordination and
13 complex case management model and plan to reduce the cost
14 of care.

15 (6) In the first 18 months of operation, unless the ACE
16 selects a shorter period, an ACE shall be paid care
17 coordination fees on a per member per month basis that are
18 projected to be cost neutral to the State during the term
19 of their payment and, subject to federal approval, be
20 eligible to share in additional savings generated by their
21 care coordination.

22 (7) In months 19 through 36 of operation, unless the
23 ACE selects a shorter period, an ACE shall be paid on a
24 pre-paid capitation basis for all medical assistance
25 covered services, under contract terms similar to Managed
26 Care Organizations (MCO), with the Department sharing the

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

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

11 The Department shall allow potential ACE entities 5 months
12 from the date of the posting of the solicitation to submit
13 proposals. After the solicitation is released, in addition to
14 the MCO rate development data available on the Department's
15 website, subject to federal and State confidentiality and
16 privacy laws and regulations, the Department shall provide 2
17 years of de-identified summary service data on the targeted
18 population, split between children and adults, showing the
19 historical type and volume of services received and the cost of
20 those services to those potential bidders that sign a data use
21 agreement. The Department may add up to 2 non-state government
22 employees with expertise in creating integrated delivery
23 systems to its review team for the purchase of care
24 solicitation described in this subsection. Any such
25 individuals must sign a no-conflict disclosure and
26 confidentiality agreement and agree to act in accordance with

1 all applicable State laws.

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

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

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

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

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

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

17 (i) Unless otherwise required by federal law, Medicaid
18 Managed Care Entities shall not divulge, directly or
19 indirectly, including by sending a bill or explanation of
20 benefits, information concerning the sensitive health services
21 received by enrollees of the Medicaid Managed Care Entity to
22 any person other than providers and care coordinators caring
23 for the enrollee and employees of the entity in the course of
24 the entity's internal operations. The Medicaid Managed Care
25 Entity may divulge information concerning the sensitive health
26 services if the enrollee who received the sensitive health

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

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

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

19 Nothing in this subsection shall be construed to relieve a
20 Medicaid Managed Care Entity or the Department of any duty to
21 report incidents of sexually transmitted infections to the
22 Department of Public Health or to the local board of health in
23 accordance with regulations adopted under a statute or
24 ordinance or to report incidents of sexually transmitted
25 infections as necessary to comply with the requirements under
26 Section 5 of the Abused and Neglected Child Reporting Act or as

1 otherwise required by State or federal law.

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

4 (Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13;
5 98-651, eff. 6-16-14.)

6 Section 99. Effective date. This Act takes effect upon
7 becoming law.