



## 99TH GENERAL ASSEMBLY

### State of Illinois

2015 and 2016

SB1754

Introduced 2/20/2015, by Sen. Daniel Biss

#### SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that for all recipients of medical assistance who are enrolled in a Medicaid Managed Care Entity, information concerning sensitive health services, including information concerning consultations, examinations, and treatments, shall not be divulged directly or indirectly to any person, including by sending a bill for such services or by sending an explanation of benefits provided by the Medicaid Managed Care Entity, unless the recipient who received the sensitive health services requests the information from the Medicaid Managed Care Entity. Provides that the term "Medicaid Managed Care Entity" includes, but is not limited to, Care Coordination Entities, Accountable Care Entities, Managed Care Community Networks, and Managed Care Organizations. Defines "sensitive health services". Provides that nothing in this provision shall be construed to relieve a Medicaid Managed Care Entity or the Department of Healthcare and Family Services of its duty to report incidents of sexually transmitted infections to the Department of Public Health or to the local board of health in accordance with regulations adopted under a statute or ordinance, or to report incidents of sexually transmitted infections as necessary to comply with certain requirements under the Abused and Neglected Child Reporting Act or as otherwise required by State or federal law. Effective immediately.

LRB099 09087 KTG 31287 b

FISCAL NOTE ACT  
MAY APPLY

A BILL FOR

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) For all recipients of medical assistance under this  
18 Article who are enrolled in a Medicaid Managed Care Entity,  
19 information concerning sensitive health services, including  
20 information concerning consultations, examinations, and  
21 treatments, shall not be divulged directly or indirectly to any  
22 person, including by sending a bill for such services or by  
23 sending an explanation of benefits provided by the Medicaid  
24 Managed Care Entity, unless the recipient who received the  
25 sensitive health services requests the information from the  
26 Medicaid Managed Care Entity.

1       For the purposes of this subsection, the term "Medicaid  
2 Managed Care Entity" includes, but is not limited to, Care  
3 Coordination Entities, Accountable Care Entities, Managed Care  
4 Community Networks, and Managed Care Organizations.

5       For the purposes of this subsection, the term "sensitive  
6 health services" includes, but is not limited to, mental health  
7 services, substance abuse treatment services, reproductive  
8 health services, family planning services, sexually  
9 transmitted infections (STI) and sexually transmitted diseases  
10 (STD) services, sexual assault services, domestic violence  
11 services, case management services, care management services,  
12 and care coordination services.

13       Nothing in this subsection shall be construed to relieve a  
14 Medicaid Managed Care Entity or the Department of its duty to  
15 report incidents of sexually transmitted infections to the  
16 Department of Public Health or to the local board of health in  
17 accordance with regulations adopted under a statute or  
18 ordinance, or to report incidents of sexually transmitted  
19 infections as necessary to comply with the requirements under  
20 Section 5 of the Abused and Neglected Child Reporting Act or as  
21 otherwise required by State or federal law.

22       (Source: P.A. 97-689, eff. 6-14-12; 98-104, eff. 7-22-13;  
23 98-651, eff. 6-16-14.)

24       Section 99. Effective date. This Act takes effect upon  
25 becoming law.