



Sen. Julie A. Morrison

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1 AMENDMENT TO SENATE BILL 647

2 AMENDMENT NO. _____. Amend Senate Bill 647 by replacing
3 everything after the enacting clause with the following:

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.
14 For 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

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

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

25 (c) To qualify for compliance with this Section, the 50%
26 goal shall be achieved by enrolling medical assistance

1 enrollees from each medical assistance enrollment category,
2 including parents, children, seniors, and people with
3 disabilities to the extent that current State Medicaid payment
4 laws would not limit federal matching funds for recipients in
5 care coordination programs. In addition, services must be more
6 comprehensively defined and more risk shall be assumed than in
7 the Department's primary care case management program as of
8 January 25, 2011 (the effective date of Public Act 96-1501).

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

21 (e) Integrated Care Program for individuals with chronic
22 mental health conditions.

23 (1) The Integrated Care Program shall encompass
24 services administered to recipients of medical assistance
25 under this Article to prevent exacerbations and
26 complications using cost-effective, evidence-based

1 practice guidelines and mental health management
2 strategies.

3 (2) The Department may utilize and expand upon
4 existing contractual arrangements with integrated care
5 plans under the Integrated Care Program for providing the
6 coordinated care provisions of this Section.

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

14 (4) The Department shall examine whether chronic
15 mental health management programs and services for
16 recipients with specific chronic mental health conditions
17 do any or all of the following:

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

20 (B) Lower costs in other aspects of the medical
21 assistance program, such as hospital admissions,
22 emergency room visits, or more frequent and
23 inappropriate psychotropic drug use.

24 (5) The Department shall work with the facilities and
25 any integrated care plan participating in the program to
26 identify and correct barriers to the successful

1 implementation of this subsection (e) prior to and during
2 the implementation to best facilitate the goals and
3 objectives of this subsection (e).

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

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

20 (2) The hospital has not been offered a contract by a
21 care coordination plan that the Department has determined
22 to be a good faith offer and that pays at least as much as
23 the Department would pay, on a fee-for-service basis, not
24 including disproportionate share hospital adjustment
25 payments or any other supplemental adjustment or add-on
26 payment to the base fee-for-service rate, except to the

1 extent such adjustments or add-on payments are
2 incorporated into the development of the applicable MCO
3 capitated rates.

4 As used in this subsection (f), "MCO" means any entity
5 which contracts with the Department to provide services where
6 payment for medical services is made on a capitated basis.

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

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

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

4 (3) An ACE shall have a governance structure that
5 includes the major components of the health care delivery
6 system, including one representative from each of the
7 groups listed in paragraph (2).

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

14 (5) An ACE must be capable of providing both care
15 coordination and complex case management, as necessary, to
16 beneficiaries. To be responsive to the solicitation, a
17 potential ACE must outline its care coordination and
18 complex case management model and plan to reduce the cost
19 of care.

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

1 (7) In months 19 through 36 of operation, unless the
2 ACE selects a shorter period, an ACE shall be paid on a
3 pre-paid capitation basis for all medical assistance
4 covered services, under contract terms similar to Managed
5 Care Organizations (MCO), with the Department sharing the
6 risk through either stop-loss insurance for extremely high
7 cost individuals or corridors of shared risk based on the
8 overall cost of the total enrollment in the ACE. The ACE
9 shall be responsible for claims processing, encounter data
10 submission, utilization control, and quality assurance.

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

16 The Department shall allow potential ACE entities 5 months
17 from the date of the posting of the solicitation to submit
18 proposals. After the solicitation is released, in addition to
19 the MCO rate development data available on the Department's
20 website, subject to federal and State confidentiality and
21 privacy laws and regulations, the Department shall provide 2
22 years of de-identified summary service data on the targeted
23 population, split between children and adults, showing the
24 historical type and volume of services received and the cost
25 of those services to those potential bidders that sign a data
26 use agreement. The Department may add up to 2 non-state

1 government employees with expertise in creating integrated
2 delivery systems to its review team for the purchase of care
3 solicitation described in this subsection. Any such
4 individuals must sign a no-conflict disclosure and
5 confidentiality agreement and agree to act in accordance with
6 all applicable State laws.

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

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

17 Nothing in this subsection precludes the Department from
18 considering future proposals for new ACEs or expansion of
19 existing ACEs at the discretion of the Department.

20 (h) Department contracts with MCOs and other entities
21 reimbursed by risk based capitation shall have a minimum
22 medical loss ratio of 85%, shall require the entity to
23 establish an appeals and grievances process for consumers and
24 providers, and shall require the entity to provide a quality
25 assurance and utilization review program. Entities contracted
26 with the Department to coordinate healthcare regardless of

1 risk shall be measured utilizing the same quality metrics. The
2 quality metrics may be population specific. Any contracted
3 entity serving at least 5,000 seniors or people with
4 disabilities or 15,000 individuals in other populations
5 covered by the Medical Assistance Program that has been
6 receiving full-risk capitation for a year shall be accredited
7 by a national accreditation organization authorized by the
8 Department within 2 years after the date it is eligible to
9 become accredited. The requirements of this subsection shall
10 apply to contracts with MCOs entered into or renewed or
11 extended after June 1, 2013.

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

23 (i) Unless otherwise required by federal law, Medicaid
24 Managed Care Entities and their respective business associates
25 shall not disclose, directly or indirectly, including by
26 sending a bill or explanation of benefits, information

1 concerning the sensitive health services received by enrollees
2 of the Medicaid Managed Care Entity to any person other than
3 covered entities and business associates, which may receive,
4 use, and further disclose such information solely for the
5 purposes permitted under applicable federal and State laws and
6 regulations if such use and further disclosure satisfies all
7 applicable requirements of such laws and regulations. The
8 Medicaid Managed Care Entity or its respective business
9 associates may disclose information concerning the sensitive
10 health services if the enrollee who received the sensitive
11 health services requests the information from the Medicaid
12 Managed Care Entity or its respective business associates and
13 authorized the sending of a bill or explanation of benefits.
14 Communications including, but not limited to, statements of
15 care received or appointment reminders either directly or
16 indirectly to the enrollee from the health care provider,
17 health care professional, and care coordinators, remain
18 permissible. Medicaid Managed Care Entities or their
19 respective business associates may communicate directly with
20 their enrollees regarding care coordination activities for
21 those enrollees.

22 For the purposes of this subsection, the term "Medicaid
23 Managed Care Entity" includes Care Coordination Entities,
24 Accountable Care Entities, Managed Care Organizations, and
25 Managed Care Community Networks.

26 For purposes of this subsection, the term "sensitive

1 health services" means mental health services, substance abuse
2 treatment services, reproductive health services, family
3 planning services, services for sexually transmitted
4 infections and sexually transmitted diseases, and services for
5 sexual assault or domestic abuse. Services include prevention,
6 screening, consultation, examination, treatment, or follow-up.

7 For purposes of this subsection, "business associate",
8 "covered entity", "disclosure", and "use" have the meanings
9 ascribed to those terms in 45 CFR 160.103.

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

19 The Department shall create policy in order to implement
20 the requirements in this subsection.

21 (j) Managed Care Entities (MCEs), including MCOs and all
22 other care coordination organizations, shall develop and
23 maintain a written language access policy that sets forth the
24 standards, guidelines, and operational plan to ensure language
25 appropriate services and that is consistent with the standard
26 of meaningful access for populations with limited English

1 proficiency. The language access policy shall describe how the
2 MCEs will provide all of the following required services:

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

6 (2) Qualified interpreter services (the oral
7 communication of a message from one language into another
8 by a qualified interpreter).

9 (3) Staff training on the language access policy,
10 including how to identify language needs, access and
11 provide language assistance services, work with
12 interpreters, request translations, and track the use of
13 language assistance services.

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

15 (5) Notification to participants on the availability
16 of language access services and on how to access such
17 services.

18 (k) The Department shall actively monitor the contractual
19 relationship between Managed Care Organizations (MCOs) and any
20 dental administrator contracted by an MCO to provide dental
21 services. The Department shall adopt appropriate dental
22 Healthcare Effectiveness Data and Information Set (HEDIS)
23 measures and shall include the Annual Dental Visit (ADV) HEDIS
24 measure in its Health Plan Comparison Tool and Illinois
25 Medicaid Plan Report Card that is available on the
26 Department's website for enrolled individuals.

1 The Department shall collect from each MCO specific
2 information about the types of contracted, broad-based care
3 coordination occurring between the MCO and any dental
4 administrator, including, but not limited to, pregnant women
5 and diabetic patients in need of oral care.

6 (1) Notwithstanding any other provision of this Code, the
7 Department may not impose and a dental provider shall not be
8 required to pay any assessment, tax, or fee, the proceeds of
9 which will fund any coordinated care program authorized by
10 this Section.

11 (Source: P.A. 99-106, eff. 1-1-16; 99-181, eff. 7-29-15;
12 99-566, eff. 1-1-17; 99-642, eff. 7-28-16; 100-587, eff.
13 6-4-18.)".