SB2006

102ND GENERAL ASSEMBLY

State of Illinois

2021 and 2022

SB2006

Introduced 2/26/2021, by Sen. David Koehler

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-2.01
305 ILCS 5/5-30.1

Amends the Medical Assistance Article of the Illinois Public Aid Code. Provides that no later than 90 days after the effective date of the amendatory Act, the Department of Healthcare and Family Services shall post on its official website: (i) a copy of all current, executed, or adopted contracts with each managed care organization (MCO), including all amendments, attachments, and exhibits, that are in effect as of January 1, 2021; (ii) all changes made to each MCO contract that are in effect on or after January 1, 2021; (iii) all operational policy changes issued to MCOs; and (iv) a copy of all contracts and operational policy changes for a period of not less than 24 months after the termination or expiration of any MCO contract. Provides that the Department shall prohibit each MCO from operating, implementing, or modifying any program or policy that concerns, but it not limited to, reducing potentially preventable hospital readmissions (PPR) until after the Department has adopted an updated PPR policy for services provided to individuals not covered under managed care. Contains provisions concerning prohibited PPR policy measures. Provides that if the Department elects to implement a comprehensive PPR policy that applies to both the fee-for-service and managed care medical assistance programs, then no MCO may operate a similar PPR policy. Provides that an MCO shall not make a material change unless the material change has been approved by the Department or agreed upon in writing by the MCO and the health care provider. Requires the Department to publish on its website a process through which an MCO may submit a written proposed material change request. Effective immediately.

LRB102 15657 KTG 21020 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 Sections 5-2.01 and 5-30.1 as follows:

6 (305 ILCS 5/5-2.01)
7 Sec. 5-2.01. Medicaid accountability through transparency
8 program.
9 (a) Internet-based transparency program. The Director of
10 the Department of Healthcare and Family Services shall be
11 authorized to implement a program under which the Director
12 shall make available through the Department's public Internet
13 website information on medical claims reimbursed under the
14 State's medical assistance program insofar as such information
15 has been de-identified in accordance with regulations
16 promulgated pursuant to the Illinois Health Insurance
17 Portability and Accountability Act. In implementing the
18 program, the Director shall ensure the following:
19 (1) The information made so available shall be in a
20 format that is easily accessible, useable, and
21 understandable to the public, including individuals
22 interested in improving the quality of care provided to
23 individuals eligible for items and services under this

1 Article, researchers, health care providers, and
2 individuals interested in reducing the prevalence of waste
3 and fraud under this Article.
4 (2) The information made so available shall be as
5 current as deemed practical by the Director and shall be
6 updated at least once per calendar quarter.
7 (3) The information made so available shall be
8 aggregated to a level to ensure patient confidentiality,
9 but shall, to the extent feasible, allow for posting of
10 information by provider or vendor name and county, number
11 of individuals served, total patient visits, payment for
12 bills submitted, average cost for bills submitted,
13 adjustments to payments, and total amounts paid.
14 (4) The Director periodically solicits comments from a
15 sampling of individuals who access the information through
16 the program on how to best improve the utility of the
17 program.
18 (b) Use of contractor. For purposes of implementing the
19 program under subsection (a) of this Section and ensuring the
20 information made available through the program is periodically
21 updated, the Director may select and enter into a contract
22 with a public or private entity meeting the criteria and
23 qualifications the Director determines appropriate.
24 (c) Annual Reports. Not later than 12 months after the
25 effective date of this amendatory Act of the 96th General
26 Assembly and annually thereafter, the Director shall submit to

1 the General Assembly a report on the status of the program
2 authorized under subsection (a). The report shall include
3 details including, but not limited to, the estimated or actual
4 costs of developing and maintaining the reporting system, the
5 actual or potential benefit or adverse consequences associated
6 with the system, and, if applicable, the extent to which
7 information made available through the program is accessed and
8 the extent to which comments received under paragraph (4) of
9 subsection (a) of this Section were used to improve the
10 utility of the program.

11 (d) Managed care contracts and operational policy changes.

12 (1) No later than 90 days after the effective date of
13 this amendatory Act of the 102nd General Assembly, the
14 Department shall post on its official website a copy of
15 all current, executed, or adopted contracts with each
16 managed care organization (MCO), including all amendments,
17 attachments, and exhibits, that are in effect as of
18 January 1, 2021. The Department shall post on its official
19 website, within 60 days of execution or adoption, all
20 changes made to each MCO contract, including all
21 amendments, attachments, and exhibits, that are in effect
22 on or after January 1, 2021.

23 (2) The Department shall post to its official website
24 all operational policy changes, as defined in paragraph
25 (1) of subsection (c) of Section 5-30.8, issued to MCOs no
26 later than 60 days prior to the effective date of the

change.

(3) No later than 180 days after the effective date of this amendatory Act of the 102nd General Assembly, the Department shall post all operational policy changes issued during the 12 months preceding the effective date of this amendatory Act of the 102nd General Assembly.

(4) The Department shall maintain a copy of all contracts and operational policy changes required under this subsection on its official website for a period of not less than 24 months after the termination or expiration of any MCO contract.

(Source: P.A. 96-941, eff. 6-25-10.)

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

"Managed care organization" or "MCO" means any entity which contracts with the Department to provide services where payment for medical services is made on a capitated basis.

"Emergency services" include:

(1) emergency services, as defined by Section 10 of the Managed Care Reform and Patient Rights Act;

(2) emergency medical screening examinations, as defined by Section 10 of the Managed Care Reform and Patient Rights Act;

(3) post-stabilization medical services, as defined by

1 Section 10 of the Managed Care Reform and Patient Rights
2 Act; and
3 (4) emergency medical conditions, as defined by
4 Section 10 of the Managed Care Reform and Patient Rights
5 Act.
6 (b) As provided by Section 5-16.12, managed care
7 organizations are subject to the provisions of the Managed
8 Care Reform and Patient Rights Act.
9 (c) An MCO shall pay any provider of emergency services
10 that does not have in effect a contract with the contracted
11 Medicaid MCO. The default rate of reimbursement shall be the
12 rate paid under Illinois Medicaid fee-for-service program
13 methodology, including all policy adjusters, including but not
14 limited to Medicaid High Volume Adjustments, Medicaid
15 Percentage Adjustments, Outpatient High Volume Adjustments,
16 and all outlier add-on adjustments to the extent such
17 adjustments are incorporated in the development of the
18 applicable MCO capitated rates.
19 (d) An MCO shall pay for all post-stabilization services
20 as a covered service in any of the following situations:
21 (1) the MCO authorized such services;
22 (2) such services were administered to maintain the
23 enrollee's stabilized condition within one hour after a
24 request to the MCO for authorization of further
25 post-stabilization services;
26 (3) the MCO did not respond to a request to authorize

such services within one hour;

(4) the MCO could not be contacted; or

(5) the MCO and the treating provider, if the treating provider is a non-affiliated provider, could not reach an agreement concerning the enrollee's care and an affiliated provider was unavailable for a consultation, in which case the MCO must pay for such services rendered by the treating non-affiliated provider until an affiliated provider was reached and either concurred with the treating non-affiliated provider's plan of care or assumed responsibility for the enrollee's care. Such payment shall be made at the default rate of reimbursement paid under Illinois Medicaid fee-for-service program methodology, including all policy adjusters, including but not limited to Medicaid High Volume Adjustments, Medicaid Percentage Adjustments, Outpatient High Volume Adjustments and all outlier add-on adjustments to the extent that such adjustments are incorporated in the development of the applicable MCO capitated rates.

(e) The following requirements apply to MCOs in determining payment for all emergency services:

(1) MCOs shall not impose any requirements for prior approval of emergency services.

(2) The MCO shall cover emergency services provided to enrollees who are temporarily away from their residence and outside the contracting area to the extent that the

1 enrollees would be entitled to the emergency services if
2 they still were within the contracting area.
3 (3) The MCO shall have no obligation to cover medical
4 services provided on an emergency basis that are not
5 covered services under the contract.
6 (4) The MCO shall not condition coverage for emergency
7 services on the treating provider notifying the MCO of the
8 enrollee's screening and treatment within 10 days after
9 presentation for emergency services.
10 (5) The determination of the attending emergency
11 physician, or the provider actually treating the enrollee,
12 of whether an enrollee is sufficiently stabilized for
13 discharge or transfer to another facility, shall be
14 binding on the MCO. The MCO shall cover emergency services
15 for all enrollees whether the emergency services are
16 provided by an affiliated or non-affiliated provider.
17 (6) The MCO's financial responsibility for
18 post-stabilization care services it has not pre-approved
19 ends when:
20 (A) a plan physician with privileges at the
21 treating hospital assumes responsibility for the
22 enrollee's care;
23 (B) a plan physician assumes responsibility for
24 the enrollee's care through transfer;
25 (C) a contracting entity representative and the
26 treating physician reach an agreement concerning the

1 enrollee's care; or
2 (D) the enrollee is discharged.
3 (f) Network adequacy and transparency.
4 (1) The Department shall:
5 (A) ensure that an adequate provider network is in
6 place, taking into consideration health professional
7 shortage areas and medically underserved areas;
8 (B) publicly release an explanation of its process
9 for analyzing network adequacy;
10 (C) periodically ensure that an MCO continues to
11 have an adequate network in place; and
12 (D) require MCOs, including Medicaid Managed Care
13 Entities as defined in Section 5-30.2, to meet
14 provider directory requirements under Section 5-30.3.
15 (2) Each MCO shall confirm its receipt of information
16 submitted specific to physician or dentist additions or
17 physician or dentist deletions from the MCO's provider
18 network within 3 days after receiving all required
19 information from contracted physicians or dentists, and
20 electronic physician and dental directories must be
21 updated consistent with current rules as published by the
22 Centers for Medicare and Medicaid Services or its
23 successor agency.
24 (g) Timely payment of claims.
25 (1) The MCO shall pay a claim within 30 days of
26 receiving a claim that contains all the essential

1 information needed to adjudicate the claim.
2 (2) The MCO shall notify the billing party of its
3 inability to adjudicate a claim within 30 days of
4 receiving that claim.
5 (3) The MCO shall pay a penalty that is at least equal
6 to the timely payment interest penalty imposed under
7 Section 368a of the Illinois Insurance Code for any claims
8 not timely paid.
9 (A) When an MCO is required to pay a timely payment
10 interest penalty to a provider, the MCO must calculate
11 and pay the timely payment interest penalty that is
12 due to the provider within 30 days after the payment of
13 the claim. In no event shall a provider be required to
14 request or apply for payment of any owed timely
15 payment interest penalties.
16 (B) Such payments shall be reported separately
17 from the claim payment for services rendered to the
18 MCO's enrollee and clearly identified as interest
19 payments.
20 (4)(A) The Department shall require MCOs to expedite
21 payments to providers identified on the Department's
22 expedited provider list, determined in accordance with 89
23 Ill. Adm. Code 140.71(b), on a schedule at least as
24 frequently as the providers are paid under the
25 Department's fee-for-service expedited provider schedule.
26 (B) Compliance with the expedited provider requirement

1 may be satisfied by an MCO through the use of a Periodic
2 Interim Payment (PIP) program that has been mutually
3 agreed to and documented between the MCO and the provider,
4 and the PIP program ensures that any expedited provider
5 receives regular and periodic payments based on prior
6 period payment experience from that MCO. Total payments
7 under the PIP program may be reconciled against future PIP
8 payments on a schedule mutually agreed to between the MCO
9 and the provider.

10 (C) The Department shall share at least monthly its
11 expedited provider list and the frequency with which it
12 pays providers on the expedited list.

13 (g-5) Recognizing that the rapid transformation of the
14 Illinois Medicaid program may have unintended operational
15 challenges for both payers and providers:

16 (1) in no instance shall a medically necessary covered
17 service rendered in good faith, based upon eligibility
18 information documented by the provider, be denied coverage
19 or diminished in payment amount if the eligibility or
20 coverage information available at the time the service was
21 rendered is later found to be inaccurate in the assignment
22 of coverage responsibility between MCOs or the
23 fee-for-service system, except for instances when an
24 individual is deemed to have not been eligible for
25 coverage under the Illinois Medicaid program; and

26 (2) the Department shall, by December 31, 2016, adopt

1 rules establishing policies that shall be included in the
2 Medicaid managed care policy and procedures manual
3 addressing payment resolutions in situations in which a
4 provider renders services based upon information obtained
5 after verifying a patient's eligibility and coverage plan
6 through either the Department's current enrollment system
7 or a system operated by the coverage plan identified by
8 the patient presenting for services:
9 (A) such medically necessary covered services
10 shall be considered rendered in good faith;
11 (B) such policies and procedures shall be
12 developed in consultation with industry
13 representatives of the Medicaid managed care health
14 plans and representatives of provider associations
15 representing the majority of providers within the
16 identified provider industry; and
17 (C) such rules shall be published for a review and
18 comment period of no less than 30 days on the
19 Department's website with final rules remaining
20 available on the Department's website.
21 The rules on payment resolutions shall include, but not be
22 limited to:
23 (A) the extension of the timely filing period;
24 (B) retroactive prior authorizations; and
25 (C) guaranteed minimum payment rate of no less than
26 the current, as of the date of service, fee-for-service

1 rate, plus all applicable add-ons, when the resulting
2 service relationship is out of network.
3 The rules shall be applicable for both MCO coverage and
4 fee-for-service coverage.
5 If the fee-for-service system is ultimately determined to
6 have been responsible for coverage on the date of service, the
7 Department shall provide for an extended period for claims
8 submission outside the standard timely filing requirements.
9 (g-6) MCO Performance Metrics Report.
10 (1) The Department shall publish, on at least a
11 quarterly basis, each MCO's operational performance,
12 including, but not limited to, the following categories of
13 metrics:
14 (A) claims payment, including timeliness and
15 accuracy;
16 (B) prior authorizations;
17 (C) grievance and appeals;
18 (D) utilization statistics;
19 (E) provider disputes;
20 (F) provider credentialing; and
21 (G) member and provider customer service.
22 (2) The Department shall ensure that the metrics
23 report is accessible to providers online by January 1,
24 2017.
25 (3) The metrics shall be developed in consultation
26 with industry representatives of the Medicaid managed care

health plans and representatives of associations representing the majority of providers within the identified industry.

(4) Metrics shall be defined and incorporated into the applicable Managed Care Policy Manual issued by the Department.

(g-7) MCO claims processing and performance analysis. In order to monitor MCO payments to hospital providers, pursuant to this amendatory Act of the 100th General Assembly, the Department shall post an analysis of MCO claims processing and payment performance on its website every 6 months. Such analysis shall include a review and evaluation of a representative sample of hospital claims that are rejected and denied for clean and unclean claims and the top 5 reasons for such actions and timeliness of claims adjudication, which identifies the percentage of claims adjudicated within 30, 60, 90, and over 90 days, and the dollar amounts associated with those claims. The Department shall post the contracted claims report required by HealthChoice Illinois on its website every 3 months.

(g-8) Dispute resolution process. The Department shall maintain a provider complaint portal through which a provider can submit to the Department unresolved disputes with an MCO. An unresolved dispute means an MCO's decision that denies in whole or in part a claim for reimbursement to a provider for health care services rendered by the provider to an enrollee

1 of the MCO with which the provider disagrees. Disputes shall
2 not be submitted to the portal until the provider has availed
3 itself of the MCO's internal dispute resolution process.
4 Disputes that are submitted to the MCO internal dispute
5 resolution process may be submitted to the Department of
6 Healthcare and Family Services' complaint portal no sooner
7 than 30 days after submitting to the MCO's internal process
8 and not later than 30 days after the unsatisfactory resolution
9 of the internal MCO process or 60 days after submitting the
10 dispute to the MCO internal process. Multiple claim disputes
11 involving the same MCO may be submitted in one complaint,
12 regardless of whether the claims are for different enrollees,
13 when the specific reason for non-payment of the claims
14 involves a common question of fact or policy. Within 10
15 business days of receipt of a complaint, the Department shall
16 present such disputes to the appropriate MCO, which shall then
17 have 30 days to issue its written proposal to resolve the
18 dispute. The Department may grant one 30-day extension of this
19 time frame to one of the parties to resolve the dispute. If the
20 dispute remains unresolved at the end of this time frame or the
21 provider is not satisfied with the MCO's written proposal to
22 resolve the dispute, the provider may, within 30 days, request
23 the Department to review the dispute and make a final
24 determination. Within 30 days of the request for Department
25 review of the dispute, both the provider and the MCO shall
26 present all relevant information to the Department for

1 resolution and make individuals with knowledge of the issues
2 available to the Department for further inquiry if needed.
3 Within 30 days of receiving the relevant information on the
4 dispute, or the lapse of the period for submitting such
5 information, the Department shall issue a written decision on
6 the dispute based on contractual terms between the provider
7 and the MCO, contractual terms between the MCO and the
8 Department of Healthcare and Family Services and applicable
9 Medicaid policy. The decision of the Department shall be
10 final. By January 1, 2020, the Department shall establish by
11 rule further details of this dispute resolution process.
12 Disputes between MCOs and providers presented to the
13 Department for resolution are not contested cases, as defined
14 in Section 1-30 of the Illinois Administrative Procedure Act,
15 conferring any right to an administrative hearing.
16 (g-9)(1) The Department shall publish annually on its
17 website a report on the calculation of each managed care
18 organization's medical loss ratio showing the following:
19 (A) Premium revenue, with appropriate adjustments.
20 (B) Benefit expense, setting forth the aggregate
21 amount spent for the following:
22 (i) Direct paid claims.
23 (ii) Subcapitation payments.
24 (iii) Other claim payments.
25 (iv) Direct reserves.
26 (v) Gross recoveries.

1 (vi) Expenses for activities that improve health
2 care quality as allowed by the Department.
3 (2) The medical loss ratio shall be calculated consistent
4 with federal law and regulation following a claims runout
5 period determined by the Department.
6 (g-10)(1) "Liability effective date" means the date on
7 which an MCO becomes responsible for payment for medically
8 necessary and covered services rendered by a provider to one
9 of its enrollees in accordance with the contract terms between
10 the MCO and the provider. The liability effective date shall
11 be the later of:
12 (A) The execution date of a network participation
13 contract agreement.
14 (B) The date the provider or its representative
15 submits to the MCO the complete and accurate standardized
16 roster form for the provider in the format approved by the
17 Department.
18 (C) The provider effective date contained within the
19 Department's provider enrollment subsystem within the
20 Illinois Medicaid Program Advanced Cloud Technology
21 (IMPACT) System.
22 (2) The standardized roster form may be submitted to the
23 MCO at the same time that the provider submits an enrollment
24 application to the Department through IMPACT.
25 (3) By October 1, 2019, the Department shall require all
26 MCOs to update their provider directory with information for

1 new practitioners of existing contracted providers within 30
2 days of receipt of a complete and accurate standardized roster
3 template in the format approved by the Department provided
4 that the provider is effective in the Department's provider
5 enrollment subsystem within the IMPACT system. Such provider
6 directory shall be readily accessible for purposes of
7 selecting an approved health care provider and comply with all
8 other federal and State requirements.

9 (g-11) The Department shall work with relevant
10 stakeholders on the development of operational guidelines to
11 enhance and improve operational performance of Illinois'
12 Medicaid managed care program, including, but not limited to,
13 improving provider billing practices, reducing claim
14 rejections and inappropriate payment denials, and
15 standardizing processes, procedures, definitions, and response
16 timelines, with the goal of reducing provider and MCO
17 administrative burdens and conflict. The Department shall
18 include a report on the progress of these program improvements
19 and other topics in its Fiscal Year 2020 annual report to the
20 General Assembly.

21 (g-12)(1) The Department shall prohibit each MCO from
22 operating, implementing, or modifying any program or policy
23 similar to subsection (d) of Section 5-5f, including, but not
24 limited to, hospital potentially preventable readmissions
25 (PPR), until after:

26 (A) the Department has adopted, by rule, an updated

1 PPR policy for services provided to individuals not
2 covered by the capitated managed care program, and has
3 published on its website guidelines for an approvable MCO
4 PPR policy that is consistent with and aligned with the
5 adopted fee-for-service PPR policy;
6 (B) the MCO has published its proposed PPR policy for
7 public comment on its public website for a period of no
8 fewer than 60 days and has publicly responded to comments;
9 and
10 (C) the Department has approved the MCO's proposed
11 policy and posted such approval on its official website,
12 after considering all public comments received by the MCO.
13 (2) No PPR policy, whether adopted by the Department or an
14 MCO, may result in the denial of payment for a hospital stay
15 that may be considered a PPR that is the result of a previous
16 discharge from another hospital.
17 (3) No PPR policy, whether adopted by the Department or an
18 MCO, may apply to behavioral health care services, including
19 mental health and substance use disorder treatment.
20 (4) No PPR policy, whether adopted by the Department or an
21 MCO, may be effective any sooner than 60 days after the
22 Department has published its approval of an MCO's policy.
23 (5) If the Department elects to implement a comprehensive
24 PPR policy which encompasses both individuals covered under
25 the fee-for-service and capitated managed care programs, then
26 no MCO may operate a similar PPR policy.

1 (g-13) MCO provider agreement material changes. As used in
2 this subsection:
3 "Adverse effect" means a change to a provision of a
4 contract between an MCO and a health care provider that
5 results in a reduction to reimbursement received by a health
6 care provider or an increase in administrative
7 responsibilities or expenses incurred by a health care
8 provider.
9 "Material change" means any action taken by an MCO to
10 implement, amend, add, expand, or otherwise alter a provision
11 of a contract with a health care provider, including by
12 amending a manual, policy, procedure document, or other
13 document referenced in the contract, that has an adverse
14 effect on the provider.
15 (1) An MCO shall not impose obligations, duties, or
16 other requirements on a provider that are inconsistent
17 with federal or State laws, regulations, or policies, or
18 the contract between the Department and the MCO.
19 (2) An MCO shall not make a material change unless the
20 material change has been approved by the Department, in
21 accordance with paragraph (6), or the material change has
22 been mutually agreed upon in writing by the MCO and the
23 health care provider.
24 (3) No provider shall be required to accept any
25 material change that has not been approved by the
26 Department consistent with the approval process outlined

1 in this subsection.
2 (4) A material change that is necessary to comply with
3 federal or State laws, regulations, or policies shall not
4 require prior approval by the Department. The Department
5 and the MCO shall provide written and electronic
6 notification of the material change to the health care
7 provider no less than 90 business days prior to
8 implementation.
9 (5) Within 120 days after the effective date of this
10 amendatory Act of the 102nd General Assembly, the
11 Department shall establish, and publish on its website, a
12 process through which an MCO may submit a written proposed
13 material change request for prior approval to the
14 Department.
15 (6) Prior to issuing a determination on any proposed
16 material change request, the Department shall:
17 (A) publish on its website a public notice that
18 includes a comprehensive description of the proposed
19 material change request;
20 (B) accept, consider, and provide responses to all
21 public comments submitted within 45 business days of
22 publication of the public notice; and
23 (C) review the proposed material change request
24 for compliance with federal and State laws,
25 regulations, and policies and the Department's
26 contract with the MCO.

1 (7) The Department shall issue a written determination
2 to deny or approve the proposed material change request
3 within 60 days of the close of the 45-day public notice
4 period. The Department's determination shall be made
5 readily accessible to the public on its website and shall
6 include a mechanism for providers to report MCO
7 noncompliance with the determination.
8 (8) A material change request that has been approved
9 by the Department shall take effect no earlier than 90
10 business days from the date the Department has made the
11 written determination of approval publicly available on
12 its website and the MCO has met the following criteria:
13 (A) offered providers and their employees, agents,
14 subcontractors, and others acting on their behalf
15 comprehensive training and education on the material
16 change; and
17 (B) notified providers of the material change, in
18 written and electronic form, at least 90 business days
19 prior to the effective date of the material change.
20 The notice shall be published on the MCO's public
21 website and shall include the following information:
22 (i) the effective date of the material change;
23 (ii) a comprehensive description of the
24 material change and references to any related
25 policies; and
26 (iii) contact information to discuss the

1 material change or to request individual
2 education.
3 (9) A provider retains the right to terminate, with
4 proper notification, its agreement with an MCO prior to
5 implementation of a material change approved by the
6 Department.
7 (10) Any provision of a provider agreement with an MCO
8 that violates this subsection shall be void, unlawful, and
9 unenforceable.
10 (11) The requirements of this subsection apply to and
11 must be described in any provider agreement with an MCO
12 issued, amended, or renewed on or after the effective date
13 of this amendatory Act of the 102nd General Assembly.
14 (h) The Department shall not expand mandatory MCO
15 enrollment into new counties beyond those counties already
16 designated by the Department as of June 1, 2014 for the
17 individuals whose eligibility for medical assistance is not
18 the seniors or people with disabilities population until the
19 Department provides an opportunity for accountable care
20 entities and MCOs to participate in such newly designated
21 counties.
22 (i) The requirements of this Section apply to contracts
23 with accountable care entities and MCOs entered into, amended,
24 or renewed after June 16, 2014 (the effective date of Public
25 Act 98-651).
26 (j) Health care information released to managed care

1 organizations. A health care provider shall release to a
2 Medicaid managed care organization, upon request, and subject
3 to the Health Insurance Portability and Accountability Act of
4 1996 and any other law applicable to the release of health
5 information, the health care information of the MCO's
6 enrollee, if the enrollee has completed and signed a general
7 release form that grants to the health care provider
8 permission to release the recipient's health care information
9 to the recipient's insurance carrier.
10 (Source: P.A. 100-201, eff. 8-18-17; 100-580, eff. 3-12-18;
11 100-587, eff. 6-4-18; 101-209, eff. 8-5-19.)

12 Section 99. Effective date. This Act takes effect upon
13 becoming law.