HB5669

100TH GENERAL ASSEMBLY

State of Illinois

2017 and 2018

HB5669

by Rep. Robert Martwick

SYNOPSIS AS INTRODUCED:

305 ILCS 5/5-30.1
305 ILCS 5/5-30.3

Amends the Medical Assistance Article of the Illinois Public Aid Code. Requires the Department of Healthcare and Family Services to report each managed care organization's operational performance concerning actual administrative costs incurred; the medical loss ratios for the previous 4 calendar years; all Medicaid provider payment data for all services; and the amount of denied claims. Requires each managed care entity to self-report the same information and publish it on a monthly basis on the managed care entity's website as soon as practical but no later than July 1, 2018. Requires the Department to: (i) regularly monitor the actual administrative costs incurred by Medicaid Managed Care Entities to ensure that the administrative costs do not exceed what is allowed by contract; (ii) annually calculate the medical loss ratios for the previous 4 calendar years, and beginning no later than July 1, 2018, annually determine whether the State should be reimbursed by the Medicaid Manage Care Entities due to overpayment; (iii) require all Medicaid Managed Care Entities to regularly submit all Medicaid provider payment data for all services; and other duties. Effective immediately.

LRB100 17191 KTG 35687 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 5-30.1 and 5-30.3 as follows:

6 (305 ILCS 5/5-30.1)
7 Sec. 5-30.1. Managed care protections.
8 (a) As used in this Section:
9 "Managed care organization" or "MCO" means any entity which
10 contracts with the Department to provide services where payment
11 for medical services is made on a capitated basis.
12 "Emergency services" include:
13 (1) emergency services, as defined by Section 10 of the
14 Managed Care Reform and Patient Rights Act;
15 (2) emergency medical screening examinations, as
16 defined by Section 10 of the Managed Care Reform and
17 Patient Rights Act;
18 (3) post-stabilization medical services, as defined by
19 Section 10 of the Managed Care Reform and Patient Rights
20 Act; and
21 (4) emergency medical conditions, as defined by
22 Section 10 of the Managed Care Reform and Patient Rights
23 Act.

1 (b) As provided by Section 5-16.12, managed care
2 organizations are subject to the provisions of the Managed Care
3 Reform and Patient Rights Act.

4 (c) An MCO shall pay any provider of emergency services
5 that does not have in effect a contract with the contracted
6 Medicaid MCO. The default rate of reimbursement shall be the
7 rate paid under Illinois Medicaid fee-for-service program
8 methodology, including all policy adjusters, including but not
9 limited to Medicaid High Volume Adjustments, Medicaid
10 Percentage Adjustments, Outpatient High Volume Adjustments,
11 and all outlier add-on adjustments to the extent such
12 adjustments are incorporated in the development of the
13 applicable MCO capitated rates.

14 (d) An MCO shall pay for all post-stabilization services as
15 a covered service in any of the following situations:

16 (1) the MCO authorized such services;

17 (2) such services were administered to maintain the
18 enrollee's stabilized condition within one hour after a
19 request to the MCO for authorization of further
20 post-stabilization services;

21 (3) the MCO did not respond to a request to authorize
22 such services within one hour;

23 (4) the MCO could not be contacted; or

24 (5) the MCO and the treating provider, if the treating
25 provider is a non-affiliated provider, could not reach an
26 agreement concerning the enrollee's care and an affiliated

1 provider was unavailable for a consultation, in which case
2 the MCO must pay for such services rendered by the treating
3 non-affiliated provider until an affiliated provider was
4 reached and either concurred with the treating
5 non-affiliated provider's plan of care or assumed
6 responsibility for the enrollee's care. Such payment shall
7 be made at the default rate of reimbursement paid under
8 Illinois Medicaid fee-for-service program methodology,
9 including all policy adjusters, including but not limited
10 to Medicaid High Volume Adjustments, Medicaid Percentage
11 Adjustments, Outpatient High Volume Adjustments and all
12 outlier add-on adjustments to the extent that such
13 adjustments are incorporated in the development of the
14 applicable MCO capitated rates.

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

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

19 (2) The MCO shall cover emergency services provided to
20 enrollees who are temporarily away from their residence and
21 outside the contracting area to the extent that the
22 enrollees would be entitled to the emergency services if
23 they still were within the contracting area.

24 (3) The MCO shall have no obligation to cover medical
25 services provided on an emergency basis that are not
26 covered services under the contract.

1 (4) The MCO shall not condition coverage for emergency
2 services on the treating provider notifying the MCO of the
3 enrollee's screening and treatment within 10 days after
4 presentation for emergency services.
5 (5) The determination of the attending emergency
6 physician, or the provider actually treating the enrollee,
7 of whether an enrollee is sufficiently stabilized for
8 discharge or transfer to another facility, shall be binding
9 on the MCO. The MCO shall cover emergency services for all
10 enrollees whether the emergency services are provided by an
11 affiliated or non-affiliated provider.
12 (6) The MCO's financial responsibility for
13 post-stabilization care services it has not pre-approved
14 ends when:
15 (A) a plan physician with privileges at the
16 treating hospital assumes responsibility for the
17 enrollee's care;
18 (B) a plan physician assumes responsibility for
19 the enrollee's care through transfer;
20 (C) a contracting entity representative and the
21 treating physician reach an agreement concerning the
22 enrollee's care; or
23 (D) the enrollee is discharged.
24 (f) Network adequacy and transparency.
25 (1) The Department shall:
26 (A) ensure that an adequate provider network is in

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

1 for any claims not timely paid.
2 (4) The Department may establish a process for MCOs to
3 expedite payments to providers based on criteria
4 established by the Department.
5 (g-5) Recognizing that the rapid transformation of the
6 Illinois Medicaid program may have unintended operational
7 challenges for both payers and providers:
8 (1) in no instance shall a medically necessary covered
9 service rendered in good faith, based upon eligibility
10 information documented by the provider, be denied coverage
11 or diminished in payment amount if the eligibility or
12 coverage information available at the time the service was
13 rendered is later found to be inaccurate; and
14 (2) the Department shall, by December 31, 2016, adopt
15 rules establishing policies that shall be included in the
16 Medicaid managed care policy and procedures manual
17 addressing payment resolutions in situations in which a
18 provider renders services based upon information obtained
19 after verifying a patient's eligibility and coverage plan
20 through either the Department's current enrollment system
21 or a system operated by the coverage plan identified by the
22 patient presenting for services:
23 (A) such medically necessary covered services
24 shall be considered rendered in good faith;
25 (B) such policies and procedures shall be
26 developed in consultation with industry

representatives of the Medicaid managed care health plans and representatives of provider associations representing the majority of providers within the identified provider industry; and

(C) such rules shall be published for a review and comment period of no less than 30 days on the Department's website with final rules remaining available on the Department's website.

(3) The rules on payment resolutions shall include, but not be limited to:

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

(C) guaranteed minimum payment rate of no less than the current, as of the date of service, fee-for-service rate, plus all applicable add-ons, when the resulting service relationship is out of network.

(4) The rules shall be applicable for both MCO coverage and fee-for-service coverage.

(g-6) MCO Performance Metrics Report.

(1) The Department shall publish, on at least a quarterly basis, each MCO's operational performance, including, but not limited to, the following categories of metrics:

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

1 (C) grievance and appeals;
2 (D) utilization statistics;
3 (E) provider disputes;
4 (F) provider credentialing; ~~and~~
5 (G) member and provider customer service; ~~.~~
6 (H) actual administrative costs incurred by the
7 MCO;
8 (I) the medical loss ratios for the previous 4
9 calendar years;
10 (J) all Medicaid provider payment data for all
11 services, including, but not limited to, alcohol and
12 substance abuse services, long-term care services, and
13 waiver services; and
14 (K) amount of denied claims.
15 (2) The Department shall ensure that the metrics report
16 is accessible to providers online by January 1, 2017.
17 (3) The metrics shall be developed in consultation with
18 industry representatives of the Medicaid managed care
19 health plans and representatives of associations
20 representing the majority of providers within the
21 identified industry.
22 (4) Metrics shall be defined and incorporated into the
23 applicable Managed Care Policy Manual issued by the
24 Department.
25 (h) The Department shall not expand mandatory MCO
26 enrollment into new counties beyond those counties already

1 designated by the Department as of June 1, 2014 for the
2 individuals whose eligibility for medical assistance is not the
3 seniors or people with disabilities population until the
4 Department provides an opportunity for accountable care
5 entities and MCOs to participate in such newly designated
6 counties.
7 (i) The requirements of this Section apply to contracts
8 with accountable care entities and MCOs entered into, amended,
9 or renewed after June 16, 2014 (the effective date of Public
10 Act 98-651).
11 (Source: P.A. 99-725, eff. 8-5-16; 99-751, eff. 8-5-16;
12 100-201, eff. 8-18-17.)

13 (305 ILCS 5/5-30.3)
14 Sec. 5-30.3. Empowering meaningful patient choice in
15 Medicaid Managed Care.
16 (a) Definitions. As used in this Section:
17 "Client enrollment services broker" means a vendor the
18 Department contracts with to carry out activities related to
19 Medicaid recipients' enrollment, disenrollment, and renewal
20 with Medicaid Managed Care Entities.
21 "Composite domains" means the synthesized categories
22 reflecting the standardized quality performance measures
23 included in the consumer quality comparison tool. At a minimum,
24 these composite domains shall display Medicaid Managed Care
25 Entities' individual Plan performance on standardized quality,

1 timeliness, and access measures.
2 "Consumer quality comparison tool" means an online and
3 paper tool developed by the Department with input from
4 interested stakeholders reflecting the performance of Medicaid
5 Managed Care Entity Plans on standardized quality performance
6 measures. This tool shall be designed in a consumer-friendly
7 and easily understandable format.
8 "Covered services" means those health care services to
9 which a covered person is entitled to under the terms of the
10 Medicaid Managed Care Entity Plan.
11 "Facilities" includes, but is not limited to, federally
12 qualified health centers, skilled nursing facilities, and
13 rehabilitation centers.
14 "Hospitals" includes, but is not limited to, acute care,
15 rehabilitation, children's, and cancer hospitals.
16 "Integrated provider directory" means a searchable
17 database bringing together network data from multiple Medicaid
18 Managed Care Entities that is available through client
19 enrollment services.
20 "Medicaid eligibility redetermination" means the process
21 by which the eligibility of a Medicaid recipient is reviewed by
22 the Department to determine if the recipient's medical benefits
23 will continue, be modified, or terminated.
24 "Medicaid Managed Care Entity" has the same meaning as
25 defined in Section 5-30.2 of this Code.
26 (b) Provider directory transparency.

1 (1) Each Medicaid Managed Care Entity shall:
2 (A) Make available on the entity's website a
3 provider directory in a machine readable file and
4 format.
5 (B) Make provider directories publicly accessible
6 without the necessity of providing a password, a
7 username, or personally identifiable information.
8 (C) Comply with all federal and State statutes and
9 regulations, including 42 CFR 438.10, pertaining to
10 provider directories within Medicaid Managed Care.
11 (D) Request, at least annually, provider office
12 hours for each of the following provider types:
13 (i) Health care professionals, including
14 dental and vision providers.
15 (ii) Hospitals.
16 (iii) Facilities, other than hospitals.
17 (iv) Pharmacies, other than hospitals.
18 (v) Durable medical equipment suppliers, other
19 than hospitals.
20 Medicaid Managed Care Entities shall publish the
21 provider office hours in the provider directory upon
22 receipt.
23 (E) Confirm with the Medicaid Managed Care
24 Entity's contracted providers who have not submitted
25 claims within the past 6 months that the contracted
26 providers intend to remain in the network and correct

1 any incorrect provider directory information as
2 necessary.
3 (F) Ensure that in situations in which a Medicaid
4 Managed Care Entity Plan enrollee receives covered
5 services from a non-participating provider due to a
6 material misrepresentation in a Medicaid Managed Care
7 Entity's online electronic provider directory, the
8 Medicaid Managed Care Entity Plan enrollee shall not be
9 held responsible for any costs resulting from that
10 material misrepresentation.
11 (G) Conspicuously display an e-mail address and a
12 toll-free telephone number to which any individual may
13 report any inaccuracy in the provider directory. If the
14 Medicaid Managed Care Entity receives a report from any
15 person who specifically identifies provider directory
16 information as inaccurate, the Medicaid Managed Care
17 Entity shall investigate the report and correct any
18 inaccurate information displayed in the electronic
19 directory.
20 (H) As soon as practical, but no later than July 1,
21 2018, make available on the entity's website a monthly
22 listing that includes, but is not limited to, the
23 following:
24 (i) actual administrative costs incurred;
25 (ii) medical loss ratios for the previous 4
26 calendar years;

1 (iii) all Medicaid provider payment data for
2 all services, including, but not limited to,
3 alcohol and substance abuse services, long-term
4 care services, and waiver services; and
5 (iv) amount of denied claims.
6 (2) The Department shall:
7 (A) Regularly monitor Medicaid Managed Care
8 Entities to ensure that they are compliant with the
9 requirements under paragraph (1) of subsection (b).
10 (B) Require that the client enrollment services
11 broker use the Medicaid provider number for all
12 providers with a Medicaid Provider number to populate
13 the provider information in the integrated provider
14 directory.
15 (C) Ensure that each Medicaid Managed Care Entity
16 shall, at minimum, make the information in
17 subparagraph (D) of paragraph (1) of subsection (b)
18 available to the client enrollment services broker.
19 (D) Ensure that the client enrollment services
20 broker shall, at minimum, have the information in
21 subparagraph (D) of paragraph (1) of subsection (b)
22 available and searchable through the integrated
23 provider directory on its website as soon as possible
24 but no later than January 1, 2017.
25 (E) Require the client enrollment services broker
26 to conspicuously display near the integrated provider

1 directory an email address and a toll-free telephone
2 number provided by the Department to which any
3 individual may report inaccuracies in the integrated
4 provider directory. If the Department receives a
5 report that identifies an inaccuracy in the integrated
6 provider directory, the Department shall provide the
7 information about the reported inaccuracy to the
8 appropriate Medicaid Managed Care Entity within 3
9 business days after the reported inaccuracy is
10 received.

11 (F) Regularly monitor the actual administrative
12 costs incurred by Medicaid Managed Care Entities to
13 ensure that the administrative costs do not exceed what
14 is allowed by contract.

15 (G) Annually calculate the medical loss ratios for
16 the previous 4 calendar years, and beginning no later
17 than July 1, 2018, annually determine whether the State
18 should be reimbursed by the Medicaid Managed Care
19 Entities due to overpayment.

20 (H) Require all Medicaid Managed Care Entities to
21 regularly submit all Medicaid provider payment data
22 for all services, including, but not limited to,
23 alcohol and substance abuse services, long-term care
24 services, and waiver services. The Department shall
25 perform on-site reviews of the Medicaid Managed Care
26 Entities' financial data systems and test the

1 completeness and accuracy of the data reported to the
2 Department by the Medicaid Managed Care Entities that
3 is used to monitor the payments made to Medicaid
4 providers.
5 (I) Provide clear guidance to Medicaid Managed
6 Care Entities on reporting denied claims and ensure
7 that Medicaid Managed Care Entities provide the denied
8 claims to the Department as required by contract.
9 (J) Ensure multiple monthly capitation payments
10 are not being made for the same Medicaid recipients,
11 immediately identify and remove all duplicative
12 recipients from its eligibility data, and recoup any
13 overpayment of duplicate capitation payments.
14 (K) Ensure that the Department effectively
15 monitors the newly awarded Medicaid Managed Care
16 Entity contracts to ensure compliance with all
17 contractual provisions.
18 (c) Formulary transparency.
19 (1) Medicaid Managed Care Entities shall publish on
20 their respective websites a formulary for each Medicaid
21 Managed Care Entity Plan offered and make the formularies
22 easily understandable and publicly accessible without the
23 necessity of providing a password, a username, or
24 personally identifiable information.
25 (2) Medicaid Managed Care Entities shall provide
26 printed formularies upon request.

1 (3) Electronic and print formularies shall display:
2 (A) the medications covered (both generic and name
3 brand);
4 (B) if the medication is preferred or not
5 preferred, and what each term means;
6 (C) what tier each medication is in and the meaning
7 of each tier;
8 (D) any utilization controls including, but not
9 limited to, step therapy, prior approval, dosage
10 limits, gender or age restrictions, quantity limits,
11 or other policies that affect access to medications;
12 (E) any required cost-sharing;
13 (F) a glossary of key terms and explanation of
14 utilization controls and cost-sharing requirements;
15 (G) a key or legend for all utilization controls
16 visible on every page in which specific medication
17 coverage information is displayed; and
18 (H) directions explaining the process or processes
19 a consumer may follow to obtain more information if a
20 medication the consumer requires is not covered or
21 listed in the formulary.
22 (4) Each Medicaid Managed Care Entity shall display
23 conspicuously with each electronic and printed medication
24 formulary an e-mail address and a toll-free telephone
25 number to which any individual may report any inaccuracy in
26 the formulary. If the Medicaid Managed Care Entity receives

1 a report that the formulary information is inaccurate, the
2 Medicaid Managed Care Entity shall investigate the report
3 and correct any inaccurate information displayed in the
4 electronic formulary.
5 (5) Each Medicaid Managed Care Entity shall include a
6 disclosure in the electronic and requested print
7 formularies that provides the date of publication, a
8 statement that the formulary is up to date as of
9 publication, and contact information for questions and
10 requests to receive updated information.
11 (6) The client enrollment services broker's website
12 shall display prominently a website URL link to each
13 Medicaid Managed Care Entity's Plan formulary. If a
14 Medicaid enrollee calls the client enrollment services
15 broker with questions regarding formularies, the client
16 enrollment services broker shall offer a brief description
17 of what a formulary is and shall refer the Medicaid
18 enrollee to the appropriate Medicaid Managed Care Entity
19 regarding his or her questions about a specific entity's
20 formulary.
21 (d) Grievances and appeals. The Department shall display
22 prominently on its website consumer-oriented information
23 describing how a Medicaid enrollee can file a complaint or
24 grievance, request a fair hearing for any adverse action taken
25 by the Department or a Medicaid Managed Care Entity, and access
26 free legal assistance or other assistance made available by the

1 State for Medicaid enrollees to pursue an action.
2 (e) Medicaid redetermination information. The Department
3 shall require the client enrollment services broker to display
4 prominently on the client enrollment services broker's website
5 a description of where a Medicaid enrollee can access
6 information regarding the Medicaid redetermination process.
7 (f) Medicaid care coordination information. The client
8 enrollment services broker shall display prominently on its
9 website, in an easily understandable format, consumer-oriented
10 information regarding the role of care coordination services
11 within Medicaid Managed Care. Such information shall include,
12 but shall not be limited to:
13 (1) a basic description of the role of care
14 coordination services and examples of specific care
15 coordination activities; and
16 (2) how a Medicaid enrollee may request care
17 coordination services from a Medicaid Managed Care Entity.
18 (g) Consumer quality comparison tool.
19 (1) The Department shall create a consumer quality
20 comparison tool to assist Medicaid enrollees with Medicaid
21 Managed Care Entity Plan selection. This tool shall provide
22 Medicaid Managed Care Entities' individual Plan
23 performance on a set of standardized quality performance
24 measures. The Department shall ensure that this tool shall
25 be accessible in both a print and online format, with the
26 online format allowing for individuals to access

1 additional detailed Plan performance information.
2 (2) At a minimum, a printed version of the consumer
3 quality comparison tool shall be provided by the Department
4 on an annual basis to Medicaid enrollees who are required
5 by the Department to enroll in a Medicaid Managed Care
6 Entity Plan during an enrollee's open enrollment period.
7 The consumer quality comparison tool shall also meet all of
8 the following criteria:
9 (A) Display Medicaid Managed Care Entities'
10 individual Plan performance on at least 4 composite
11 domains that reflect Plan quality, timeliness, and
12 access. The composite domains shall draw from the most
13 current available performance data sets including, but
14 not limited to:
15 (i) Healthcare Effectiveness Data and
16 Information Set (HEDIS) measures.
17 (ii) Core Set of Children's Health Care
18 Quality measures as required under the Children's
19 Health Insurance Program Reauthorization Act
20 (CHIPRA).
21 (iii) Adult Core Set measures.
22 (iv) Consumer Assessment of Healthcare
23 Providers and Systems (CAHPS) survey results.
24 (v) Additional performance measures the
25 Department deems appropriate to populate the
26 composite domains.

1 (B) Use a quality rating system developed by the
2 Department to reflect Medicaid Managed Care Entities'
3 individual Plan performance. The quality rating system
4 for each composite domain shall reflect the Medicaid
5 Managed Care Entities' individual Plan performance
6 and, when possible, plan performance relative to
7 national Medicaid percentiles.
8 (C) Be customized to reflect the specific Medicaid
9 Managed Care Entities' Plans available to the Medicaid
10 enrollee based on his or her geographic location and
11 Medicaid eligibility category.
12 (D) Include contact information for the client
13 enrollment services broker and contact information for
14 Medicaid Managed Care Entities available to the
15 Medicaid enrollee based on his or her geographic
16 location and Medicaid eligibility category.
17 (E) Include guiding questions designed to assist
18 individuals selecting a Medicaid Managed Care Entity
19 Plan.
20 (3) At a minimum, the online version of the consumer
21 quality comparison tool shall meet all of the following
22 criteria:
23 (A) Display Medicaid Managed Care Entities'
24 individual Plan performance for the same composite
25 domains selected by the Department in the printed
26 version of the consumer quality comparison tool. The

1 Department may display additional composite domains in
2 the online version of the consumer quality comparison
3 tool as appropriate.
4 (B) Display Medicaid Managed Care Entities'
5 individual Plan performance on each of the
6 standardized performance measures that contribute to
7 each composite domain displayed on the online version
8 of the consumer quality comparison tool.
9 (C) Use a quality rating system developed by the
10 Department to reflect Medicaid Managed Care Entities'
11 individual Plan performance. The quality rating system
12 for each composite domain shall reflect the Medicaid
13 Managed Care Entities' individual Plan performance
14 and, when possible, plan performance relative to
15 national Medicaid percentiles.
16 (D) Include the specific Medicaid Managed Care
17 Entity Plans available to the Medicaid enrollee based
18 on his or her geographic location and Medicaid
19 eligibility category.
20 (E) Include a sort function to view Medicaid
21 Managed Care Entities' individual Plan performance by
22 quality rating and by standardized quality performance
23 measures.
24 (F) Include contact information for the client
25 enrollment services broker and for each Medicaid
26 Managed Care Entity.

1 (G) Include guiding questions designed to assist
2 individuals in selecting a Medicaid Managed Care
3 Entity Plan.
4 (H) Prominently display current notice of quality
5 performance sanctions against Medicaid Managed Care
6 Entities. Notice of the sanctions shall remain present
7 on the online version of the consumer quality
8 comparison tool until the sanctions are lifted.
9 (4) The online version of the consumer quality
10 comparison tool shall be displayed prominently on the
11 client enrollment services broker's website.
12 (5) In the development of the consumer quality
13 comparison tool, the Department shall establish and
14 publicize a formal process to collect and consider written
15 and oral feedback from consumers, advocates, and
16 stakeholders on aspects of the consumer quality comparison
17 tool, including, but not limited to, the following:
18 (A) The standardized data sets and surveys,
19 specific performance measures, and composite domains
20 represented in the consumer quality comparison tool.
21 (B) The format and presentation of the consumer
22 quality comparison tool.
23 (C) The methods undertaken by the Department to
24 notify Medicaid enrollees of the availability of the
25 consumer quality comparison tool.
26 (6) The Department shall review and update as

appropriate the composite domains and performance measures represented in the print and online versions of the consumer quality comparison tool at least once every 3 years. During the Department's review process, the Department shall solicit engagement in the public feedback process described in paragraph (5).

(7) The Department shall ensure that the consumer quality comparison tool is available for consumer use as soon as possible but no later than January 1, 2018.

(h) The Department may adopt rules and take any other appropriate action necessary to implement its responsibilities under this Section.

(Source: P.A. 99-725, eff. 8-5-16; 100-201, eff. 8-18-17.)

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