TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS
PART 143 MANAGED CARE COMMUNITY NETWORKS
SECTION 143.300 GENERAL PROVISIONS

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a) The Department shall enter into contracts with MCCNs for the provision of medical care to eligible enrollees in accordance with Section 5-11 of the Illinois Public Aid Code [305 ILCS 5/5-11].

b) The Department may limit the number of MCCNs with which it contracts and may specify a maximum enrollment capacity per MCCN.

c) Covered services to be provided or arranged by an MCCN shall be established in each MCCN's contract.

d) The Department shall include, in every contract with an MCCN, language describing the sanctions that the Department may impose upon the MCCN for failure to comply with this Part or the terms and conditions of that contract.

1) The contract shall provide for sanctions including, but not limited to, one or more of the following:

A) Monetary sanctions established and assessed by the Department against the MCCN;

B) Freezing enrollment for a period to be determined by the Department;

C) Liquidated damages;

D) Disenrollment of enrollees;

E) Withholding all payments or any portion thereof due the MCCN; and

F) Any other sanctions that are deemed appropriate by the Department.

2) In addition to any sanctions, the Department shall have the right to terminate the contract with or without cause.

e) To be certified as an MCCN by the Department, an MCCN must meet each of the following requirements:

1) An MCCN must execute a written contract with the Department.

2) An MCCN must meet each of the requirements as set forth in the applicable federal and State statutes, regulations, rules, this Part and as defined in the contract.

3) An MCCN must maintain procedures for enrollee complaints as established in contract with the Department. Such procedures shall, at a minimum, meet the standards set forth in the Health Maintenance Organization Act [215 ILCS 125] and applicable rules, applicable federal law and as described in the contract. Those requirements shall include, but are not limited to, requirements that MCCNs maintain:

A) Procedures for registering and responding to complaints and grievances in a specified time;

B) Procedures for recording the substance of the complaints;

C) A method for monitoring complaints against providers, and coordinating this function with established grievance procedures; and

D) A method for tracking minor but regular complaints about specific providers that may be indicative of problems.

4) An MCCN must maintain a quality assurance and utilization review program. Such procedures shall, at a minimum, meet the standards set forth in the Health Maintenance Organization Act [215 ILCS 125], applicable federal law and as described in the contract. Requirements shall include, but are not limited to:

A) The establishment of a quality assurance plan that satisfies any and all applicable State and federal statutory, regulatory, administrative, and policy requirements that address quality of care oversight in managed care;

B) Utilization and quality assurance monitoring and reporting;

C) The establishment of a peer review committee that is responsible for reviewing medical care provided, including issues involving conflicts of interest, and making recommendations for changes when problems are identified; and

D) Other quality assurance requirements that are established by the Department.

f) The rates to be paid to MCCNs shall be established by the Department.

g) If the MCCN's enrollment exceeds the maximum enrollment capacity set forth in the contract or its monthly total capitation amount to be paid exceeds $10,000,000, the Department may limit further enrollment until the enrollment no longer exceeds the maximum enrollment capacity set for in the contract and the monthly total capitation amount does not exceed $10,000,000. If the MCCN receives a certificate of authority to operate a health maintenance organization (HMO) from the Department of Insurance, then the Department may open enrollment to a level commensurate with the HMO's ability to serve the enrollees.