**Section 140.1010 Mandatory Enrollment in MCOs**

a) To the extent allowed by federal law and regulations, the Department may require individuals to enroll with a Managed Care Organization (MCO) under contract with the Department and to receive some or all of their medical benefits through that MCO.

b) HFS shall send a notice to each individual for whom enrollment in a MCO is mandatory, notifying the individual of the need to enroll with an MCO and explaining the options for doing so. If the individual has not chosen an MCO within 30 days after the date of the first notice, the Department shall send a second notice to the individual that the Department will assign him or her to an MCO if he or she does not choose one.

c) Individuals who have not chosen an MCO within 60 days after the date of their first notice shall be assigned to an MCO by HFS. The algorithm used in the default enrollment process shall be in compliance with 42 CFR 438.50. The individuals will be mailed a notice to inform them of their assigned MCO. Assignment to an MCO shall be effective no sooner than 60 days after the date that the first notice is mailed by the Department. An individual and the MCO with whom that individual is enrolled will receive notice of the enrollment.

d) Individuals may change MCOs within the first 90 days after the effective date of their enrollment. An individual who changes enrollment within the first 90 days may change MCO again within 90 days after enrollment in the second MCO. After the first 90 days or, in the case of an individual who changed twice, after the second enrollment, an individual may not change his or her enrollment until the end of the 12-month period following enrollment in the current plan.

e) If an individual enrolled in an MCO loses Medical Assistance eligibility and his or her Medical Assistance eligibility is reinstated within 60 days, that individual will be enrolled with the MCO with which he or she was enrolled when Medical Assistance eligibility terminated.

f) In circumstances in which an individual does not have a choice of MCO, the procedures outlined in subsections (b) through (e) shall be followed for choosing a primary care provider.

g) For purposes of this Section, Managed Care Organization includes any entity with a contract for a Care Coordination Program pursuant to Section 5-30 of the Public Aid Code [305 ILCS 5/5-30], Section 23 of the Children's Health Insurance Program Act [215 ILCS 106/23] or Section 56 of the Covering All Kids Health Insurance Act [215 ILCS 170/56]. Any contract subject to this Section shall have outcome measures, enrollee protections to assure quality and access, and financial accountability for the contractor based on quality measures.

(Source: Added at 35 Ill. Reg. 7648, effective May 1, 2011)