# HB3189

LRB09808448KTG38555b

## 98TH GENERAL ASSEMBLY

## State of Illinois

## 2013 and 2014

### HB3189

by Rep. Patricia R. Bellock

## SYNOPSIS AS INTRODUCED:

New Act

Creates the Patient-Centered Medicaid Reform Act. Provides that the Medicaid Managed Care Program is established as a statewide, integrated managed care program for all covered services, including long-term care services. Requires the Department of Healthcare and Family Services to apply for and implement appropriate amendments to the Illinois Title XIX State Plan and waivers of applicable federal laws and regulations necessary to implement the program and that before submitting the waiver or State Plan amendment, the Department shall provide public notice and the opportunity for public comment and shall include public feedback to the U.S. Department of Health and Human Services. Provides that services provided under the Medicaid Managed Care Program shall be provided by managed care plans that are capable of coordinating or delivering all covered services to enrollees. Requires the Department to select managed care plans to participate in the Medicaid Managed Care Program using invitations to negotiate. Contains provisions concerning the quality factor the Department must consider when selecting manage care plans; plan accountability; managed care payments; enrollment, choice counseling, and opt-out standards; mandatory, exempt, and voluntary populations standards; services covered by the managed plans; the implementation of a Medicaid Long-Term Care Managed Care Program; eligibility criteria for the Medicaid Long-Term Care Managed Care Program; and other matters. Effective immediately.

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FISCAL NOTE ACT
MAY APPLY

A BILL FOR

AN ACT concerning public aid.

**Be it enacted by the People of the State of Illinois, represented in the General Assembly:**

Section 1. Short title. This Act may be cited as the Patient-Centered Medicaid Reform Act.

Section 5. Definitions. As used in this Act:

(a) "Department" means the Department of Healthcare and Family Services or any State department which may administer in the future the Medicaid Managed Care Program established under this Act.

(b) "Managed care plan" means a health insurer, a specialty plan, a health maintenance organization authorized under the Illinois Insurance Code, or a Medicaid-authorized provider service network under contract with the Department to provide services to clients eligible for medical assistance under the State's Medical Assistance Program established under Article V of the Illinois Public Aid Code.

(c) "Medicaid" means the medical assistance program authorized by Title XIX of the Social Security Act, and regulations thereunder, as administered in this State by the Department of Healthcare and Family Services.

(d) "Medicaid recipient" or "recipient" means an individual who receives medical assistance as provided under

Article V of the Illinois Public Aid Code.

(e) "Prepaid plan" means a managed care plan that is licensed or certified as a risk-bearing entity or is an approved provider service network, and is paid a prospective per-member, per-month payment by the Department.

(f) "Provider service network" means a Department-approved entity, a controlling interest of which is owned by a health care provider, or by a group of affiliated providers, or by a public agency or entity that delivers health services. Health care providers include State-licensed health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies.

(g) "Specialty plan" means a managed care plan that serves Medicaid recipients who meet specified criteria based on age, medical condition, or diagnosis.

(h) "Comprehensive long-term care plan" means a managed care plan, provider-sponsored organization, health maintenance organization, or coordinated care plan that provides long-term care services as outlined in this Act.

(i) "Long-term care plan" means a managed care plan that provides the services described in Section 60 of this Act for the Medicaid Long-Term Care Managed Care Program established under this Act.

(j) "Long-term care provider service network" means a provider service network, a controlling interest of which is owned by one or more licensed nursing homes, assisted living

facilities with 17 or more beds, home health agencies, community care for the elderly lead agencies, or hospices.

Section 10. Authorization for Medicaid waiver or amendment to the Medicaid State Plan. The Medicaid Managed Care Program is established as a statewide, integrated managed care program for all covered services, including long-term care services. The Department shall apply for and implement appropriate amendments to the Illinois Title XIX State Plan and waivers of applicable federal laws and regulations necessary to implement the program. Before submitting the waiver or State Plan amendment, the Department shall provide public notice and the opportunity for public comment and shall include public feedback to the U.S. Department of Health and Human Services.

Section 15. Criteria for managed care plans.

(a) Services provided under the Medicaid Managed Care Program shall be provided by managed care plans that are capable of coordinating or delivering all covered services to enrollees.

(b) The Department shall select managed care plans to participate in the Medicaid Managed Care Program using invitations to negotiate. The procurement method must give the State the most flexibility and broadest power to negotiate value and must provide potential bidders the most room to innovate. Separate and simultaneous procurements shall be

conducted in regions to be determined by the Department.

(c) The Department shall consider quality factors in the selection of managed care plans, including all of the following:

(1) Accreditation by a nationally recognized accrediting body.

(2) Documentation of policies and procedures for preventing fraud and abuse.

(3) Experience serving and achieving quality standards for similar populations.

(4) The availability or accessibility of primary and specialty care physicians in the network.

(5) The provision of additional benefits, particularly dental care and disease management, and other initiatives that improve health outcomes.

(d) After negotiations are conducted, the Department shall select the managed care plans that are determined to be responsive and provide the best value to the State. Preference shall be given to plans that have signed contracts with primary and specialty physicians in sufficient numbers to meet the specific standards established pursuant to this Act.

(e) To ensure managed care plan participation in all regions, the Department shall award an additional contract in a more populous region to each plan with a contract award in a more rural region. If a plan terminates its contract in a more rural region, the additional contract in the more populous

region shall be automatically terminated within 180 days. The plan must also reimburse the Department for the cost of enrollment changes and other transition activities.

(f) The Department may not execute contracts with managed care plans at payment rates not supported by appropriations made to the Department for these purposes.

Section 20. Selection of managed care plans.

(a) The Department shall select managed care plans through the procurement process described in this Act. The Department shall notice invitations to negotiate no later than June 30, 2014. The Department shall procure at least 3 plans and no more than 11 plans for each region. At least one plan in each region must be a provider service network.

(b) Participation by specialty plans shall be subject to the procurement requirements in this Act. The enrollment of a specialty plan in a region may not exceed 10% of the total number of enrollees of that region. However, a specialty plan whose target population includes no more than 10% of the enrollees of that region shall not be subject to the regional plan number limits under this Section.

(c) Participation by a Medicare Advantage Preferred Provider Organization, a Medicare Advantage Provider-Sponsored Organization, a Medicare Advantage Health Maintenance Organization, a Medicare Advantage Coordinated Care Plan, or a Medicare Advantage Special Needs Plan shall not be subject to

the procurement requirements under this Section if the plan's Medicaid enrollees consist exclusively of dually eligible recipients who are enrolled in the plan in order to receive Medicare benefits.

Section 25. Plan accountability.

(a) The Department shall establish a 5-year contract with each managed care plan selected through the procurement process described in this Act. A plan contract may not be renewed. However, the Department may extend the term of a plan contract to cover any delays during the transition to a new plan.

(b) The Department shall establish such contract requirements as are necessary for the operation of the statewide Medicaid Managed Care Program. In addition to any other provisions the Department may deem necessary, the contract must require all of the following:

(1) Physician compensation: Managed care plans are expected to coordinate care, manage chronic disease, and prevent the need for more costly services. Effective care management should enable plans to redirect available resources and increase compensation for physicians.

(2) Hospital compensation: Managed care plans and hospitals shall negotiate mutually acceptable rates, methods, and terms of payment. Payment rates may be updated periodically.

(3) Access:

(A) The Department shall establish specific, population-based standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Consistent with standards established by the Department, provider networks may include providers located outside the region. Plans may limit the providers in their networks based on credentials, quality indicators, and price.

(B) Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, or specialty credentials and other certifications. The database must be available online to both the Department and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients.

(C) Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to

health care providers, including posting appropriate contact information on its website and providing timely responses to providers.

(4) Encounter data: The Department shall maintain and operate a Medicaid encounter data system to collect, process, store, and report on covered services provided to all Medicaid recipients enrolled in prepaid plans. The Department shall make encounter data available to those plans accepting enrollees who are assigned to them from other plans leaving a region.

(5) Continuous improvement: The Department shall establish specific performance standards and expected milestones or timelines for improving performance over the term of the contract.

(A) Each managed care plan shall establish an internal health care quality improvement system, including enrollee satisfaction and disenrollment surveys. The quality improvement system must include incentives and disincentives for network providers.

(B) Each plan must collect and report Health Plan Employer Data and Information Set (HEDIS) measures, as specified by the Department. These measures must be published on the plan's website in a manner that allows recipients to reliably compare the performance of plans. The Department shall use the HEDIS measures as a tool to monitor plan performance.

(C) Each managed care plan must be accredited by the National Committee for Quality Assurance, the Joint Commission, or another nationally recognized accrediting body, or have initiated the accreditation process, within one year after the contract is executed.

(6) Program integrity: Each managed care plan shall establish program integrity functions and activities to reduce the incidence of fraud and abuse, including, at a minimum, all of the following:

(A) A provider credentialing system and ongoing provider monitoring.

(B) Procedures for reporting instances of fraud and abuse.

(C) Designation of a program integrity compliance officer.

(7) Grievance resolution: Consistent with federal law, each managed care plan shall establish and the Department shall approve an internal process for reviewing and responding to grievances from enrollees. Each plan shall submit quarterly reports on the number, description, and outcome of grievances filed by enrollees.

(8) Penalties: Managed care plans shall incur penalties for withdrawal and enrollment reductions; failure to comply with encounter data reporting requirements; or termination of a regional contract due to

noncompliance.

(9) Prompt payment: Managed care plans shall comply with the prompt payment requirements of the Illinois Insurance Code.

(10) Electronic claims: Managed care plans, and their fiscal agents or intermediaries, shall accept electronic claims in compliance with federal standards.

(11) Itemized payment: Any claims payment to a provider by a managed care plan or by a fiscal agent or intermediary of the plan must be accompanied by an itemized accounting of the individual claims included in the payment, including, but not limited to, the enrollee's name, the date of service, the procedure code, the amount of reimbursement, and the identification of the plan on whose behalf the payment is made.

(c) The Department shall be responsible for verifying the achieved savings rebate for all Medicaid prepaid plans. The achieved savings rebate shall be established by determining pretax income as a percentage of revenues and applying the following income-sharing ratios:

(1) 100% of income, up to and including 5% of revenue, shall be retained by the plan.

(2) 50% of income above 5% and up to and including 10% of revenue shall be retained by the plan, and the other 50% refunded to the State.

(3) 100% of income above 10% of revenue shall be

refunded to the State.

(d) Each managed care plan must accept any medically needy recipient eligible for medical assistance under paragraph 2 of Section 5-2 of the Illinois Public Aid Code who selects or is assigned to the plan and must provide that medically needy recipient with continuous enrollment for 12 months. After the first month of qualifying as a medically needy recipient and enrolling in a plan, and contingent upon federal approval, the medically needy recipient shall pay the plan a portion of the monthly premium equal to the medically needy recipient's share of the cost as determined by the Department. The Department shall pay any remaining portion of the monthly premium. A plan is not obligated to pay claims for medically needy recipients for services provided before enrollment in the plan. Medically needy recipients are responsible for payment of incurred claims that are used to determine eligibility. A plan must provide a grace period of at least 90 days before disenrolling medically needy recipients who fail to pay their shares of the premium.

Section 30. Managed care payments.

(a) Prepaid plans shall receive per-member, per-month payments negotiated pursuant to the procurements described in this Act. Payments shall be risk-adjusted rates based on historical utilization and spending data, and shall be projected forward and adjusted to reflect the eligibility category, geographic area, and clinical risk profile of the

recipients. In negotiating rates with the plans, the Department shall consider any adjustments necessary to encourage plans to use the most cost-effective modalities for treatment of chronic disease.

(b) Provider service networks may be prepaid plans and receive per-member, per-month payments. The fee-for-service option shall be available to a provider service network only for the first 2 years of its operation.

(c) The Department may not approve any plan request for a rate increase unless sufficient funds to support the increase have been authorized by appropriations made to the Department for the purposes of this Act.

Section 35. Enrollment, choice counseling, and opt-out.

(a) All Medicaid recipients shall be enrolled in a managed care plan unless specifically exempted under this Act. Each recipient shall have a choice of plans and may select any available plan unless that plan is restricted by contract to a specific population that does not include the recipient. Recipients shall have 30 days in which to make a choice of plans.

(b) The Department shall implement a choice counseling system to ensure that recipients have timely access to accurate information on the available plans. The counseling system shall include plan-to-plan comparative information on benefits, provider networks, drug formularies, quality measures, and

other data points as determined by the Department. Choice counseling must be made available through face-to-face interaction, through the Internet, by telephone, in writing, and through other forms of relevant media. Materials must be provided in a culturally relevant manner, consistent with federal requirements. The Department shall contract for any or all choice counseling functions.

(c) After a recipient has enrolled in a managed care plan, the recipient shall have 90 days to voluntarily disenroll and select another plan. After 90 days, no further changes may be made except for good cause.

(d) The Department shall automatically enroll into a managed care plan those Medicaid recipients who do not voluntarily choose a plan. Except as otherwise outlined in this Act, the Department may not engage in practices that are designed to favor one managed care plan over another.

(1) The Department shall automatically enroll recipients in plans that meet or exceed the performance or quality standards established in this Act, and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards.

(2) If a specialty plan is available to accommodate a specific condition or diagnosis of a recipient, the Department shall assign the recipient to that plan.

(3) In the first year of the first contract term only, if a recipient was previously enrolled in a plan that is

still available in the region, the Department shall automatically enroll the recipient in that plan unless an applicable specialty plan is available.

(4) A newborn of a mother enrolled in a plan at the time of the child's birth shall be enrolled in the mother's plan. Upon birth, such a newborn is deemed enrolled in the managed care plan, regardless of the administrative enrollment procedures, and the managed care plan is responsible for providing services to the newborn. The mother may choose another plan for the newborn within 90 days after the child's birth.

(5) Otherwise, the Department shall automatically enroll recipients based on the following criteria:

(A) Whether the plan has sufficient network capacity to meet the needs of the recipient.

(B) Whether the recipient has previously received services from one of the plan's primary care providers.

(C) Whether primary care providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

(e) A recipient with access to private health care coverage shall opt out of all managed care plans and use Medicaid financial assistance to pay for his or her share of the cost in such coverage. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for

that recipient. The Department shall seek federal approval to require Medicaid recipients with access to employer-sponsored health care coverage to enroll in that coverage and use Medicaid financial assistance to pay for the recipient's share of the cost for such coverage. The amount of financial assistance provided for each recipient may not exceed the amount of the Medicaid premium that would have been paid to a managed care plan for that recipient.

Section 40. Mandatory, exempt, and voluntary populations.

(a) All Medicaid recipients shall receive covered services through the Medicaid Managed Care Program. The following Medicaid recipients are exempt from participation in the Medicaid Managed Care program:

(1) Recipients who are eligible for both Medicaid and Medicare and who reside in a facility licensed under the Nursing Home Care Act.

(2) Medicaid recipients residing in a facility licensed under the ID/DD Community Care Act.

(3) Medicaid recipients enrolled in a home and community-based waiver services program administered by the Department of Healthcare and Family Services.

(4) SSI-eligible or other children with special needs.

(5) Children in foster care or subsidized adoption.

(6) Populations who receive only limited services, including women eligible only for family planning services

and women who are eligible only for breast and cervical cancer services.

(b) The following persons eligible for Medicaid are exempt from mandatory managed care enrollment required by this Act, and may voluntarily choose to participate in the managed medical assistance program:

(1) Recipients who are eligible for both Medicaid and Medicare.

(2) Medicaid recipients residing in residential commitment facilities operated by the Department of Juvenile Justice or residing in State-owned or State-operated residential mental health treatment facilities.

(3) Persons eligible for refugee assistance.

(4) Medicaid recipients who are residents of a State developmental disability center.

(5) Medicaid recipients enrolled in the State's Home and Community-Based Services Waiver Program for persons with disabilities.

(c) Medically needy recipients eligible for medical assistance under paragraph 2 of Section 5-2 of the Illinois Public Aid Code shall enroll in managed care plans. Such recipients shall meet their share of the cost by paying the plan premium, up to the share of the cost amount.

Section 45. Benefits.

(a) Managed care plans shall cover, at a minimum, those mandatory and optional services provided under the State's medical assistance program pursuant to Article V of the Illinois Public Aid Code.

(b) Managed care plans may customize benefit packages for non-pregnant adults, vary cost-sharing provisions, and provide coverage for additional services. The Department shall evaluate the proposed benefit packages to ensure that services are sufficient to meet the needs of the plan's enrollees and to verify actuarial equivalence.

(c) Each plan operating in the Medicaid Managed Care Program shall establish a program to encourage and reward healthy behaviors. At a minimum, each plan must establish a medically approved smoking cessation program, a medically directed weight loss program, and a medically approved alcohol or substance abuse recovery program. Each plan must identify enrollees who smoke, who are morbidly obese, or who are diagnosed with alcohol or substance abuse in order to establish written agreements to secure the enrollees' commitment to participation in these programs.

Section 50. Medicaid Long-Term Care Managed Care Program.

(a) The Department shall make payments for long-term care home and community-based and residential services, and for primary and acute medical assistance and related services for recipients eligible for long-term care, using a managed care

model. By June 30, 2014, the Department shall begin implementation of the Medicaid Long-Term Care Managed Care Program, with full implementation in all regions by June 30, 2015.

(b) The Department on Aging shall: (i) assist the Department in developing specifications for the invitation to negotiate and the model contract; (ii) determine clinical eligibility for enrollment in managed long-term care plans; (iii) monitor plan performance and measure quality of service delivery; (iv) assist clients and families to address complaints with the plans; (v) facilitate working relationships between plans and providers serving elders and disabled adults; and (vi) perform other functions specified in a memorandum of agreement.

Section 55. Eligibility criteria for the Medicaid Long-Term Care Managed Care Program.

(a) Medicaid recipients who meet all of the following criteria are eligible to receive long-term care services and must receive long-term care services by participating in the Medicaid Long-Term Care Managed Care Program. The recipient must be:

(1) 65 years of age or older, or age 18 or older and eligible for Medicaid by reason of a disability; or

(2) determined to require nursing facility care.

(b) Medicaid recipients who, on the date long-term care

managed care plans become available in their region, reside in a facility licensed under the Nursing Home Care Act or the ID/DD Community Care Act or who are enrolled in an existing State long-term care Medicaid waiver program are eligible to participate in the Medicaid Long-Term Care Managed Care Program for up to 12 months without being reevaluated for their need for nursing facility care.

(c) The Department shall make offers for enrollment to eligible individuals based on a wait-list prioritization and subject to the availability of funds. Before enrollment offers, the Department shall determine that sufficient funds exist to support additional enrollment into plans.

Section 60. Long-Term Care Plan Benefits. Long-term care managed care plans shall, at a minimum, cover those mandatory and optional services provided under the State's medical assistance program pursuant to Article V of the Illinois Public Aid Code.

Section 65. Selection of long-term care managed care plans.

(a) Provider service networks must be long-term care provider service networks. Other eligible plans may be long-term care plans or comprehensive long-term care plans.

(b) The Department shall select managed care plans through the procurement process described in this Act. The Department shall notice invitations to negotiate no later than June 30,

2014. The Department shall procure at least 3 plans and no more than 11 plans for each region. At least one plan in each region must be a provider service network.

(c) In addition to the criteria established in this Act, the Department shall consider all of the following factors in the selection of long-term care managed care plans:

(1) Evidence of the employment of executive managers with expertise and experience in serving aged and disabled persons who require long-term care.

(2) Whether a plan has established a network of service providers dispersed throughout the region and in sufficient numbers to meet specific service standards established by the Department for specialty services for persons receiving home and community-based care.

(3) Whether a plan is proposing to establish a comprehensive long-term care plan and whether the plan has a contract to provide managed medical assistance services in the same region.

(4) Whether a plan offers consumer-directed care services to enrollees.

(5) Whether a plan is proposing to provide home and community-based services in addition to the minimum benefits required by this Act.

(d) Participation by a Medicare Advantage Special Needs Plan is not subject to the procurement requirements if the plan's Medicaid enrollees consist exclusively of recipients

eligible for both Medicaid and Medicare services who are enrolled in the plan in order to receive Medicare services.

Section 70. Long-term care managed care plan accountability. In addition to the requirements enumerated elsewhere in this Act, managed care plans and providers participating in the Medicaid Long-Term Care Managed Care Program must comply with the requirements of this Section.

(a) Managed care plans may limit the providers in their networks based on credentials, quality indicators, and price. For the period between June 30, 2014 and June 30, 2015, each selected plan must offer a network contract to all the following providers in the region:

(1) Nursing homes.

(2) Hospices.

(3) Aging network service providers that have previously participated in the State's home and community-based waiver programs serving seniors, or that have previously participated in community-service programs administered by the Department on Aging.

(b) Except as provided in this Section, providers may limit the managed care plans they join. Nursing homes and hospices that are enrolled Medicaid providers must participate in all managed care plans selected by the Department in the region in which the provider is located.

(c) Each managed care plan shall monitor the quality and

performance of each participating provider using measures adopted by and collected by the Department and any additional measures mutually agreed upon by the provider and the plan.

(d) The Department shall establish, and each managed care plan must comply with, specific standards for the number, type, and regional distribution of providers in the plan's network.

(e) Managed care plans and providers shall negotiate mutually acceptable rates, methods, and terms of payment. Plans shall pay nursing homes an amount equal to the nursing facility-specific payment rates set by the Department. However, mutually acceptable higher rates may be negotiated for medically complex care. Plans must ensure that electronic nursing home and hospice claims that contain sufficient information for processing are paid within 10 business days after receipt.

Section 75. Long-term care managed care plan payment. In addition to the payment provisions enumerated elsewhere in this Act, the Department shall provide payment to plans in the Medicaid Long-Term Care Managed Care Program pursuant to this Section.

(a) Payment rates to plans shall be blended for some long-term care services.

(b) Payment rates for plans must reflect historic utilization and spending for covered services projected forward and adjusted to reflect the level of care profile for

enrollees in each plan. The Department shall periodically adjust payment rates to account for changes in the level of care profile for each managed care plan based on encounter data.

(1) Level 1 Care consists of recipients residing in or who must be placed in a nursing home.

(2) Level 2 Care consists of recipients at imminent risk of nursing home placement, as evidenced by the need for the constant availability of routine medical and nursing treatment and care, and require extensive health-related care and services because of mental or physical incapacitation.

(3) Level 3 Care consists of recipients at imminent risk of nursing home placement, as evidenced by the need for the constant availability of routine medical and nursing treatment and care, who have a limited need for health-related care and services and are mildly, medically, or physically incapacitated.

(c) The Department shall make an incentive adjustment in payment rates to encourage the increased utilization of home and community-based services and a commensurate reduction of institutional placement. The incentive adjustment shall continue until no more than 35% of the plan's enrollees are placed in institutional settings. The Department shall annually report to the General Assembly the actual change in the utilization mix of home and community-based services

compared to institutional placements and provide a recommendation for utilization mix requirements for future contracts.

Section 80. Enrollment in a long-term care managed care plan.

(a) The Department shall automatically enroll into a long-term care managed care plan those Medicaid recipients who do not voluntarily choose a plan. Except as otherwise provided in this Act, the Department may not engage in practices designed to favor one managed care plan over another.

(b) The Department shall automatically enroll Medicaid recipients in plans that meet or exceed the performance or quality standards established in this Act, or by the Department through contract, and may not automatically enroll recipients in a plan that is deficient in those performance or quality standards.

(1) If a Medicaid recipient is deemed eligible for both Medicaid and Medicare services and is currently receiving Medicare services from a Medicare Advantage Preferred Provider Organization, a Medicare Advantage Provider-Sponsored Organization, or a Medicare Advantage Special Needs Plan, the Department shall automatically enroll the recipient in such plan for Medicaid services if the plan is currently participating in the Medicaid Long-Term Care Managed Care Program.

(2) Otherwise, the Department shall automatically enroll Medicaid recipients based on all of the following criteria:

(a) Whether the plan has sufficient network capacity to meet the needs of the recipient.

(b) Whether the recipient has previously received services from one of the plan's home and community-based service providers.

(c) Whether the home and community-based providers in one plan are more geographically accessible to the recipient's residence than those in other plans.

(c) If a recipient is referred for hospice services, the recipient has 30 days during which the recipient may select to enroll in another managed care plan to access the hospice provider of the recipient's choice.

(d) If a recipient is referred for placement in a nursing home or assisted living facility, the plan must inform the recipient of any facilities within the plan that have specific cultural or religious affiliations and, if requested by the recipient, make a reasonable effort to place the recipient in the facility of the recipient's choice.

Section 97. Severability. The provisions of this Act are severable under Section 1.31 of the Statute on Statutes.

Section 999. Effective date. This Act takes effect upon becoming law.