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42 U.S. Code § 1396u-2

Provisions relating to managed care

(a) State option to use managed care

(1) Use of medicaid managed care organizations and primary care case managers

(A) In general

Subject to the succeeding provisions of this section, and notwithstanding paragraph (1), (10)(B), or (23)(A) of section 1396a(a) of this title, a State—

(i) may require an individual who is eligible for medical assistance under the State plan under this subchapter to enroll with a managed care entity as a condition of receiving such assistance (and, with respect to assistance furnished by or under arrangements with such entity, to receive such assistance through the entity), if—

(I) the entity and the contract with the State meet the applicable requirements of this section and section 1396b(m) of this title or section 1396d(t) of this title, and

(II) the requirements described in the succeeding paragraphs of this subsection are met; and

(ii) may restrict the number of provider agreements with managed care entities under the State plan if such restriction does not substantially impair access to services.

(B) "Managed care entity" defined

In this section, the term "managed care entity" means—

(i) a medicaid managed care organization, as defined in section 1396b(m)(1)(A) of this title, that provides or arranges for services for enrollees under a contract pursuant to section 1396b(m) of this title; and

(ii) a primary care case manager, as defined in section 1396d(t)(2) of this title.

(2) Special rules

(A) Exemption of certain children with special needs

A State may not require under paragraph (1) the enrollment in a managed care entity of an individual under 19 years of age who—

(i) is eligible for supplemental security income under subchapter XVI;

(ii) is described in section 701(a)(1)(D) of this title;

(iii) is described in section 1396a(e)(3) of this title;

(iv) is receiving foster care or adoption assistance under part E of subchapter IV; or

(v) is in foster care or otherwise in an out-of-home placement.

(B) Exemption of medicare beneficiaries

A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is a qualified medicare beneficiary (as defined in section 1396d(p)(1) of this title) or an individual otherwise eligible for benefits under subchapter XVIII.

(C) Indian enrollment

A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is an Indian (as defined in section 4(c)[1] of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)) unless the entity is one of the following (and only if such entity is participating under the plan):

(i) The Indian Health Service.

(ii) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act [25 U.S.C. 5321 et seq.].

(iii) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act [25 U.S.C. 1651 et seq.].

(3) Choice of coverage

(A) In general

A State must permit an individual to choose a managed care entity from not less than two such entities that meet the applicable requirements of this section, and of section 1396b(m) of this title or section 1396d(t) of this title.

(B) State option

At the option of the State, a State shall be considered to meet the requirements of subparagraph (A) in the case of an individual residing in a rural area, if the State requires the individual to enroll with a managed care entity if such entity—

(i) permits the individual to receive such assistance through not less than two physicians or case managers (to the extent that at least two physicians or case managers are available to provide such assistance in the area), and

(ii) permits the individual to obtain such assistance from any other provider in appropriate circumstances (as established by the State under regulations of the Secretary).

(C) Treatment of certain county-operated health insuring organizations

A State shall be considered to meet the requirement of subparagraph (A) if—

(i) the managed care entity in which the individual is enrolled is a health-insuring organization which—

(I) first became operational prior to January 1, 1986, or

(II) is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as added by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990), and

(ii) the individual is given a choice between at least two providers within such entity.

(4) Process for enrollment and termination and change of enrollment

As conditions under paragraph (1)(A)—

(A) In general

The State, enrollment broker (if any), and managed care entity shall permit an individual eligible for medical assistance under the State plan under this subchapter who is enrolled with the entity under this subchapter to terminate (or change) such enrollment—

(i) for cause at any time (consistent with section 1396b(m)(2)(A)(vi) of this title), and

(ii) without cause—

(I) during the 90-day period beginning on the date the individual receives notice of such enrollment, and

(II) at least every 12 months thereafter.

(B) Notice of termination rights

The State shall provide for notice to each such individual of the opportunity to terminate (or change) enrollment under such conditions. Such notice shall be provided at least 60 days before each annual enrollment opportunity described in subparagraph (A)(ii)(II).

(C) Enrollment priorities

In carrying out paragraph (1)(A), the State shall establish a method for establishing enrollment priorities in the case of a managed care entity that does not have sufficient capacity to enroll all such individuals seeking enrollment under which individuals already enrolled with the entity are given priority in continuing enrollment with the entity.

(D) Default enrollment process

In carrying out paragraph (1)(A), the State shall establish a default enrollment process—

(i) under which any such individual who does not enroll with a managed care entity during the enrollment period specified by the State shall be enrolled by the State with such an entity which has not been found to be out of substantial compliance with the applicable requirements of this section and of section 1396b(m) of this title or section 1396d(t) of this title; and

(ii) that takes into consideration—

(I) maintaining existing provider-individual relationships or relationships with providers that have traditionally served beneficiaries under this subchapter; and

(II) if maintaining such provider relationships is not possible, the equitable distribution of such individuals among qualified managed care entities available to enroll such individuals, consistent with the enrollment capacities of the entities.

(5) Provision of information

(A) Information in easily understood form

Each State, enrollment broker, or managed care entity shall provide all enrollment notices and informational and instructional materials relating to such an entity under this subchapter in a manner and form which may be easily understood by enrollees and potential enrollees of the entity who are eligible for medical assistance under the State plan under this subchapter.

(B) Information to enrollees and potential enrollees

Each managed care entity that is a medicaid managed care organization shall, upon request, make available to enrollees and potential enrollees in the organization's service area information concerning the following:

(i) Providers

The identity, locations, qualifications, and availability of health care providers that participate with the organization.

(ii) Enrollee rights and responsibilities

The rights and responsibilities of enrollees.

(iii) Grievance and appeal procedures

The procedures available to an enrollee and a health care provider to challenge or appeal the failure of the organization to cover a service.

(iv) Information on covered items and services

All items and services that are available to enrollees under the contract between the State and the organization that are covered either directly or through a method of referral and prior authorization. Each managed care entity that is a primary care case manager shall, upon request, make available to enrollees and potential enrollees in the organization's service area the information described in clause (iii).

(C) Comparative information

A State that requires individuals to enroll with managed care entities under paragraph (1)(A) shall annually (and upon request) provide, directly or through the managed care entity, to such individuals a list identifying the managed care entities that are (or will be) available and information (presented in a comparative, chart-like form) relating to the following for each such entity offered:

(i) Benefits and cost-sharing

The benefits covered and cost-sharing imposed by the entity.

(ii) Service area

The service area of the entity.

(iii) Quality and performance

To the extent available, quality and performance indicators for the benefits under the entity.

(D) Information on benefits not covered under managed care arrangement

A State, directly or through managed care entities, shall, on or before an individual enrolls with such an entity under this subchapter, inform the enrollee in a written and prominent manner of any benefits to which the enrollee may be entitled to under this subchapter but which are not made available to the enrollee through the entity. Such information shall include information on where and how such enrollees may access benefits not made available to the enrollee through the entity.