REFERENCES IN TEXT

For effective date, with respect to a State, of title I of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (as specified in section 116 of such Act), referred to in subsec. (i), see section 116 of Pub. L. 104–193, set out as an Effective Date note under section 601 of this title.

PRIOR PROVISIONS

A prior section 1931 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

1999—Subsec. (h)(3). Pub. L. 106–113, § 1000(a)(6) [title VI, § 602(a)(1)], struck out ''and ending with fiscal year 2000'' after ''fiscal year 1997''.

Subsec. (h)(4). Pub. L. 106–113, § 1000(a)(6) [title VI, § 602(a)(2)], struck out heading and text of par. (4). Prior to amendment, text read as follows: ''This subsection shall only apply with respect to a State for expenditures incurred during the first 12 calendar quarters in which the State program funded under part A of subchapter IV of this chapter (as in effect on and after the welfare reform effective date) is in effect.''

EFFECTIVE DATE OF 1999 AMENDMENT

Pub. L. 106–113, div. B, § 1000(a)(6) [title VI, § 602(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–394, provided that: ''The amendments made by this section [amending this section] shall take effect as if included in the enactment of section 114 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2177).''

EFFECTIVE DATE

Section effective July 1, 1997, with transition rules relating to State options to accelerate such date, rules relating to claims, actions, and proceedings commenced before such date, rules relating to closing out of accounts for terminated or substantially modified programs and continuance in office of Assistant Secretary for Family Support, and provisions relating to termination of entitlement under AFDC program, see section 116 of Pub. L. 104–193, as amended, set out as a note under section 601 of this title.

§ 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 appli-

[1] See References in Text note below.

cable 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.

(b) Beneficiary protections

(1) Specification of benefits

Each contract with a managed care entity under section 1396b(m) of this title or under section 1396d(t)(3) of this title shall specify the benefits the provision (or arrangement) for which the entity is responsible.

(2) Assuring coverage to emergency services

(A) In general

Each contract with a medicaid managed care organization under section 1396b(m) of this title and each contract with a primary care case manager under section 1396d(t)(3) of this title shall require the organization or manager—

(i) to provide coverage for emergency services (as defined in subparagraph (B)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization or manager, and

(ii) to comply with guidelines established under section 1395w–22(d)(2) of this title (respecting coordination of post-stabilization care) in the same manner as such guidelines apply to Medicare+Choice plans offered under part C of subchapter XVIII.

The requirement under clause (ii) shall first apply 30 days after the date of promulgation of the guidelines referred to in such clause.

(B) "Emergency services" defined

In subparagraph (A)(i), the term ''emergency services'' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this subchapter, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (C)).

(C) "Emergency medical condition" defined

In subparagraph (B)(ii), the term ''emergency medical condition'' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

(D) Emergency services furnished by non-contract providers

Any provider of emergency services that does not have in effect a contract with a Medicaid managed care entity that establishes payment amounts for services furnished to a beneficiary enrolled in the entity's Medicaid managed care plan must accept as payment in full no more than the amounts (less any payments for indirect costs of medical education and direct costs of graduate medical education) that it could collect if the beneficiary received medical assistance under this subchapter other than through enrollment in such an entity. In a State where rates paid to hospitals under the State plan are negotiated by contract and not publicly released, the payment amount applicable under this subparagraph shall be the average contract rate that would apply under the State plan for general acute care hospitals or the average contract rate that would apply under such plan for tertiary hospitals.

(3) Protection of enrollee-provider communications

(A) In general

Subject to subparagraphs (B) and (C), under a contract under section 1396b(m) of this title a medicaid managed care organization (in relation to an individual enrolled

under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the contract, if the professional is acting within the lawful scope of practice.

(B) Construction

Subparagraph (A) shall not be construed as requiring a medicaid managed care organization to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization—

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization adopts a change in policy regarding such a counseling or referral service.

Nothing in this subparagraph shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.].

(C) "Health care professional" defined

For purposes of this paragraph, the term ''health care professional'' means a physician (as defined in section 1395x(r) of this title) or other health care professional if coverage for the professional's services is provided under the contract referred to in subparagraph (A) for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) Grievance procedures

Each medicaid managed care organization shall establish an internal grievance procedure under which an enrollee who is eligible for medical assistance under the State plan under this subchapter, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such assistance.

(5) Demonstration of adequate capacity and services

Each medicaid managed care organization shall provide the State and the Secretary with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization—

(A) offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area, and

(B) maintains a sufficient number, mix, and geographic distribution of providers of services.

(6) Protecting enrollees against liability for payment

Each medicaid managed care organization shall provide that an individual eligible for medical assistance under the State plan under this subchapter who is enrolled with the organization may not be held liable—

(A) for the debts of the organization, in the event of the organization's insolvency,

(B) for services provided to the individual—

(i) in the event of the organization failing to receive payment from the State for such services; or

(ii) in the event of a health care provider with a contractual, referral, or other arrangement with the organization failing to receive payment from the State or the organization for such services, or

(C) for payments to a provider that furnishes covered services under a contractual, referral, or other arrangement with the organization in excess of the amount that would be owed by the individual if the organization had directly provided the services.

(7) Antidiscrimination

A medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

(8) Compliance with certain maternity and mental health requirements

Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act[1] insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage.

(c) Quality assurance standards

(1) Quality assessment and improvement strategy

(A) In general

If a State provides for contracts with medicaid managed care organizations under section 1396b(m) of this title, the State shall develop and implement a quality assessment

and improvement strategy consistent with this paragraph. Such strategy shall include the following:

(i) Access standards

Standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.

(ii) Other measures

Examination of other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards).

(iii) Monitoring procedures

Procedures for monitoring and evaluating the quality and appropriateness of care and services to enrollees that reflect the full spectrum of populations enrolled under the contract and that includes requirements for provision of quality assurance data to the State using the data and information set that the Secretary has specified for use under part C of subchapter XVIII or such alternative data as the Secretary approves, in consultation with the State.

(iv) Periodic review

Regular, periodic examinations of the scope and content of the strategy.

(B) Standards

The strategy developed under subparagraph (A) shall be consistent with standards that the Secretary first establishes within 1 year after August 5, 1997. Such standards shall not preempt any State standards that are more stringent than such standards. Guidelines relating to quality assurance that are applied under section 1396n(b)(1) of this title shall apply under this subsection until the effective date of standards for quality assurance established under this subparagraph.

(C) Monitoring

The Secretary shall monitor the development and implementation of strategies under subparagraph (A).

(D) Consultation

The Secretary shall conduct activities under subparagraphs (B) and (C) in consultation with the States.

(2) External independent review of managed care activities

(A) Review of contracts

(i) In general

Each contract under section 1396b(m) of this title with a medicaid managed care organization shall provide for an annual (as appropriate) external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract. The requirement for such a review shall not apply until after the date that the Secretary establishes the identification method described in clause (ii).

(ii) Qualifications of reviewer

The Secretary, in consultation with the States, shall establish a method for the identification of entities that are qualified to conduct reviews under clause (i).

(iii) Use of protocols

The Secretary, in coordination with the National Governors' Association, shall contract with an independent quality review organization (such as the National Committee for Quality Assurance) to develop the protocols to be used in external independent reviews conducted under this paragraph on and after January 1, 1999.

(iv) Availability of results

The results of each external independent review conducted under this subparagraph shall be available to participating health care providers, enrollees, and potential enrollees of the organization, except that the results may not be made available in a manner that discloses the identity of any individual patient.

(B) Nonduplication of accreditation

A State may provide that, in the case of a medicaid managed care organization that is accredited by a private independent entity (such as those described in section 1395w–22(e)(4) of this title) or that has an external review conducted under section 1395w–22(e)(3) of this title, the external review activities conducted under subparagraph (A) with respect to the organization shall not be duplicative of review activities conducted as part of the accreditation process or the external review conducted under such section.

(C) Deemed compliance for medicare managed care organizations

At the option of a State, the requirements of subparagraph (A) shall not apply with respect to a medicaid managed care organization if the organization is an eligible organization with a contract in effect under section 1395mm of this title or a Medicare+Choice organization with a contract in effect under part C of subchapter XVIII and the organization has had a contract in effect under section 1396b(m) of this title at least during the previous 2-year period.

(d) Protections against fraud and abuse

(1) Prohibiting affiliations with individuals debarred by Federal agencies

(A) In general

A managed care entity may not knowingly—

(i) have a person described in subparagraph (C) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the entity's equity, or

(ii) have an employment, consulting, or other agreement with a person described

in such subparagraph for the provision of items and services that are significant and material to the entity's obligations under its contract with the State.

(B) Effect of noncompliance

If a State finds that a managed care entity is not in compliance with clause (i) or (ii) of subparagraph (A), the State—

(i) shall notify the Secretary of such noncompliance;

(ii) may continue an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) directs otherwise; and

(iii) may not renew or otherwise extend the duration of an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

(C) Persons described

A person is described in this subparagraph if such person—

(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or

(ii) is an affiliate (as defined in such Regulation) of a person described in clause (i).

(2) Restrictions on marketing

(A) Distribution of materials

(i) In general

A managed care entity, with respect to activities under this subchapter, may not distribute directly or through any agent or independent contractor marketing materials within any State—

(I) without the prior approval of the State, and

(II) that contain false or materially misleading information.

The requirement of subclause (I) shall not apply with respect to a State until such date as the Secretary specifies in consultation with such State.

(ii) Consultation in review of market materials

In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

(B) Service market

A managed care entity shall distribute marketing materials to the entire service area of such entity covered under the contract under section 1396b(m) of this title or section 1396d(t)(3) of this title.

(C) Prohibition of tie-ins

A managed care entity, or any agency of such entity, may not seek to influence an individual's enrollment with the entity in conjunction with the sale of any other insurance.

(D) Prohibiting marketing fraud

Each managed care entity shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the entity, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

(E) Prohibition of "cold-call" marketing

Each managed care entity shall not, directly or indirectly, conduct door-to-door, telephonic, or other ''cold-call'' marketing of enrollment under this subchapter.

(3) State conflict-of-interest safeguards in medicaid risk contracting

A medicaid managed care organization may not enter into a contract with any State under section 1396b(m) of this title unless the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations or to the default enrollment process described in subsection (a)(4)(C)(ii) that are at least as effective as the Federal safeguards provided under chapter 21 of title 41, against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

(4) Use of unique physician identifier for participating physicians

Each medicaid managed care organization shall require each physician providing services to enrollees eligible for medical assistance under the State plan under this subchapter to have a unique identifier in accordance with the system established under section 1320d–2(b) of this title.

(5) Contract requirement for managed care entities

With respect to any contract with a managed care entity under section 1396b(m) or 1396d(t)(3) of this title (as applicable), no later than July 1, 2018, such contract shall include a provision that providers of services or persons terminated (as described in section 1396a(kk)(8) of this title) from participation under this subchapter, subchapter XVIII, or subchapter XXI shall be terminated from participating under this subchapter as a provider in any network of such entity that serves individuals eligible to receive medical assistance under this subchapter.

(6) Enrollment of participating providers

(A) In general

Beginning not later than January 1, 2018, a State shall require that, in order to participate as a provider in the network of a managed care entity that provides services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this subchapter (or under a waiv-

er of the plan) and who are enrolled with the entity, the provider is enrolled consistent with section 1396a(kk) of this title with the State agency administering the State plan under this subchapter. Such enrollment shall include providing to the State agency the provider's identifying information, including the name, specialty, date of birth, Social Security number, national provider identifier, Federal taxpayer identification number, and the State license or certification number of the provider.

(B) Rule of construction

Nothing in subparagraph (A) shall be construed as requiring a provider described in such subparagraph to provide services to individuals who are not enrolled with a managed care entity under this subchapter.

(e) Sanctions for noncompliance

(1) Use of intermediate sanctions by the State to enforce requirements

(A) In general

A State may not enter into or renew a contract under section 1396b(m) of this title unless the State has established intermediate sanctions, which may include any of the types described in paragraph (2), other than the termination of a contract with a medicaid managed care organization, which the State may impose against a medicaid managed care organization with such a contract, if the organization—

(i) fails substantially to provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to an enrollee covered under the contract;

(ii) imposes premiums or charges on enrollees in excess of the premiums or charges permitted under this subchapter;

(iii) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this subchapter, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the organization by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

(iv) misrepresents or falsifies information that is furnished—

(I) to the Secretary or the State under this subchapter; or

(II) to an enrollee, potential enrollee, or a health care provider under such subchapter; or

(v) fails to comply with the applicable requirements of section 1396b(m)(2)(A)(x) of this title.

The State may also impose such intermediate sanction against a managed care entity if the State determines that the entity distributed directly or through any agent or independent contractor marketing materials in violation of subsection (d)(2)(A)(i)(II).

(B) Rule of construction

Clause (i) of subparagraph (A) shall not apply to the provision of abortion services, except that a State may impose a sanction on any medicaid managed care organization that has a contract to provide abortion services if the organization does not provide such services as provided for under the contract.

(2) Intermediate sanctions

The sanctions described in this paragraph are as follows:

(A) Civil money penalties as follows:

(i) Except as provided in clause (ii), (iii), or (iv), not more than $25,000 for each determination under paragraph (1)(A).

(ii) With respect to a determination under clause (iii) or (iv)(I) of paragraph (1)(A), not more than $100,000 for each such determination.

(iii) With respect to a determination under paragraph (1)(A)(ii), double the excess amount charged in violation of such subsection (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

(iv) Subject to clause (ii), with respect to a determination under paragraph (1)(A)(iii), $15,000 for each individual not enrolled as a result of a practice described in such subsection.

(B) The appointment of temporary management—

(i) to oversee the operation of the medicaid managed care organization upon a finding by the State that there is continued egregious behavior by the organization or there is a substantial risk to the health of enrollees; or

(ii) to assure the health of the organization's enrollees, if there is a need for temporary management while—

(I) there is an orderly termination or reorganization of the organization; or

(II) improvements are made to remedy the violations found under paragraph (1),

except that temporary management under this subparagraph may not be terminated until the State has determined that the medicaid managed care organization has the capability to ensure that the violations shall not recur.

(C) Permitting individuals enrolled with the managed care entity to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.

(D) Suspension or default of all enrollment of individuals under this subchapter after the date the Secretary or the State notifies the entity of a determination of a violation of any requirement of section 1396b(m) of this title or this section.

(E) Suspension of payment to the entity under this subchapter for individuals enrolled after the date the Secretary or State notifies the entity of such a determination and until the Secretary or State is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) Treatment of chronic substandard entities

In the case of a medicaid managed care organization which has repeatedly failed to meet the requirements of section 1396b(m) of this title and this section, the State shall (regardless of what other sanctions are provided) impose the sanctions described in subparagraphs (B) and (C) of paragraph (2).

(4) Authority to terminate contract

(A) In general

In the case of a managed care entity which has failed to meet the requirements of this part or a contract under section 1396b(m) or 1396d(t)(3) of this title, the State shall have the authority to terminate such contract with the entity and to enroll such entity's enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the State plan under this subchapter other than through a managed care entity).

(B) Availability of hearing prior to termination of contract

A State may not terminate a contract with a managed care entity under subparagraph (A) unless the entity is provided with a hearing prior to the termination.

(C) Notice and right to disenroll in cases of termination hearing

A State may—

(i) notify individuals enrolled with a managed care entity which is the subject of a hearing to terminate the entity's contract with the State of the hearing, and

(ii) in the case of such an entity, permit such enrollees to disenroll immediately with the entity without cause.

(5) Other protections for managed care entities against sanctions imposed by State

Before imposing any sanction against a managed care entity other than termination of the entity's contract, the State shall provide the entity with notice and such other due process protections as the State may provide, except that a State may not provide a managed care entity with a pre-termination hearing before imposing the sanction described in paragraph (2)(B).

(f) Timeliness of payment; adequacy of payment for primary care services

A contract under section 1396b(m) of this title with a medicaid managed care organization shall provide that the organization shall make payment to health care providers for items and services which are subject to the contract and that are furnished to individuals eligible for medical assistance under the State plan under this subchapter who are enrolled with the organization on a timely basis consistent with the claims payment procedures described in section 1396a(a)(37)(A) of this title, unless the health care provider and the organization agree to an alternate payment schedule and, in the case of primary care services described in section 1396a(a)(13)(C) of this title, consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation).

(g) Identification of patients for purposes of making DSH payments

Each contract with a managed care entity under section 1396b(m) of this title or under section 1396d(t)(3) of this title shall require the entity either—

(1) to report to the State information necessary to determine the hospital services provided under the contract (and the identity of hospitals providing such services) for purposes of applying sections 1395ww(d)(5)(F) and 1396r–4 of this title; or

(2) to include a sponsorship code in the identification card issued to individuals covered under this subchapter in order that a hospital may identify a patient as being entitled to benefits under this subchapter.

(h) Special rules with respect to Indian enrollees, Indian health care providers, and Indian managed care entities

(1) Enrollee option to select an Indian health care provider as primary care provider

In the case of a non-Indian Medicaid managed care entity that—

(A) has an Indian enrolled with the entity; and

(B) has an Indian health care provider that is participating as a primary care provider within the network of the entity,

insofar as the Indian is otherwise eligible to receive services from such Indian health care provider and the Indian health care provider has the capacity to provide primary care services to such Indian, the contract with the entity under section 1396b(m) of this title or under section 1396d(t)(3) of this title shall require, as a condition of receiving payment under such contract, that the Indian shall be allowed to choose such Indian health care provider as the Indian's primary care provider under the entity.

(2) Assurance of payment to Indian health care providers for provision of covered services

Each contract with a managed care entity under section 1396b(m) of this title or under section 1396d(t)(3) of this title shall require any such entity, as a condition of receiving payment under such contract, to satisfy the following requirements:

(A) Demonstration of access to Indian health care providers and application of alternative payment arrangements

Subject to subparagraph (C), to—

(i) demonstrate that the number of Indian health care providers that are participating providers with respect to such entity are sufficient to ensure timely access to covered Medicaid managed care services for those Indian enrollees who are eligible to receive services from such providers; and

(ii) agree to pay Indian health care providers, whether such providers are participating or nonparticipating providers with respect to the entity, for covered Medicaid managed care services provided to those

Indian enrollees who are eligible to receive services from such providers at a rate equal to the rate negotiated between such entity and the provider involved or, if such a rate has not been negotiated, at a rate that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a participating provider which is not an Indian health care provider.

The Secretary shall establish procedures for applying the requirements of clause (i) in States where there are no or few Indian health providers.

(B) Prompt payment

To agree to make prompt payment (consistent with rule for prompt payment of providers under section 1396u–2(f) of this title) to Indian health care providers that are participating providers with respect to such entity or, in the case of an entity to which subparagraph (A)(ii) or (C) applies, that the entity is required to pay in accordance with that subparagraph.

(C) Application of special payment requirements for federally-qualified health centers and for services provided by certain Indian health care providers

(i) Federally-qualified health centers

(I) Managed care entity payment requirement

To agree to pay any Indian health care provider that is a federally-qualified health center under this subchapter but not a participating provider with respect to the entity, for the provision of covered Medicaid managed care services by such provider to an Indian enrollee of the entity at a rate equal to the amount of payment that the entity would pay a federally-qualified health center that is a participating provider with respect to the entity but is not an Indian health care provider for such services.

(II) Continued application of State requirement to make supplemental payment

Nothing in subclause (I) or subparagraph (A) or (B) shall be construed as waiving the application of section 1396a(bb)(5) of this title regarding the State plan requirement to make any supplemental payment due under such section to a federally-qualified health center for services furnished by such center to an enrollee of a managed care entity (regardless of whether the federally-qualified health center is or is not a participating provider with the entity).

(ii) Payment rate for services provided by certain Indian health care providers

If the amount paid by a managed care entity to an Indian health care provider that is not a federally-qualified health center for services provided by the provider to an Indian enrollee with the managed care entity is less than the rate that applies to the provision of such services by the provider under the State plan, the plan shall provide for payment to the Indian health care provider, whether the provider is a participating or nonparticipating provider with respect to the entity, of the difference between such applicable rate and the amount paid by the managed care entity to the provider for such services.

(D) Construction

Nothing in this paragraph shall be construed as waiving the application of section 1396a(a)(30)(A) of this title (relating to application of standards to assure that payments are consistent with efficiency, economy, and quality of care).

(3) Special rule for enrollment for Indian managed care entities

Regarding the application of a Medicaid managed care program to Indian Medicaid managed care entities, an Indian Medicaid managed care entity may restrict enrollment under such program to Indians in the same manner as Indian Health Programs may restrict the delivery of services to Indians.

(4) Definitions

For purposes of this subsection:

(A) Indian health care provider

The term ''Indian health care provider'' means an Indian Health Program or an Urban Indian Organization.

(B) Indian Medicaid managed care entity

The term ''Indian Medicaid managed care entity'' means a managed care entity that is controlled (within the meaning of the last sentence of section 1396b(m)(1)(C) of this title) by the Indian Health Service, a Tribe, Tribal Organization, or Urban Indian Organization, or a consortium, which may be composed of 1 or more Tribes, Tribal Organizations, or Urban Indian Organizations, and which also may include the Service.

(C) Non-Indian Medicaid managed care entity

The term ''non-Indian Medicaid managed care entity'' means a managed care entity that is not an Indian Medicaid managed care entity.

(D) Covered Medicaid managed care services

The term ''covered Medicaid managed care services'' means, with respect to an individual enrolled with a managed care entity, items and services for which benefits are available with respect to the individual under the contract between the entity and the State involved.

(E) Medicaid managed care program

The term ''Medicaid managed care program'' means a program under sections 1396b(m), 1396d(t), and 1396u–2 of this title and includes a managed care program operating under a waiver under section 1396n(b) or 1315 of this title or otherwise.

(Aug. 14, 1935, ch. 531, title XIX, § 1932, as added and amended Pub. L. 105–33, title IV, §§ 4701(a),

4704(a), 4705(a), 4707(a), 4708(c), Aug. 5, 1997, 111 Stat. 489, 495, 498, 501, 506; Pub. L. 106–113, div. B, §1000(a)(6) [title VI, §608(w)], Nov. 29, 1999, 113 Stat. 1536, 1501A–398; Pub. L. 106–554, §1(a)(6) [title VII, §701(b)(1)], Dec. 21, 2000, 114 Stat. 2763, 2763A–570; Pub. L. 109–171, title VI, §6085(a), Feb. 8, 2006, 120 Stat. 121; Pub. L. 111–5, div. B, title V, §5006(d)(1), Feb. 17, 2009, 123 Stat. 507; Pub. L. 111–152, title I, §1202(a)(2), Mar. 30, 2010, 124 Stat. 1053; Pub. L. 114–255, div. A, title V, §5005(a)(2), (b)(2), Dec. 13, 2016, 130 Stat. 1192, 1193.)

REFERENCES IN TEXT

Section 4(c) of the Indian Health Care Improvement Act of 1976, referred to in subsec. (a)(2)(C), probably means section 4(c) of the Indian Health Care Improvement Act, which was redesignated section 4(13) of the Act by Pub. L. 111–148, title X, §10221(a), Mar. 23, 2010, 124 Stat. 935, and is classified to section 1603(13) of Title 25, Indians.

The Indian Self-Determination Act, referred to in subsec. (a)(2)(C)(ii), is title I of Pub. L. 93–638, Jan. 4, 1975, 88 Stat. 2206, which is classified principally to subchapter I (§5321 et seq.) of chapter 46 of Title 25, Indians. For complete classification of this Act to the Code, see Short Title note set out under section 5301 of Title 25 and Tables.

The Indian Health Care Improvement Act, referred to in subsec. (a)(2)(C)(iii), is Pub. L. 94–437, Sept. 30, 1976, 90 Stat. 1400. Title V of the Act is classified generally to subchapter IV (§1651 et seq.) of chapter 18 of Title 25. For complete classification of this Act to the Code, see Short Title note set out under section 1601 of Title 25 and Tables.

Section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985, referred to in subsec. (a)(3)(C)(i)(II), is section 9517(c)(3) of Pub. L. 99–272, which is set out as a note under section 1396b of this title.

The Employee Retirement Income Security Act of 1974, referred to in subsec. (b)(3)(B), is Pub. L. 93–406, Sept. 2, 1974, 88 Stat. 832, which is classified principally to chapter 18 (§1001 et seq.) of Title 29, Labor. For complete classification of this Act to the Code, see Short Title note set out under section 1001 of Title 29 and Tables.

The Public Health Service Act, referred to in subsec. (b)(8), is act July 1, 1944, ch. 373, 58 Stat. 682. Subpart 2 of part A of title XXVII of the Act may refer to subpart II of part A of subchapter XXV of chapter 6A of this title. Pub. L. 111–148, title I, §§1001(5), 1563(c)(2), (11), formerly §1562(c)(2), (11), title X, §10107(b)(1), Mar. 23, 2010, 124 Stat. 130, 265, 268, 911, amended part A by inserting ''SUBPART II—IMPROVING COVERAGE'' (preceding section 300gg–11 of this title), by striking out ''SUBPART 2—OTHER REQUIREMENTS'' (preceding section 300gg–4 of this title), and by redesignating subpart 4 as subpart 2 ''EXCLUSION OF PLANS; ENFORCEMENT; PREEMPTION'' (preceding section 300gg–21 of this title). For complete classification of this Act to the Code, see Short Title note set out under section 201 of this title and Tables.

Executive Order No. 12549, referred to in subsec. (d)(1)(C)(i), is set out as a note under section 6101 of Title 31, Money and Finance.

CODIFICATION

In subsec. (d)(3), ''chapter 21 of title 41'' substituted for ''section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423)'' on authority of Pub. L. 111–350, §6(c), Jan. 4, 2011, 124 Stat. 3854, which Act enacted Title 41, Public Contracts.

PRIOR PROVISIONS

A prior section 1932 of act Aug. 14, 1935, was renumbered section 1939 and is classified to section 1396v of this title.

AMENDMENTS

2016—Subsec. (d)(5). Pub. L. 114–255, §5005(a)(2), added par. (5).

Subsec. (d)(6). Pub. L. 114–255, §5005(b)(2), added par. (6).

2010—Subsec. (f). Pub. L. 111–152 inserted ''; adequacy of payment for primary care services'' after ''payment'' in heading and ''and, in the case of primary care services described in section 1396a(a)(13)(C) of this title, consistent with the minimum payment rates specified in such section (regardless of the manner in which such payments are made, including in the form of capitation or partial capitation)'' before period at end of text.

2009—Subsec. (h). Pub. L. 111–5 added subsec. (h).

2006—Subsec. (b)(2)(D). Pub. L. 109–171 added subpar. (D).

2000—Subsec. (g). Pub. L. 106–554 added subsec. (g).

1999—Subsec. (c)(2)(C). Pub. L. 106–113, §1000(a)(6) [title VI, §608(w)(1)], inserted ''part'' before ''C of subchapter XVIII''.

Subsec. (d)(1)(C)(ii). Pub. L. 106–113, §1000(a)(6) [title VI, §608(w)(2)(A)], substituted ''Regulation'' for ''Act''.

Subsec. (d)(2)(B). Pub. L. 106–113, §1000(a)(6) [title VI, §608(w)(2)(B)], substituted ''1396d(t)(3) of this title'' for ''1396b(t)(3) of this title''.

1997—Subsec. (b). Pub. L. 105–33, §4704(a), added subsec. (b).

Subsec. (c). Pub. L. 105–33, §4705(a), added subsec. (c).

Subsecs. (d), (e). Pub. L. 105–33, §4707(a), added subsecs. (d) and (e).

Subsec. (f). Pub. L. 105–33, §4708(c), added subsec. (f).

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2009 AMENDMENT

Amendment by Pub. L. 111–5 effective July 1, 2009, see section 5006(f) of Pub. L. 111–5, set out as a note under section 1396a of this title.

EFFECTIVE DATE OF 2006 AMENDMENT

Pub. L. 109–171, title VI, §6085(b), Feb. 8, 2006, 120 Stat. 121, provided that: ''The amendment made by subsection (a) [amending this section] shall take effect on January 1, 2007.''

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VII, §701(b)(3)(A)], Dec. 21, 2000, 114 Stat. 2763, 2763A–570, provided that: ''The amendment made by paragraph (1) [amending this section] shall apply to contracts as of January 1, 2001.''

EFFECTIVE DATE

Section effective Aug. 5, 1997, and applicable to contracts entered into or renewed on or after Oct. 1, 1997, except that, subject to provisions relating to extension of effective date for State law amendments, and to nonapplication to waivers, subsec. (c)(1) effective Jan. 1, 1999, and subsec. (e) applicable to contracts entered into or renewed on or after Apr. 1, 1998, see section 4710(a), (b)(3), (5) of Pub. L. 105–33, set out as an Effective Date of 1997 Amendment note under section 1396b of this title.

CONSTRUCTION OF 2016 AMENDMENT

Nothing in amendment by Pub. L. 114–255 to be construed as changing or limiting the appeal rights of providers or the process for appeals of States under the Social Security Act, see section 5005(d) of Pub. L. 114–255, set out as a note under section 1396a of this title.

STUDIES AND REPORTS

Pub. L. 105–33, title IV, §4705(c), Aug. 5, 1997, 111 Stat. 500, provided that:

''(1) GAO STUDY AND REPORT ON QUALITY ASSURANCE AND ACCREDITATION STANDARDS.—

''(A) STUDY.—The Comptroller General of the United States shall conduct a study and analysis of the quality assurance programs and accreditation standards applicable to managed care entities operating in the private sector, or to such entities that operate under contracts under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such study shall determine—

''(i) if such programs and standards include consideration of the accessibility and quality of the health care items and services delivered under such contracts to low-income individuals; and

''(ii) the appropriateness of applying such programs and standards to medicaid managed care organizations under section 1932(c) of such Act [42 U.S.C. 1396u–2(c)].

''(B) REPORT.—The Comptroller General shall submit a report to the Committee on Commerce [now Committee on Energy and Commerce] of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subparagraph (A).

''(2) STUDY AND REPORT ON SERVICES PROVIDED TO INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS.—

''(A) STUDY.—The Secretary of Health and Human Services, in consultation with States, managed care organizations, the National Academy of State Health Policy, representatives of beneficiaries with special health care needs, experts in specialized health care, and others, shall conduct a study concerning safeguards (if any) that may be needed to ensure that the health care needs of individuals with special health care needs and chronic conditions who are enrolled with medicaid managed care organizations are adequately met.

''(B) REPORT.—Not later than 2 years after the date of the enactment of this Act [Aug. 5, 1997], the Secretary shall submit to Committees described in paragraph (1)(B) a report on such study.''

§ 1396u–3. State coverage of medicare cost-sharing for additional low-income medicare beneficiaries

(a) In general

A State plan under this subchapter shall provide, under section 1396a(a)(10)(E)(iv) of this title and subject to the succeeding provisions of this section and through a plan amendment, for medical assistance for payment of the cost of medicare cost-sharing described in such section on behalf of all individuals described in such section (in this section referred to as ''qualifying individuals'') who are selected to receive such assistance under subsection (b).

(b) Selection of qualifying individuals

A State shall select qualifying individuals, and provide such individuals with assistance, under this section consistent with the following:

(1) All qualifying individuals may apply

The State shall permit all qualifying individuals to apply for assistance during a calendar year.

(2) Selection on first-come, first-served basis

(A) In general

For each calendar year (beginning with 1998), from (and to the extent of) the amount of the allocation under subsection (c) for the State for the fiscal year ending in such calendar year, the State shall select qualifying individuals who apply for the assistance in the order in which they apply.

(B) Carryover

For calendar years after 1998, the State shall give preference to individuals who were provided such assistance (or other assistance described in section 1396a(a)(10)(E) of this title) in the last month of the previous year and who continue to be (or become) qualifying individuals.

(3) Limit on number of individuals based on allocation

The State shall limit the number of qualifying individuals selected with respect to assistance in a calendar year so that the aggregate amount of such assistance provided to such individuals in such year is estimated to be equal to (but not exceed) the State's allocation under subsection (c) for the fiscal year ending in such calendar year.

(4) Receipt of assistance during duration of year

If a qualifying individual is selected to receive assistance under this section for a month in a year, the individual is entitled to receive such assistance for the remainder of the year if the individual continues to be a qualifying individual. The fact that an individual is selected to receive assistance under this section at any time during a year does not entitle the individual to continued assistance for any succeeding year.

(c) Allocation

(1) Total allocation

The total amount available for allocation under this section for—

(A) fiscal year 1998 is $200,000,000;

(B) fiscal year 1999 is $250,000,000;

(C) fiscal year 2000 is $300,000,000;

(D) fiscal year 2001 is $350,000,000; and

(E) each of fiscal years 2002 and 2003 is $400,000,000.

(2) Allocation to States

The Secretary shall provide for the allocation of the total amount described in paragraph (1) for a fiscal year, among the States that executed a plan amendment in accordance with subsection (a), based upon the Secretary's estimate of the ratio of—

(A) an amount equal to the total number of individuals described in section 1396a(a)(10)(E)(iv) of this title in the State; to

(B) the sum of the amounts computed under subparagraph (A) for all eligible States.

(d) Applicable FMAP

With respect to assistance described in section 1396a(a)(10)(E)(iv) of this title furnished in a State for calendar quarters in a calendar year—

(1) to the extent that such assistance does not exceed the State's allocation under subsection (c) for the fiscal year ending in the calendar year, the Federal medical assistance percentage shall be equal to 100 percent; and

(2) to the extent that such assistance exceeds such allocation, the Federal medical assistance percentage is 0 percent.

(e) Limitation on entitlement

Except as specifically provided under this section, nothing in this subchapter shall be construed as establishing any entitlement of indi-