

104TH CONGRESS  
1ST SESSION

# S. 839

To amend title XIX of the Social Security Act to permit greater flexibility for States to enroll medicaid beneficiaries in managed care arrangements, to remove barriers preventing the provision of medical assistance under State medicaid plans through managed care, and for other purposes.

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## IN THE SENATE OF THE UNITED STATES

MAY 22 (legislative day, MAY 15), 1995

Mr. CHAFEE (for himself, Mr. GRAHAM, and Mr. CONRAD) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To amend title XIX of the Social Security Act to permit greater flexibility for States to enroll medicaid beneficiaries in managed care arrangements, to remove barriers preventing the provision of medical assistance under State medicaid plans through managed care, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicaid Managed  
5 Care Act of 1995”.

1 **SEC. 2. PERMITTING GREATER FLEXIBILITY FOR STATES**  
2 **TO ENROLL BENEFICIARIES IN MANAGED**  
3 **CARE ARRANGEMENTS.**

4 (a) IN GENERAL.—Title XIX of the Social Security  
5 Act (42 U.S.C. 1396 et seq.) is amended—

6 (1) by redesignating section 1931 as section  
7 1932; and

8 (2) by inserting after section 1930 the following  
9 new section:

10 “STATE OPTIONS FOR ENROLLMENT OF BENEFICIARIES  
11 IN MANAGED CARE ARRANGEMENTS

12 “SEC. 1931. (a) MANDATORY ENROLLMENT.—

13 “(1) IN GENERAL.—Subject to the succeeding  
14 provisions of this section, a State may require an in-  
15 dividual eligible for medical assistance under the  
16 State plan under this title to enroll with an eligible  
17 managed care provider as a condition of receiving  
18 such assistance and, with respect to assistance fur-  
19 nished by or under arrangements with such provider,  
20 to receive such assistance through the provider, if  
21 the following provisions are met:

22 “(A) The provider meets the requirements  
23 of section 1932.

24 “(B) The provider enters into a contract  
25 with the State to provide services for the bene-  
26 fit of individuals eligible for benefits under this

1 title under which prepaid payments to such pro-  
2 vider are made on an actuarially sound basis.

3 “(C) There is sufficient capacity among all  
4 providers meeting such requirements to enroll  
5 and serve the individuals required to enroll with  
6 such providers.

7 “(D) The individual is not a special needs  
8 individual (as defined in subsection (c)).

9 “(E) The State—

10 “(i) permits an individual to choose  
11 an eligible managed care provider—

12 “(I) from among not less than 2  
13 medicaid managed care plans; or

14 “(II) between a medicaid man-  
15 aged care plan and a primary care  
16 case management provider;

17 “(ii) provides the individual with the  
18 opportunity to change enrollment among  
19 eligible managed care providers not less  
20 than once annually and notifies the indi-  
21 vidual of such opportunity not later than  
22 60 days prior to the first date on which  
23 the individual may change enrollment;

24 “(iii) establishes a method for estab-  
25 lishing enrollment priorities in the case of

1 an eligible managed care provider that  
2 does not have sufficient capacity to enroll  
3 all such individuals seeking enrollment  
4 under which individuals already enrolled  
5 with the provider are given priority in con-  
6 tinuing enrollment with the provider;

7 “(iv) establishes a default enrollment  
8 process which meets the requirements de-  
9 scribed in paragraph (2) and under which  
10 any such individual who does not enroll  
11 with an eligible managed care provider  
12 during the enrollment period specified by  
13 the State shall be enrolled by the State  
14 with such a provider in accordance with  
15 such process; and

16 “(v) establishes the sanctions provided  
17 for in section 1933.

18 “(2) DEFAULT ENROLLMENT PROCESS RE-  
19 QUIREMENTS.—The default enrollment process es-  
20 tablished by a State under paragraph (1)(E)(iv)  
21 shall—

22 “(A) provide that the State may not enroll  
23 individuals with an eligible managed care pro-  
24 vider which is not in compliance with the re-  
25 quirements of section 1932; and

1           “(B) provide for an equitable distribution  
2 of individuals among all eligible managed care  
3 providers available to enroll individuals through  
4 such default enrollment process, consistent with  
5 the enrollment capacities of such providers.

6           “(3) EXCEPTION FOR CERTAIN SERVICES.—A  
7 State may not require an individual eligible for med-  
8 ical assistance under the State plan under this title  
9 to enroll with an eligible managed care provider as  
10 a condition of receiving medical assistance consisting  
11 of payment for medicare cost-sharing under section  
12 1905(p)(3).

13           “(b) REENROLLMENT OF INDIVIDUALS WHO REGAIN  
14 ELIGIBILITY.—

15           “(1) IN GENERAL.—If an individual eligible for  
16 medical assistance under a State plan under this  
17 title and enrolled with an eligible managed care pro-  
18 vider with a contract under subsection (a)(1)(B)  
19 ceases to be eligible for such assistance for a period  
20 of not greater than 2 months, the State may provide  
21 for the automatic reenrollment of the individual with  
22 the provider as of the first day of the month in  
23 which the individual is again eligible for such assist-  
24 ance.

1           “(2) CONDITIONS.—Paragraph (1) shall only  
2 apply if—

3           “(A) the month for which the individual is  
4 to be reenrolled occurs during the enrollment  
5 period covered by the individual’s original en-  
6 rollment with the eligible managed care pro-  
7 vider;

8           “(B) the eligible managed care provider  
9 continues to have a contract with the State  
10 agency under subsection (a)(1)(B) as of the  
11 first day of such month; and

12           “(C) the eligible managed care provider  
13 complies with the requirements of section 1932.

14           “(3) NOTICE OF REENROLLMENT.—The State  
15 shall provide timely notice to an eligible managed  
16 care provider of any reenrollment of an individual  
17 under this subsection.

18           “(c) SPECIAL NEEDS INDIVIDUALS DESCRIBED.—In  
19 this section, a ‘special needs individual’ means any of the  
20 following:

21           “(1) SPECIAL NEEDS CHILD.—An individual  
22 who is under 19 years of age who—

23           “(A) is eligible for supplemental security  
24 income under title XVI;

1           “(B) is described under section  
2           501(a)(1)(D);

3           “(C) is a child described in section  
4           1902(e)(3); or

5           “(D) is in foster care or is otherwise in an  
6           out-of-home placement.

7           “(2) HOMELESS INDIVIDUALS.—An individual  
8           who is homeless (without regard to whether the indi-  
9           vidual is a member of a family), including—

10           “(A) an individual whose primary residence  
11           during the night is a supervised public or pri-  
12           vate facility that provides temporary living ac-  
13           commodations; or

14           “(B) an individual who is a resident in  
15           transitional housing.

16           “(3) MIGRANT AGRICULTURAL WORKERS.—A  
17           migratory agricultural worker or a seasonal agricul-  
18           tural worker (as such terms are defined in section  
19           329 of the Public Health Service Act), or the spouse  
20           or dependent of such a worker.”.

21           (b) CONFORMING AMENDMENT.—Section  
22           1902(a)(23) of such Act (42 U.S.C. 1396a(a)(23)) is  
23           amended—

24           (1) in the matter preceding subparagraph (A),  
25           by striking “subsection (g) and in section 1915” and

1 inserting “subsection (g), section 1915, and section  
2 1931,”; and

3 (2) in subparagraph (B)—

4 (A) by striking “a health maintenance or-  
5 ganization, or a” and inserting “or with an eli-  
6 gible managed care provider, as defined in sec-  
7 tion 1932(g)(1), or”.

8 **SEC. 3. REMOVAL OF BARRIERS TO PROVISION OF MEDIC-**  
9 **AID SERVICES THROUGH MANAGED CARE.**

10 (a) REPEAL OF CURRENT BARRIERS.—Except as  
11 provided in subsection (b), section 1903(m) of the Social  
12 Security Act (42 U.S.C. 1396b(m)) is repealed on the date  
13 of the enactment of this Act.

14 (b) EXISTING CONTRACTS.—In the case of any con-  
15 tract under section 1903(m) of such Act which is in effect  
16 on the day before the date of the enactment of this Act,  
17 the provisions of such section shall apply to such contract  
18 until the earlier of—

19 (1) the day after the date of the expiration of  
20 the contract; or

21 (2) the date which is 1 year after the date of  
22 the enactment of this Act.

23 (c) ELIGIBLE MANAGED CARE PROVIDERS DE-  
24 SCRIBED.—Title XIX of such Act (42 U.S.C. 1396 et  
25 seq.), as amended by section 2(a), is amended—

1 (1) by redesignating section 1932 as section  
2 1933; and

3 (2) by inserting after section 1931 the following  
4 new section:

5 “ELIGIBLE MANAGED CARE PROVIDERS

6 “SEC. 1932. (a) DEFINITIONS.—In this section, the  
7 following definitions shall apply:

8 “(1) ELIGIBLE MANAGED CARE PROVIDER.—

9 The term ‘eligible managed care provider’ means—

10 “(A) a medicaid managed care plan; or

11 “(B) a primary care case management pro-  
12 vider.

13 “(2) MEDICAID MANAGED CARE PLAN.—The

14 term ‘medicaid managed care plan’ means a health

15 maintenance organization or any other plan which

16 provides or arranges for the provision of one or more

17 items and services to individuals eligible for medical

18 assistance under the State plan under this title in

19 accordance with a contract with the State under sec-

20 tion 1931(a)(1)(B).

21 “(3) PRIMARY CARE CASE MANAGEMENT PRO-

22 VIDER.—

23 “(A) IN GENERAL.—The term ‘primary

24 care case management provider’ means a health

25 care provider that—

1           “(i) is a physician, group of physi-  
2           cians, a Federally-qualified health center, a  
3           rural health clinic, or an entity employing  
4           or having other arrangements with physi-  
5           cians that provides or arranges for the pro-  
6           vision of one or more items and services to  
7           individuals eligible for medical assistance  
8           under the State plan under this title in ac-  
9           cordance with a contract with the State  
10          under section 1931(a)(1)(B);

11          “(ii) receives payment on a fee-for-  
12          service basis (or, in the case of a Feder-  
13          ally-qualified health center or a rural  
14          health clinic, on a reasonable cost per en-  
15          counter basis) for the provision of health  
16          care items and services specified in such  
17          contract to enrolled individuals;

18          “(iii) receives an additional fixed fee  
19          per enrollee for a period specified in such  
20          contract for providing case management  
21          services (including approving and arrang-  
22          ing for the provision of health care items  
23          and services specified in such contract on  
24          a referral basis) to enrolled individuals;  
25          and

1 “(iv) is not an entity that is at risk.

2 “(B) AT RISK.—In subparagraph (A)(iv),  
3 the term ‘at risk’ means an entity that—

4 “(i) has a contract with the State  
5 under which such entity is paid a fixed  
6 amount for providing or arranging for the  
7 provision of health care items or services  
8 specified in such contract to an individual  
9 eligible for medical assistance under the  
10 State plan and enrolled with such entity,  
11 regardless of whether such items or serv-  
12 ices are furnished to such individual; and

13 “(ii) is liable for all or part of the cost  
14 of furnishing such items or services, re-  
15 gardless of whether such cost exceeds such  
16 fixed payment.

17 “(b) ENROLLMENT.—

18 “(1) NONDISCRIMINATION.—An eligible man-  
19 aged care provider may not discriminate on the basis  
20 of health status or anticipated need for services in  
21 the enrollment, reenrollment, or disenrollment of in-  
22 dividuals eligible to receive medical assistance under  
23 a State plan under this title.

24 “(2) TERMINATION OF ENROLLMENT.—

1           “(A) IN GENERAL.—An eligible managed  
2 care provider shall permit an individual eligible  
3 for medical assistance under the State plan  
4 under this title who is enrolled with the pro-  
5 vider to terminate such enrollment for cause at  
6 any time, and without cause during the 60-day  
7 period beginning on the date the individual re-  
8 ceives notice of enrollment, and shall notify  
9 each such individual of the opportunity to ter-  
10minate enrollment under these conditions.

11           “(B) FRAUDULENT INDUCEMENT OR CO-  
12ERCION AS GROUNDS FOR CAUSE.—For pur-  
13poses of subparagraph (A), an individual termi-  
14nating enrollment with an eligible managed care  
15provider on the grounds that the enrollment  
16was based on fraudulent inducement or was ob-  
17tained through coercion shall be considered to  
18terminate such enrollment for cause.

19           “(C) NOTICE OF TERMINATION.—

20           “(i) NOTICE TO STATE.—

21           “(I) BY INDIVIDUALS.—Each in-  
22dividual terminating enrollment with  
23an eligible managed care provider  
24under subparagraph (A) shall do so  
25by providing notice of the termination

1 to an office of the State agency ad-  
2 ministering the State plan under this  
3 title, the State or local welfare agency,  
4 or an office of an eligible managed  
5 care provider.

6 “(II) BY PLANS.—Any eligible  
7 managed care provider which receives  
8 notice of an individual’s termination  
9 of enrollment with such provider  
10 through receipt of such notice at an  
11 office of an eligible managed care pro-  
12 vider shall provide timely notice of the  
13 termination to the State agency ad-  
14 ministering the State plan under this  
15 title.

16 “(ii) NOTICE TO PLAN.—The State  
17 agency administering the State plan under  
18 this title or the State or local welfare agen-  
19 cy which receives notice of an individual’s  
20 termination of enrollment with an eligible  
21 managed care provider under clause (i)  
22 shall provide timely notice of the termi-  
23 nation to such provider.

24 “(D) REENROLLMENT.—Each State shall  
25 establish a process under which an individual

1           terminating enrollment under this paragraph  
2           shall be promptly enrolled with another eligible  
3           managed care provider and notified of such en-  
4           rollment.

5           “(3) PROVISION OF ENROLLMENT MATERIALS  
6           IN UNDERSTANDABLE FORM.—Each eligible man-  
7           aged care provider shall provide all enrollment mate-  
8           rials in a manner and form which may be easily un-  
9           derstood by a typical adult enrollee of the provider  
10          who is eligible for medical assistance under the State  
11          plan under this title.

12          “(c) QUALITY ASSURANCE.—

13                 “(1) ACCESS TO SERVICES.—Each eligible man-  
14                 aged care provider shall provide or arrange for the  
15                 provision of all medically necessary medical assist-  
16                 ance under this title which is specified in the con-  
17                 tract entered into between such provider and the  
18                 State under section 1931(a)(1)(B) for enrollees who  
19                 are eligible for medical assistance under the State  
20                 plan under this title.

21                 “(2) TIMELY DELIVERY OF SERVICES.—Each  
22                 eligible managed care provider shall respond to re-  
23                 quests from enrollees for the delivery of medical as-  
24                 sistance in a manner which—

25                         “(A) makes such assistance—

1           “(i) available and accessible to each  
2           such individual, within the area served by  
3           the provider, with reasonable promptness  
4           and in a manner which assures continuity;  
5           and

6           “(ii) when medically necessary, avail-  
7           able and accessible 24 hours a day and 7  
8           days a week; and

9           “(B) with respect to assistance provided to  
10          such an individual other than through the pro-  
11          vider, or without prior authorization, in the  
12          case of a primary care case management pro-  
13          vider, provides for reimbursement to the indi-  
14          vidual (if applicable under the contract between  
15          the State and the provider) if—

16               “(i) the services were medically nec-  
17               essary and immediately required because of  
18               an unforeseen illness, injury, or condition;  
19               and

20               “(ii) it was not reasonable given the  
21               circumstances to obtain the services  
22               through the provider, or, in the case of a  
23               primary care case management provider,  
24               with prior authorization.

1           “(3) EXTERNAL INDEPENDENT REVIEW OF ELI-  
2           GIBLE MANAGED CARE PROVIDER ACTIVITIES.—

3                   “(A) REVIEW OF MEDICAID MANAGED  
4           CARE PLAN CONTRACT.—

5                           “(i) IN GENERAL.—Except as pro-  
6                           vided in subparagraph (B), each medicaid  
7                           managed care plan shall be subject to an  
8                           annual external independent review of the  
9                           quality and timeliness of, and access to,  
10                           the items and services specified in such  
11                           plan’s contract with the State under sec-  
12                           tion 1931(a)(1)(B). Such review shall spe-  
13                           cifically evaluate the extent to which the  
14                           medicaid managed care plan provides such  
15                           services in a timely manner.

16                           “(ii) AVAILABILITY OF RESULTS.—  
17                           The results of each external independent  
18                           review conducted under this subparagraph  
19                           shall be available to participating health  
20                           care providers, enrollees, and potential en-  
21                           rollees of the medicaid managed care plan,  
22                           except that the results may not be made  
23                           available in a manner that discloses the  
24                           identity of any individual patient.

25                           “(B) DEEMED COMPLIANCE.—

1           “(i) MEDICARE PLANS.—The require-  
2           ments of subparagraph (A) shall not apply  
3           with respect to a medicaid managed care  
4           plan if the plan is an eligible organization  
5           with a contract in effect under section  
6           1876.

7           “(ii) PRIVATE ACCREDITATION.—

8           “(I) IN GENERAL.—The require-  
9           ments of subparagraph (A) shall not  
10          apply with respect to a medicaid man-  
11          aged care plan if—

12                 “(aa) the plan is accredited  
13                 by an organization meeting the  
14                 requirements described in clause  
15                 (iii); and

16                 “(bb) the standards and  
17                 process under which the plan is  
18                 accredited meet such require-  
19                 ments as are established under  
20                 subclause (II), without regard to  
21                 whether or not the time require-  
22                 ment of such subclause is satis-  
23                 fied.

24                 “(II) STANDARDS AND PROC-  
25                 ESS.—Not later than 180 days after

1 the date of the enactment of this Act,  
2 the Secretary shall specify require-  
3 ments for the standards and process  
4 under which a medicaid managed care  
5 plan is accredited by an organization  
6 meeting the requirements of clause  
7 (iii).

8 “(iii) ACCREDITING ORGANIZATION.—  
9 An accrediting organization meets the re-  
10 quirements of this clause if the organiza-  
11 tion—

12 “(I) is a private, nonprofit orga-  
13 nization;

14 “(II) exists for the primary pur-  
15 pose of accrediting managed care  
16 plans or health care providers; and

17 “(III) is independent of health  
18 care providers or associations of  
19 health care providers.

20 “(C) REVIEW OF PRIMARY CARE CASE  
21 MANAGEMENT PROVIDER CONTRACT.—Each  
22 primary care case management provider shall  
23 be subject to an annual external independent  
24 review of the quality and timeliness of, and ac-  
25 cess to, the items and services specified in the

1 contract entered into between the State and the  
2 primary care case management provider under  
3 section 1931(a)(1)(B).

4 “(4) PROVIDING INFORMATION ON SERVICES.—

5 “(A) REQUIREMENTS FOR MEDICAID MAN-  
6 AGED CARE PLANS.—

7 “(i) INFORMATION TO THE STATE.—

8 Each medicaid managed care plan shall  
9 provide to the State (at such frequency as  
10 the Secretary may require), complete and  
11 timely information concerning the follow-  
12 ing:

13 “(I) The services that the plan  
14 provides to (or arranges to be pro-  
15 vided to) individuals eligible for medi-  
16 cal assistance under the State plan  
17 under this title.

18 “(II) The identity, locations,  
19 qualifications, and availability of par-  
20 ticipating health care providers.

21 “(III) The rights and responsibil-  
22 ities of enrollees.

23 “(IV) The services provided by  
24 the plan which are subject to prior au-  
25 thorization by the plan as a condition

1 of coverage (in accordance with para-  
2 graph (6)(A)).

3 “(V) The procedures available to  
4 an enrollee and a health care provider  
5 to appeal the failure of the plan to  
6 cover a service.

7 “(VI) The performance of the  
8 plan in serving individuals eligible for  
9 medical assistance under the State  
10 plan under this title.

11 “(ii) INFORMATION TO HEALTH CARE  
12 PROVIDERS, ENROLLEES, AND POTENTIAL  
13 ENROLLEES.—Each medicaid managed  
14 care plan shall—

15 “(I) upon request, make the in-  
16 formation described in clause (i) avail-  
17 able to participating health care pro-  
18 viders, enrollees, and potential enroll-  
19 ees in the plan’s service area; and

20 “(II) provide to enrollees and po-  
21 tential enrollees information regarding  
22 all items and services that are avail-  
23 able to enrollees under the contract  
24 between the State and the plan that  
25 are covered either directly or through

1 a method of referral and prior author-  
2 ization.

3 “(B) REQUIREMENTS FOR PRIMARY CARE  
4 CASE MANAGEMENT PROVIDERS.—Each pri-  
5 mary care case management provider shall—

6 “(i) provide to the State (at such fre-  
7 quency as the Secretary may require),  
8 complete and timely information concern-  
9 ing the services that the primary care case  
10 management provider provides to (or ar-  
11 ranges to be provided to) individuals eligi-  
12 ble for medical assistance under the State  
13 plan under this title;

14 “(ii) make available to enrollees and  
15 potential enrollees information concerning  
16 services available to the enrollee for which  
17 prior authorization by the primary care  
18 case management provider is required; and

19 “(iii) provide enrollees and potential  
20 enrollees information regarding all items  
21 and services that are available to enrollees  
22 under the contract between the State and  
23 the primary care case management pro-  
24 vider that are covered either directly or

1 through a method of referral and prior au-  
2 thorization.

3 “(C) REQUIREMENTS FOR BOTH MEDICAID  
4 MANAGED CARE PLANS AND PRIMARY CARE  
5 CASE MANAGEMENT PROVIDERS.—Each eligible  
6 managed care provider shall provide the State  
7 with aggregate encounter data for early and  
8 periodic screening, diagnostic, and treatment  
9 services under section 1905(r) furnished to in-  
10 dividuals under 21 years of age. Any such data  
11 provided may be audited by the State and the  
12 Secretary.

13 “(5) TIMELINESS OF PAYMENT.—An eligible  
14 managed care provider shall make payment to health  
15 care providers for items and services which are sub-  
16 ject to the contract under section 1931(a)(1)(B) and  
17 which are furnished to individuals eligible for medi-  
18 cal assistance under the State plan under this title  
19 who are enrolled with the provider on a timely basis  
20 and under the claims payment procedures described  
21 in section 1902(a)(37)(A), unless the health care  
22 provider and the eligible managed care provider  
23 agree to an alternate payment schedule.

1           “(6) ADDITIONAL QUALITY ASSURANCE RE-  
2           QUIREMENTS FOR MEDICAID MANAGED CARE  
3           PLANS.—

4           “(A) CONDITIONS FOR PRIOR AUTHORIZA-  
5           TION.—A medicaid managed care plan may re-  
6           quire the approval of medical assistance for  
7           nonemergency services before the assistance is  
8           furnished to an enrollee only if the system pro-  
9           viding for such approval—

10           “(i) provides that such decisions are  
11           made in a timely manner, depending upon  
12           the urgency of the situation; and

13           “(ii) permits coverage of medically  
14           necessary medical assistance provided to  
15           an enrollee without prior authorization in  
16           the event of an emergency.

17           “(B) INTERNAL GRIEVANCE PROCE-  
18           DURE.—Each medicaid managed care plan shall  
19           establish an internal grievance procedure under  
20           which a plan enrollee or a provider on behalf of  
21           such an enrollee who is eligible for medical as-  
22           sistance under the State plan under this title  
23           may challenge the denial of coverage of or pay-  
24           ment for such assistance.

1           “(C) USE OF UNIQUE PHYSICIAN IDENTIFI-  
2           FIER FOR PARTICIPATING PHYSICIANS.—Each  
3           medicaid managed care plan shall require each  
4           physician providing services to enrollees eligible  
5           for medical assistance under the State plan  
6           under this title to have a unique identifier in  
7           accordance with the system established under  
8           section 1902(x).

9           “(D) PATIENT ENCOUNTER DATA.—

10           “(i) IN GENERAL.—Each medicaid  
11           managed care plan shall maintain suffi-  
12           cient patient encounter data to identify the  
13           health care provider who delivers services  
14           to patients and to otherwise enable the  
15           State plan to meet the requirements of sec-  
16           tion 1902(a)(27). The plan shall incor-  
17           porate such information in the mainte-  
18           nance of patient encounter data with re-  
19           spect to such health care provider.

20           “(ii) COMPLIANCE.—A medicaid man-  
21           aged care plan shall—

22           “(I) submit the data maintained  
23           under clause (i) to the State; or

24           “(II) demonstrate to the State  
25           that the data complies with managed

1 care quality assurance guidelines es-  
2 tablished by the Secretary in accord-  
3 ance with clause (iii).

4 “(iii) STANDARDS.—In establishing  
5 managed care quality assurance guidelines  
6 under clause (ii)(II), the Secretary shall  
7 consider—

8 “(I) managed care industry  
9 standards for—

10 “(aa) internal quality assur-  
11 ance; and

12 “(bb) performance meas-  
13 ures; and

14 “(II) any managed care quality  
15 standards established by the National  
16 Association of Insurance Commis-  
17 sioners.

18 “(d) DUE PROCESS REQUIREMENTS FOR ELIGIBLE  
19 MANAGED CARE PROVIDERS.—

20 “(1) DENIAL OF OR UNREASONABLE DELAY IN  
21 DETERMINING COVERAGE AS GROUNDS FOR HEAR-  
22 ING.—If an eligible managed care provider—

23 “(A) denies coverage of or payment for  
24 medical assistance with respect to an enrollee

1           who is eligible for such assistance under the  
2           State plan under this title; or

3           “(B) fails to make any eligibility or cov-  
4           erage determination sought by an enrollee or, in  
5           the case of a medicaid managed care plan, by  
6           a participating health care provider or enrollee,  
7           in a timely manner, depending upon the ur-  
8           gency of the situation,

9           the enrollee or the health care provider furnishing  
10          such assistance to the enrollee (as applicable) may  
11          obtain a hearing before the State agency administer-  
12          ing the State plan under this title in accordance  
13          with section 1902(a)(3), but only, with respect to a  
14          medicaid managed care plan, after completion of the  
15          internal grievance procedure established by the plan  
16          under subsection (c)(6)(B).

17          “(2) COMPLETION OF INTERNAL GRIEVANCE  
18          PROCEDURE.—Nothing in this subsection shall re-  
19          quire completion of an internal grievance procedure  
20          if such procedure does not exist or if the procedure  
21          does not provide for timely review of health needs  
22          considered by the enrollee’s health care provider to  
23          be of an urgent nature.

24          “(e) MISCELLANEOUS.—

1           “(1) PROTECTING ENROLLEES AGAINST THE  
2           INSOLVENCY OF ELIGIBLE MANAGED CARE PROVID-  
3           ERS AND AGAINST THE FAILURE OF THE STATE TO  
4           PAY SUCH PROVIDERS.—Each eligible managed care  
5           provider shall provide that an individual eligible for  
6           medical assistance under the State plan under this  
7           title who is enrolled with the provider may not be  
8           held liable—

9                   “(A) for the debts of the eligible managed  
10                  care provider, in the event of the provider’s in-  
11                  solvency;

12                  “(B) for services provided to the individ-  
13                  ual—

14                          “(i) in the event of the provider fail-  
15                          ing to receive payment from the State for  
16                          such services; or

17                          “(ii) in the event of a health care pro-  
18                          vider with a contractual or other arrange-  
19                          ment with the eligible managed care pro-  
20                          vider failing to receive payment from the  
21                          State or the eligible managed care provider  
22                          for such services; or

23                          “(C) for the debts of any health care pro-  
24                          vider with a contractual or other arrangement  
25                          with the provider to provide services to the indi-

1           vidual, in the event of the insolvency of the  
2           health care provider.

3           “(2) TREATMENT OF CHILDREN WITH SPECIAL  
4           HEALTH CARE NEEDS.—

5                   “(A) IN GENERAL.—In the case of an en-  
6           rollee of an eligible managed care provider who  
7           is a child with special health care needs—

8                           “(i) if any medical assistance specified  
9                           in the contract with the State is identified  
10                          in a treatment plan prepared for the en-  
11                          rollee by a program described in subpara-  
12                          graph (C), the eligible managed care pro-  
13                          vider shall provide (or arrange to be pro-  
14                          vided) such assistance in accordance with  
15                          the treatment plan either—

16                                   “(I) by referring the enrollee to a  
17                                   pediatric health care provider who is  
18                                   trained and experienced in the provi-  
19                                   sion of such assistance and who has a  
20                                   contract with the eligible managed  
21                                   care provider to provide such assist-  
22                                   ance; or

23                                   “(II) if appropriate services are  
24                                   not available through the eligible man-  
25                                   aged care provider, permitting such

1 enrollee to seek appropriate specialty  
2 services from pediatric health care  
3 providers outside of or apart from the  
4 eligible managed care provider; and

5 “(ii) the eligible managed care pro-  
6 vider shall require each health care pro-  
7 vider with whom the eligible managed care  
8 provider has entered into an agreement to  
9 provide medical assistance to enrollees to  
10 furnish the medical assistance specified in  
11 such enrollee’s treatment plan to the ex-  
12 tent the health care provider is able to  
13 carry out such treatment plan.

14 “(B) PRIOR AUTHORIZATION.—An enrollee  
15 referred for treatment under subparagraph  
16 (A)(i)(I), or permitted to seek treatment out-  
17 side of or apart from the eligible managed care  
18 provider under subparagraph (A)(i)(II) shall be  
19 deemed to have obtained any prior authoriza-  
20 tion required by the provider.

21 “(C) CHILD WITH SPECIAL HEALTH CARE  
22 NEEDS.—For purposes of subparagraph (A), a  
23 child with special health care needs is a child  
24 who is receiving services under—

1           “(i) a program administered under  
2           part B or part H of the Individuals with  
3           Disabilities Education Act;

4           “(ii) a program for children with spe-  
5           cial health care needs under title V;

6           “(iii) a program under part B or part  
7           D of title IV; or

8           “(iv) any other program for children  
9           with special health care needs identified by  
10          the Secretary.

11          “(3) PHYSICIAN INCENTIVE PLANS.—Each  
12          medicaid managed care plan shall require that any  
13          physician incentive plan covering physicians who are  
14          participating in the medicaid managed care plan  
15          shall meet the requirements of section 1876(i)(8).

16          “(4) INCENTIVES FOR HIGH QUALITY ELIGIBLE  
17          MANAGED CARE PROVIDERS.—The Secretary and the  
18          State may establish a program to reward, through  
19          public recognition, incentive payments, or enrollment  
20          of additional individuals (or combinations of such re-  
21          wards), eligible managed care providers that provide  
22          the highest quality care to individuals eligible for  
23          medical assistance under the State plan under this  
24          title who are enrolled with such providers. For pur-  
25          poses of section 1903(a)(7), proper expenses in-

1 curred by a State in carrying out such a program  
2 shall be considered to be expenses necessary for the  
3 proper and efficient administration of the State plan  
4 under this title.”.

5 (d) CLARIFICATION OF APPLICATION OF FFP DE-  
6 NIAL RULES TO PAYMENTS MADE PURSUANT TO MEDIC-  
7 AID MANAGED CARE PLANS.—Section 1903(i) of such Act  
8 (42 U.S.C. 1396b(i)) is amended by adding at the end  
9 the following sentence: “Paragraphs (1)(A), (1)(B), (2),  
10 (5), and (12) shall apply with respect to items or services  
11 furnished and amounts expended by or through an eligible  
12 managed care provider (as defined in section 1932(a)(1))  
13 in the same manner as such paragraphs apply to items  
14 or services furnished and amounts expended directly by  
15 the State.”.

16 (e) CLARIFICATION OF CERTIFICATION REQUIRE-  
17 MENTS FOR PHYSICIANS PROVIDING SERVICES TO CHIL-  
18 DREN AND PREGNANT WOMEN.—Section 1903(i)(12) of  
19 such Act (42 U.S.C. 1396b(i)(12)) is amended—

20 (1) in subparagraph (A)(i), to read as follows:

21 “(i) is certified in family practice or  
22 pediatrics by the medical specialty board  
23 recognized by the American Board of Med-  
24 ical Specialties for family practice or pedi-  
25 atrics or is certified in general practice or

1           pediatrics by the medical specialty board  
2           recognized by the American Osteopathic  
3           Association,”;

4           (2) in subparagraph (B)(i), to read as follows:

5                   “(i) is certified in family practice or  
6                   obstetrics by the medical specialty board  
7                   recognized by the American Board of Med-  
8                   ical Specialties for family practice or ob-  
9                   stetrics or is certified in family practice or  
10                  obstetrics by the medical specialty board  
11                  recognized by the American Osteopathic  
12                  Association,”; and

13          (3) in both subparagraphs (A) and (B)—

14                  (A) by striking “or” at the end of clause  
15                  (v);

16                  (B) by redesignating clause (vi) as clause  
17                  (vii); and

18                  (C) by inserting after clause (v) the follow-  
19                  ing new clause:

20                          “(vi) delivers such services in the  
21                          emergency department of a hospital par-  
22                          ticipating in the State plan approved under  
23                          this title, or”.

1 **SEC. 4. ADDITIONAL REQUIREMENTS FOR MEDICAID MAN-**  
2 **AGED CARE PLANS.**

3 Section 1932 of the Social Security Act, as added by  
4 section 3(c)(2), is amended—

5 (1) by redesignating subsections (d) and (e) as  
6 subsections (e) and (f), respectively; and

7 (2) by inserting after subsection (c) the follow-  
8 ing new subsection:

9 “(d) ADDITIONAL REQUIREMENTS FOR MEDICAID  
10 MANAGED CARE PLANS.—

11 “(1) DEMONSTRATION OF ADEQUATE CAPACITY  
12 AND SERVICES.—

13 “(A) IN GENERAL.—Subject to subpara-  
14 graph (C), each medicaid managed care plan  
15 shall provide the State and the Secretary with  
16 adequate assurances (as determined by the Sec-  
17 retary) that the plan, with respect to a service  
18 area—

19 “(i) has the capacity to serve the ex-  
20 pected enrollment in such service area;

21 “(ii) offers an appropriate range of  
22 services for the population expected to be  
23 enrolled in such service area, including  
24 transportation services and translation  
25 services consisting of the principal lan-  
26 guages spoken in the service area;

1           “(iii) maintains sufficient numbers of  
2 providers of services included in the con-  
3 tract with the State to ensure that services  
4 are available to individuals receiving medi-  
5 cal assistance and enrolled in the plan to  
6 the same extent that such services are  
7 available to individuals enrolled in the plan  
8 who are not recipients of medical assist-  
9 ance under the State plan under this title;

10           “(iv) maintains extended hours of op-  
11 eration with respect to primary care serv-  
12 ices that are beyond those maintained dur-  
13 ing a normal business day;

14           “(v) provides preventive and primary  
15 care services in locations that are readily  
16 accessible to members of the community;  
17 and

18           “(vi) provides information concerning  
19 educational, social, health, and nutritional  
20 services offered by other programs for  
21 which enrollees may be eligible.

22           “(B) PROOF OF ADEQUATE PRIMARY CARE  
23 CAPACITY AND SERVICES.—Subject to subpara-  
24 graph (C), a medicaid managed care plan that  
25 contracts with a reasonable number of primary

1 care providers (as determined by the Secretary)  
2 and whose primary care membership includes a  
3 reasonable number (as so determined) of the  
4 following providers will be deemed to have satis-  
5 fied the requirements of subparagraph (A):

6 “(i) Rural health clinics, as defined in  
7 section 1905(l)(1).

8 “(ii) Federally-qualified health cen-  
9 ters, as defined in section 1905(l)(2)(B).

10 “(iii) Clinics which are eligible to re-  
11 ceive payment for services provided under  
12 title X of the Public Health Service Act.

13 “(C) SUFFICIENT PROVIDERS OF SPECIAL-  
14 IZED SERVICES.—Notwithstanding subpara-  
15 graphs (A) and (B), a medicaid managed care  
16 plan may not be considered to have satisfied the  
17 requirements of subparagraph (A) if the plan  
18 does not have a sufficient number (as deter-  
19 mined by the Secretary) of providers of special-  
20 ized services, including perinatal and pediatric  
21 specialty care, to ensure that such services are  
22 available and accessible.

23 “(2) WRITTEN PROVIDER PARTICIPATION  
24 AGREEMENTS FOR CERTAIN PROVIDERS.—Each  
25 medicaid managed care plan that enters into a writ-

1 ten provider participation agreement with a provider  
2 described in paragraph (1)(B) shall—

3 “(A) include terms and conditions that are  
4 no more restrictive than the terms and condi-  
5 tions that the medicaid managed care plan in-  
6 cludes in its agreements with other participat-  
7 ing providers with respect to—

8 “(i) the scope of covered services for  
9 which payment is made to the provider;

10 “(ii) the assignment of enrollees by  
11 the plan to the provider;

12 “(iii) the limitation on financial risk  
13 or availability of financial incentives to the  
14 provider;

15 “(iv) accessibility of care;

16 “(v) professional credentialing and  
17 recredentialing;

18 “(vi) licensure;

19 “(vii) quality and utilization manage-  
20 ment;

21 “(viii) confidentiality of patient  
22 records;

23 “(ix) grievance procedures; and

24 “(x) indemnification arrangements be-  
25 tween the plans and providers; and

1           “(B) provide for payment to the provider  
2           on a basis that is comparable to the basis on  
3           which other providers are paid.”.

4 **SEC. 5. PREVENTING FRAUD IN MEDICAID MANAGED CARE.**

5           (a) IN GENERAL.—Section 1932 of the Social Secu-  
6 rity Act, as added by section 3(c)(2) and amended by sec-  
7 tion 4, is amended—

8           (1) by redesignating subsection (f) as sub-  
9 section (g); and

10          (2) by inserting after subsection (e) the follow-  
11 ing new subsection:

12          “(f) ANTI-FRAUD PROVISIONS.—

13                 “(1) PROVISIONS APPLICABLE TO ELIGIBLE  
14 MANAGED CARE PROVIDERS.—

15                 “(A) PROHIBITING AFFILIATIONS WITH IN-  
16 DIVIDUALS DEBARRED BY FEDERAL AGEN-  
17 CIES.—

18                 “(i) IN GENERAL.—An eligible man-  
19 aged care provider may not knowingly—

20                         “(I) have a person described in  
21 clause (iii) as a director, officer, part-  
22 ner, or person with beneficial owner-  
23 ship of more than 5 percent of the  
24 plan’s equity; or

1           “(II) have an employment, con-  
2           sulting, or other agreement with a  
3           person described in clause (iii) for the  
4           provision of items and services that  
5           are significant and material to the or-  
6           ganization’s obligations under its con-  
7           tract with the State.

8           “(ii) EFFECT OF NONCOMPLIANCE.—  
9           If a State finds that an eligible managed  
10          care provider is not in compliance with  
11          subclause (I) or (II) of clause (i), the  
12          State—

13               “(I) shall notify the Secretary of  
14               such noncompliance;

15               “(II) may continue an existing  
16               agreement with the provider unless  
17               the Secretary (in consultation with the  
18               Inspector General of the Department  
19               of Health and Human Services) di-  
20               rects otherwise; and

21               “(III) may not renew or other-  
22               wise extend the duration of an exist-  
23               ing agreement with the provider un-  
24               less the Secretary (in consultation  
25               with the Inspector General of the De-

1 department of Health and Human Serv-  
2 ices) provides to the State and to the  
3 Congress a written statement describ-  
4 ing compelling reasons that exist for  
5 renewing or extending the agreement.

6 “(iii) PERSONS DESCRIBED.—A per-  
7 son is described in this clause if such per-  
8 son—

9 “(I) is debarred or suspended by  
10 the Federal Government, pursuant to  
11 the Federal acquisition regulation,  
12 from Government contracting and  
13 subcontracting;

14 “(II) is an affiliate (within the  
15 meaning of the Federal acquisition  
16 regulation) of a person described in  
17 clause (i); or

18 “(III) is excluded from participa-  
19 tion in any program under title XVIII  
20 or any State health care program, as  
21 defined in section 1128(h).

22 “(B) RESTRICTIONS ON MARKETING.—

23 “(i) DISTRIBUTION OF MATERIALS.—

24 “(I) IN GENERAL.—An eligible  
25 managed care provider may not dis-

1           tribute marketing materials within  
2           any State—

3                   “(aa) without the prior ap-  
4                   proval of the State; and

5                   “(bb) that contain false or  
6                   materially misleading informa-  
7                   tion.

8                   “(II) PROHIBITION.—The State  
9                   may not enter into or renew a con-  
10                  tract with an eligible managed care  
11                  provider for the provision of services  
12                  to individuals enrolled under the State  
13                  plan under this title if the State de-  
14                  termines that the provider inten-  
15                  tionally distributed false or materially  
16                  misleading information in violation of  
17                  subclause (I)(bb).

18                  “(ii) SERVICE MARKET.—An eligible  
19                  managed care provider shall distribute  
20                  marketing materials to the entire service  
21                  area of such provider.

22                  “(iii) PROHIBITION OF TIE-INS.—An  
23                  eligible managed care provider, or any  
24                  agency of such provider, may not seek to  
25                  influence an individual’s enrollment with

1 the provider in conjunction with the sale of  
2 any other insurance.

3 “(iv) PROHIBITING MARKETING  
4 FRAUD.—Each eligible managed care pro-  
5 vider shall comply with such procedures  
6 and conditions as the Secretary prescribes  
7 in order to ensure that, before an individ-  
8 ual is enrolled with the provider, the indi-  
9 vidual is provided accurate and sufficient  
10 information to make an informed decision  
11 whether or not to enroll.

12 “(2) PROVISIONS APPLICABLE ONLY TO MEDIC-  
13 AID MANAGED CARE PLANS.—

14 “(A) STATE CONFLICT-OF-INTEREST SAFE-  
15 GUARDS IN MEDICAID RISK CONTRACTING.—A  
16 medicaid managed care plan may not enter into  
17 a contract with any State under section  
18 1931(a)(1)(B) unless the State has in effect  
19 conflict-of-interest safeguards with respect to  
20 officers and employees of the State with respon-  
21 sibilities relating to contracts with such plans or  
22 to the default enrollment process described in  
23 section 1931(a)(1)(D)(iv) that are at least as  
24 effective as the Federal safeguards provided  
25 under section 27 of the Office of Federal Pro-

1           curement Policy Act (41 U.S.C. 423), against  
2           conflicts of interest that apply with respect to  
3           Federal procurement officials with comparable  
4           responsibilities with respect to such contracts.

5           “(B) REQUIRING DISCLOSURE OF FINAN-  
6           CIAL INFORMATION.—In addition to any re-  
7           quirements applicable under section  
8           1902(a)(27) or 1902(a)(35), a medicaid man-  
9           aged care plan shall—

10           “(i) report to the State (and to the  
11           Secretary upon the Secretary’s request)  
12           such financial information as the State or  
13           the Secretary may require to demonstrate  
14           that—

15           “(I) the plan has the ability to  
16           bear the risk of potential financial  
17           losses and otherwise has a fiscally  
18           sound operation;

19           “(II) the plan uses the funds  
20           paid to it by the State and the Sec-  
21           retary for activities consistent with  
22           the requirements of this title and the  
23           contract between the State and plan;  
24           and

1           “(III) the plan does not place an  
2           individual physician, physician group,  
3           or other health care provider at sub-  
4           stantial risk (as determined by the  
5           Secretary) for services not provided by  
6           such physician, group, or health care  
7           provider, by providing adequate pro-  
8           tection (as determined by the Sec-  
9           retary) to limit the liability of such  
10          physician, group, or health care pro-  
11          vider, through measures such as stop  
12          loss insurance or appropriate risk cor-  
13          ridors;

14          “(ii) agree that the Secretary and the  
15          State (or any person or organization des-  
16          ignated by either) shall have the right to  
17          audit and inspect any books and records of  
18          the plan (and of any subcontractor) relat-  
19          ing to the information reported pursuant  
20          to clause (i) and any information required  
21          to be furnished under section paragraphs  
22          (27) or (35) of section 1902(a);

23          “(iii) make available to the Secretary  
24          and the State a description of each trans-  
25          action described in subparagraphs (A)

1 through (C) of section 1318(a)(3) of the  
2 Public Health Service Act between the  
3 plan and a party in interest (as defined in  
4 section 1318(b) of such Act); and

5 “(iv) agree to make available to its  
6 enrollees upon reasonable request—

7 “(I) the information reported  
8 pursuant to clause (i); and

9 “(II) the information required to  
10 be disclosed under sections 1124 and  
11 1126.

12 “(C) ADEQUATE PROVISION AGAINST RISK  
13 OF INSOLVENCY.—

14 “(i) ESTABLISHMENT OF STAND-  
15 ARDS.—The Secretary shall establish  
16 standards, including appropriate equity  
17 standards, under which each medicaid  
18 managed care plan shall make adequate  
19 provision against the risk of insolvency.

20 “(ii) CONSIDERATION OF OTHER  
21 STANDARDS.—In establishing the stand-  
22 ards described in clause (i), the Secretary  
23 shall consider—

1           “(I) such solvency standards as  
2           the National Association of Insurance  
3           Commissioners may prescribe; and

4           “(II) solvency standards applica-  
5           ble to eligible organizations with a  
6           risk-sharing contract under section  
7           1876.

8           “(D) REQUIRING REPORT ON NET EARN-  
9           INGS AND ADDITIONAL BENEFITS.—Each med-  
10          icaid managed care plan shall submit a report  
11          to the State and the Secretary not later than  
12          12 months after the close of a contract year  
13          containing—

14               “(i) the most recent audited financial  
15               statement of the plan’s net earnings, in ac-  
16               cordance with guidelines established by the  
17               Secretary in consultation with the States,  
18               and consistent with generally accepted ac-  
19               counting principles; and

20               “(ii) a description of any benefits that  
21               are in addition to the benefits required to  
22               be provided under the contract that were  
23               provided during the contract year to mem-  
24               bers enrolled with the plan and entitled to

1           medical assistance under the State plan  
2           under this title.”.

3 **SEC. 6. SANCTIONS FOR NONCOMPLIANCE BY ELIGIBLE**  
4 **MANAGED CARE PROVIDERS.**

5           (a) SANCTIONS DESCRIBED.—Title XIX of such Act  
6 (42 U.S.C. 1396 et seq.), as amended by section 3(c), is  
7 amended—

8           (1) by redesignating section 1933 as section  
9           1934; and

10           (2) by inserting after section 1932 the following  
11           new section:

12           “SANCTIONS FOR NONCOMPLIANCE BY ELIGIBLE  
13   MANAGED CARE PROVIDERS

14           “SEC. 1933. (a) USE OF INTERMEDIATE SANCTIONS  
15 BY THE STATE TO ENFORCE REQUIREMENTS.—Each  
16 State shall establish intermediate sanctions, which may in-  
17 clude any of the types described in subsection (b) other  
18 than the termination of a contract with an eligible man-  
19 aged care provider, which the State may impose against  
20 an eligible managed care provider with a contract under  
21 section 1931(a)(1)(B) if the provider—

22           “(1) fails substantially to provide medically nec-  
23           essary items and services that are required (under  
24           law or under such provider’s contract with the  
25           State) to be provided to an enrollee covered under  
26           the contract, if the failure has adversely affected (or

1 has a substantial likelihood of adversely affecting)  
2 the enrollee;

3 “(2) imposes premiums on enrollees in excess of  
4 the premiums permitted under this title;

5 “(3) acts to discriminate among enrollees on  
6 the basis of their health status or requirements for  
7 health care services, including expulsion or refusal to  
8 reenroll an individual, except as permitted by sec-  
9 tions 1931 and 1932, or engaging in any practice  
10 that would reasonably be expected to have the effect  
11 of denying or discouraging enrollment with the pro-  
12 vider by eligible individuals whose medical condition  
13 or history indicates a need for substantial future  
14 medical services;

15 “(4) misrepresents or falsifies information that  
16 is furnished—

17 “(A) to the Secretary or the State under  
18 section 1931 or 1932; or

19 “(B) to an enrollee, potential enrollee, or a  
20 health care provider under such sections; or

21 “(5) fails to comply with the requirements of  
22 section 1876(i)(8).

23 “(b) INTERMEDIATE SANCTIONS.—The sanctions de-  
24 scribed in this subsection are as follows:

25 “(1) Civil money penalties as follows:

1           “(A) Except as provided in subparagraph  
2           (B), (C), or (D), not more than \$25,000 for  
3           each determination under subsection (a).

4           “(B) With respect to a determination  
5           under paragraph (3) or (4)(A) of subsection  
6           (a), not more than \$100,000 for each such de-  
7           termination.

8           “(C) With respect to a determination  
9           under subsection (a)(2), double the excess  
10          amount charged in violation of such subsection  
11          (and the excess amount charged shall be de-  
12          ducted from the penalty and returned to the in-  
13          dividual concerned).

14          “(D) Subject to subparagraph (B), with  
15          respect to a determination under subsection  
16          (a)(3), \$15,000 for each individual not enrolled  
17          as a result of a practice described in such sub-  
18          section.

19          “(2) The appointment of temporary manage-  
20          ment to oversee the operation of the eligible man-  
21          aged care provider and to assure the health of the  
22          provider’s enrollees, if there is a need for temporary  
23          management while—

1           “(A) there is an orderly termination or re-  
2           organization of the eligible managed care pro-  
3           vider; or

4           “(B) improvements are made to remedy  
5           the violations found under subsection (a),  
6           except that temporary management under this para-  
7           graph may not be terminated until the State has de-  
8           termined that the eligible managed care provider has  
9           the capability to ensure that the violations shall not  
10          recur.

11          “(3) Permitting individuals enrolled with the el-  
12          igible managed care provider to terminate enroll-  
13          ment without cause, and notifying such individuals  
14          of such right to terminate enrollment.

15          “(c) TREATMENT OF CHRONIC SUBSTANDARD PRO-  
16          VIDERS.—In the case of an eligible managed care provider  
17          which has repeatedly failed to meet the requirements of  
18          section 1931 or 1932, the State shall (regardless of what  
19          other sanctions are provided) impose the sanctions de-  
20          scribed in paragraphs (2) and (3) of subsection (b).

21          “(d) AUTHORITY TO TERMINATE CONTRACT.—In  
22          the case of an eligible managed care provider which has  
23          failed to meet the requirements of section 1931 or 1932,  
24          the State shall have the authority to terminate its contract  
25          with such provider under section 1931(a)(1)(B) and to en-

1 roll such provider's enrollees with other eligible managed  
2 care providers (or to permit such enrollees to receive medi-  
3 cal assistance under the State plan under this title other  
4 than through an eligible managed care provider).

5 “(e) AVAILABILITY OF SANCTIONS TO THE SEC-  
6 RETARY.—

7 “(1) INTERMEDIATE SANCTIONS.—In addition  
8 to the sanctions described in paragraph (2) and any  
9 other sanctions available under law, the Secretary  
10 may provide for any of the sanctions described in  
11 subsection (b) if the Secretary determines that—

12 “(A) an eligible managed care provider  
13 with a contract under section 1931(a)(1)(B)  
14 fails to meet any of the requirements of section  
15 1931 or 1932; and

16 “(B) the State has failed to act appro-  
17 priately to address such failure.

18 “(2) DENIAL OF PAYMENTS TO THE STATE.—  
19 The Secretary may deny payments to the State for  
20 medical assistance furnished under the contract  
21 under section 1931(a)(1)(B) for individuals enrolled  
22 after the date the Secretary notifies an eligible man-  
23 aged care provider of a determination under sub-  
24 section (a) and until the Secretary is satisfied that

1 the basis for such determination has been corrected  
2 and is not likely to recur.

3 “(f) DUE PROCESS FOR ELIGIBLE MANAGED CARE  
4 PROVIDERS.—

5 “(1) AVAILABILITY OF HEARING PRIOR TO TER-  
6 MINATION OF CONTRACT.—A State may not termi-  
7 nate a contract with an eligible managed care pro-  
8 vider under section 1931(a)(1)(B) unless the pro-  
9 vider is provided with a hearing prior to the termi-  
10 nation.

11 “(2) NOTICE TO ENROLLEES OF TERMINATION  
12 HEARING.—A State shall notify all individuals en-  
13 rolled with an eligible managed care provider which  
14 is the subject of a hearing to terminate the provid-  
15 er’s contract with the State of the hearing and that  
16 the enrollees may immediately disenroll with the pro-  
17 vider for cause.

18 “(3) OTHER PROTECTIONS FOR ELIGIBLE MAN-  
19 AGED CARE PROVIDERS AGAINST SANCTIONS IM-  
20 POSED BY STATE.—Before imposing any sanction  
21 against an eligible managed care provider other than  
22 termination of the provider’s contract, the State  
23 shall provide the provider with notice and such other  
24 due process protections as the State may provide,  
25 except that a State may not provide an eligible man-

1 aged care provider with a pretermination hearing be-  
2 fore imposing the sanction described in subsection  
3 (b)(2).

4 “(4) IMPOSITION OF CIVIL MONETARY PEN-  
5 ALTIES BY SECRETARY.—The provisions of section  
6 1128A (other than subsections (a) and (b)) shall  
7 apply with respect to a civil money penalty imposed  
8 by the Secretary under subsection (b)(1) in the same  
9 manner as such provisions apply to a penalty or pro-  
10 ceeding under section 1128A.”.

11 (b) CONFORMING AMENDMENT RELATING TO TERMI-  
12 NATION OF ENROLLMENT FOR CAUSE.—Section  
13 1932(b)(2)(B) of the Social Security Act, as added by sec-  
14 tion 3(c)(2), is amended by inserting after “coercion” the  
15 following: “, or pursuant to the imposition against the eli-  
16 gible managed care provider of the sanction described in  
17 section 1933(b)(3),”.

18 **SEC. 7. CONFORMING AMENDMENTS.**

19 (a) EXCLUSION OF CERTAIN INDIVIDUALS AND EN-  
20 TITIES FROM PARTICIPATION IN PROGRAM.—Section  
21 1128(b)(6)(C) of the Social Security Act (42 U.S.C.  
22 1320a-7(b)(6)(C)) is amended—

23 (1) in clause (i), by striking “a health mainte-  
24 nance organization (as defined in section 1903(m))”

1 and inserting “an eligible managed care provider, as  
2 defined in section 1932(a)(1),”; and

3 (2) in clause (ii), by inserting “section 1115 or”  
4 after “approved under”.

5 (b) STATE PLAN REQUIREMENTS.—Section 1902 of  
6 the Social Security Act (42 U.S.C. 1396a) is amended—

7 (1) in subsection (a)(30)(C), by striking “sec-  
8 tion 1903(m)” and inserting “section  
9 1931(a)(1)(B)”; and

10 (2) in subsection (a)(57), by striking “hospice  
11 program, or health maintenance organization (as de-  
12 fined in section 1903(m)(1)(A))” and inserting “or  
13 hospice program”;

14 (3) in subsection (e)(2)(A), by striking “or with  
15 an entity described in paragraph (2)(B)(iii), (2)(E),  
16 (2)(G), or (6) of section 1903(m) under a contract  
17 described in section 1903(m)(2)(A)”;

18 (4) in subsection (p)(2)—

19 (A) by striking “a health maintenance or-  
20 ganization (as defined in section 1903(m))” and  
21 inserting “an eligible managed care provider, as  
22 defined in section 1932(a)(1),”;

23 (B) by striking “an organization” and in-  
24 serting “a provider”; and

1 (C) by striking “any organization” and in-  
2 serting “any provider”; and

3 (5) in subsection (w)(1), by striking “sections  
4 1903(m)(1)(A) and” and inserting “section”.

5 (c) PAYMENT TO STATES.—Section  
6 1903(w)(7)(A)(viii) of the Social Security Act (42 U.S.C.  
7 1396b(w)(7)(A)(viii)) is amended to read as follows:

8 “(viii) Services of an eligible managed care  
9 provider with a contract under section  
10 1931(a)(1)(B).”.

11 (d) USE OF ENROLLMENT FEES AND OTHER  
12 CHARGES.—Section 1916 of the Social Security Act (42  
13 U.S.C. 1396o) is amended in subsections (a)(2)(D) and  
14 (b)(2)(D) by striking “a health maintenance organization  
15 (as defined in section 1903(m))” and inserting “an eligible  
16 managed care provider, as defined in section 1932(a)(1),”  
17 each place it appears.

18 (e) EXTENSION OF ELIGIBILITY FOR MEDICAL AS-  
19 SISTANCE.—Section 1925(b)(4)(D)(iv) of the Social Secu-  
20 rity Act (42 U.S.C. 1396r-6(b)(4)(D)(iv)) is amended to  
21 read as follows:

22 “(iv) ENROLLMENT WITH ELIGIBLE  
23 MANAGED CARE PROVIDER.—Enrollment of  
24 the caretaker relative and dependent chil-  
25 dren with an eligible managed care pro-

1 vider, as defined in section 1932(a)(1), less  
2 than 50 percent of the membership (en-  
3 rolled on a prepaid basis) of which consists  
4 of individuals who are eligible to receive  
5 benefits under this title (other than be-  
6 cause of the option offered under this  
7 clause). The option of enrollment under  
8 this clause is in addition to, and not in lieu  
9 of, any enrollment option that the State  
10 might offer under subparagraph (A)(i)  
11 with respect to receiving services through  
12 an eligible managed care provider in ac-  
13 cordance with sections 1931, 1932, and  
14 1933.”.

15 (f) ASSURING ADEQUATE PAYMENT LEVELS FOR OB-  
16 STETRICAL AND PEDIATRIC SERVICES.—Section 1926(a)  
17 of the Social Security Act (42 U.S.C. 1396r-7(a)) is  
18 amended in paragraphs (1) and (2) by striking “health  
19 maintenance organizations under section 1903(m)” and  
20 inserting “eligible managed care providers under contracts  
21 entered into under section 1931(a)(1)(B)” each place it  
22 appears.

23 (g) PAYMENT FOR COVERED OUTPATIENT DRUGS.—  
24 Section 1927(j)(1) of the Social Security Act (42 U.S.C.  
25 1396r-8(j)(1)) is amended by striking “\*\*\*Health Main-

1 tenance Organizations, including those organizations that  
2 contract under section 1903(m),” and inserting “health  
3 maintenance organizations and medicaid managed care  
4 plans, as defined in section 1932(a)(2),”.

5 (h) DEMONSTRATION PROJECTS TO STUDY EFFECT  
6 OF ALLOWING STATES TO EXTEND MEDICAID COVERAGE  
7 FOR CERTAIN FAMILIES.—Section 4745(a)(5)(A) of the  
8 Omnibus Budget Reconciliation Act of 1990 (42 U.S.C.  
9 1396a note) is amended by striking “(except section  
10 1903(m))” and inserting “(except sections 1931, 1932, and  
11 1933)”.

12 **SEC. 8. EFFECTIVE DATE; STATUS OF WAIVERS.**

13 (a) EFFECTIVE DATE.—Except as provided in sub-  
14 section (b), the amendments made by this Act shall apply  
15 to medical assistance furnished—

16 (1) during quarters beginning on or after Octo-  
17 ber 1, 1995; or

18 (2) in the case of assistance furnished under a  
19 contract described in section 3(b), during quarters  
20 beginning after the earlier of—

21 (A) the date of the expiration of the con-  
22 tract; or

23 (B) the expiration of the 1-year period  
24 which begins on the date of the enactment of  
25 this Act.

1 (b) APPLICATION TO WAIVERS.—

2 (1) EXISTING WAIVERS.—If any waiver granted  
3 to a State under section 1115 or 1915 of the Social  
4 Security Act (42 U.S.C. 1315, 1396n) or otherwise  
5 which relates to the provision of medical assistance  
6 under a State plan under title XIX of the such Act  
7 (42 U.S.C. 1396 et seq.), is in effect or approved by  
8 the Secretary of Health and Human Services (in this  
9 subsection referred to as the “Secretary”) as of the  
10 applicable effective date described in subsection (a),  
11 the amendments made by this Act shall not apply  
12 with respect to the State before the expiration (de-  
13 termined without regard to any extensions) of the  
14 waiver to the extent such amendments are inconsis-  
15 tent with the terms of the waiver.

16 (2) SECRETARIAL EVALUATION AND REPORT  
17 FOR EXISTING WAIVERS AND EXTENSIONS.—

18 (A) PRIOR TO APPROVAL.—On and after  
19 the applicable effective date described in sub-  
20 section (a), the Secretary, prior to extending  
21 any waiver granted under section 1115 or 1915  
22 of the Social Security Act (42 U.S.C. 1315,  
23 1396n) or otherwise which relates to the provi-  
24 sion of medical assistance under a State plan

1 under title XIX of the such Act (42 U.S.C.  
2 1396 et seq.), shall—

3 (i) conduct an evaluation of—

4 (I) the waivers existing under  
5 such sections or other provision of law  
6 as of the date of the enactment of this  
7 Act; and

8 (II) any applications pending, as  
9 of the date of the enactment of this  
10 Act, for extensions of waivers under  
11 such sections or other provision of  
12 law; and

13 (ii) submit a report to the Congress  
14 recommending whether the extension of a  
15 waiver under such sections or provision of  
16 law should be conditioned on the State  
17 submitting the request for an extension  
18 complying with the provisions of sections  
19 1931, 1932, and 1933 of the Social Secu-  
20 rity Act (as added by this Act).

21 (B) DEEMED APPROVAL.—If the Congress  
22 has not enacted legislation based on a report  
23 submitted under subparagraph (A)(ii) within  
24 120 days after the date such report is submit-  
25 ted to the Congress, the recommendations con-

1           tained in such report shall be deemed to be ap-  
2           proved by the Congress.

3           (3) FUTURE WAIVERS.—

4           (A) IN GENERAL.—Except as provided in  
5           paragraphs (1) and (2), and subparagraph (B),  
6           the Secretary may not waive the application of  
7           section 1931, 1932, or 1933 of such Act (as  
8           added by this Act) with respect to any State.

9           (B) SPECIAL RULE REGARDING A WAIVER  
10          OF THE REQUIREMENTS APPLICABLE TO ELIGI-  
11          BLE MANAGED CARE PROVIDERS FOR CHIL-  
12          DREN WITH SPECIAL HEALTH CARE NEEDS.—  
13          Notwithstanding the provisions of subparagraph  
14          (A), the Secretary may waive, pursuant to sec-  
15          tion 1115 or 1915 of the Social Security Act  
16          (42 U.S.C. 1315, 1396n), or otherwise, the ap-  
17          plication of section 1932(g)(2) of such Act (as  
18          added by this Act) if the State applying for the  
19          waiver demonstrates that, with respect to each  
20          eligible managed care provider having an en-  
21          rollee who is a child with special health care  
22          needs (as defined in section 1932(g)(2)(B) of  
23          such Act), such provider shall—

24                   (i) provide (or arrange to be provided)  
25                   any medical assistance specified in the pro-

1 vider's contract with the State that is iden-  
2 tified in a treatment plan for the enrollee  
3 prepared by a program described in section  
4 1932(g)(2)(B) of such Act in accordance  
5 with such treatment plan—

6 (I) without regard to any prior  
7 authorization requirement which  
8 would otherwise apply to the provision  
9 of such assistance; and

10 (II) unless the eligible managed  
11 care provider demonstrates to the sat-  
12 isfaction of the Secretary that the  
13 provider is or has an arrangement  
14 with a health care provider with the  
15 specialized pediatric expertise required  
16 to provide the medical assistance spec-  
17 ified in the treatment plan, without  
18 regard to whether or not the health  
19 care provider specified in the treat-  
20 ment plan has otherwise entered into  
21 an agreement with the eligible man-  
22 aged care provider to provide medical  
23 assistance to plan enrollees;

24 (ii) require each health care provider  
25 with whom the eligible managed care pro-

1 vider has entered into an agreement to  
2 provide medical assistance to enrollees to  
3 furnish medical assistance specified in such  
4 treatment plan to the extent necessary to  
5 carry out such treatment plan; and  
6 (iii) demonstrate that it has adequate  
7 written agreements with pediatric special-  
8 ists as determined by the Secretary to en-  
9 sure appropriate specialist care and refer-  
10 rals.

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