§ 438.52 Choice of MCOs, PIHPs, PAHPs, and PCCMs.

(a) General rule. Except as specified in paragraphs (b) and (c) of this section, a State that requires Medicaid recipients to enroll in an MCO, PIHP, PAHP, or PCCM must give those recipients a choice of at least two entities.

(b) Exception for rural area residents. 

(1) Under any of the following programs, and subject to the requirements of paragraph (b)(2) of this section, a State may limit a rural area resident to a single MCO, PIHP, PAHP, or PCCM system:

(i) A program authorized by a plan amendment under section 1932(a) of the Act.

(ii) A waiver under section 1115 of the Act.

(iii) A waiver under section 1915(b) of the Act.

(2) A State that elects the option provided under paragraph (b)(1) of this section, must permit the recipient—

(i) To choose from at least two physicians or case managers; and

(ii) To obtain services from any other provider under any of the following circumstances:

(A) The service or type of provider (in terms of training, experience, and specialization) is not available within the MCO, PIHP, PAHP, or PCCM network.

(B) The provider is not part of the network, but is the main source of a service to the recipient, provided that—

(1) The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO, PIHP, PAHP, or PCCM network;

(2) The provider is not part of the network, but is the main source of a service to the recipient provided that—

(i) The provider is given the opportunity to become a participating provider under the same requirements for participation in the MCO, PIHP, PAHP, or PCCM network;

(ii) The only plan or provider available to the recipient does not, because of moral or religious objections, provide the service the enrollee seeks.

(D) The recipient’s primary care provider or other provider determines that the recipient needs related services that would subject the recipient to unnecessary risk if received separately (for example, a cesarean section and a tubal ligation) and not all of the related services are available within the network.


(3) As used in this paragraph, “rural area” is any area other than an “urban area” as defined in §412.62(f)(1)(ii) of this chapter.

(c) Exception for certain health insuring organizations (HIOs). The State may limit recipients to a single HIO if—

(1) The HIO is one of those described in section 1932(a)(3)(C) of the Act; and

(2) The recipient who enrolls in the HIO has a choice of at least two primary care providers within the entity.

(d) Limitations on changes between primary care providers. For an enrollee of a single MCO, PIHP, PAHP, or HIO under paragraph (b) or (c) of this section, any limitation the State imposes on his or her freedom to change between primary care providers may be no more restrictive than the limitations on disenrollment under §438.56(c).

[67 FR 41095, June 14, 2002; 67 FR 65505, Oct. 25, 2002]

§ 438.56 Disenrollment: Requirements and limitations.

(a) Applicability. The provisions of this section apply to all mandatory or voluntary managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with an MCO, a PIHP, a PAHP, or a PCCM.

(b) Disenrollment requested by the MCO, PIHP, PAHP, or PCCM. All MCO, PIHP, PAHP, and PCCM contracts must—

(1) Specify the reasons for which the MCO, PIHP, PAHP, or PCCM may request disenrollment of an enrollee;

(2) Provide that the MCO, PIHP, PAHP, or PCCM may not request disenrollment because of an adverse change in the enrollee’s health status, or because of the enrollee’s utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the MCO, PIHP, PAHP, or PCCM seriously impairs the entity’s ability to furnish...
services to either this particular enrollee or other enrollees); and
(3) Specify the methods by which the MCO, PIHP, PAHP, or PCCM assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

(c) Disenrollment requested by the enrollee. If the State chooses to limit disenrollment, its MCO, PIHP, PAHP, and PCCM contracts must provide that a recipient may request disenrollment as follows:

(1) For cause, at any time.
(2) Without cause, at the following times:
   (i) During the 90 days following the date of the recipient’s initial enrollment with the MCO, PIHP, PAHP, or PCCM, or the date the State sends the recipient notice of the enrollment, whichever is later.
   (ii) At least once every 12 months thereafter.
   (iii) Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

(iv) When the State imposes the intermediate sanction specified in §438.702(a)(3).

(d) Procedures for disenrollment—(1) Request for disenrollment. The recipient (or his or her representative) must submit an oral or written request—
   (i) To the State agency (or its agent); or
   (ii) To the MCO, PIHP, PAHP, or PCCM, if the State permits MCOs, PIHPs, PAHPs, and PCCMs to process disenrollment requests.

(2) Cause for disenrollment. The following are cause for disenrollment:
   (i) The enrollee moves out of the MCO’s, PIHP’s, PAHP’s, or PCCM’s service area.
   (ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks—
   (i) The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee’s primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

(iv) Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee’s health care needs.

(3) MCO, PIHP, PAHP, or PCCM action on request. (i) An MCO, PIHP, PAHP, or PCCM may either approve a request for disenrollment or refer the request to the State.

(ii) If the MCO, PIHP, PAHP, PCCM, or State agency (whichever is responsible) fails to make a disenrollment determination so that the recipient can be disenrolled within the timeframes specified in paragraph (e)(1) of this section, the disenrollment is considered approved.

(4) State agency action on request. For a request received directly from the recipient, or one referred by the MCO, PIHP, PAHP, or PCCM, the State agency must take action to approve or disapprove the request based on the following:

(i) Reasons cited in the request.
(ii) Information provided by the MCO, PIHP, PAHP, or PCCM at the agency’s request.
(iii) Any of the reasons specified in paragraph (d)(2) of this section.

(5) Use of the MCO, PIHP, PAHP, or PCCM grievance procedures. (i) The State agency may require that the enrollee seek redress through the MCO, PIHP, PAHP, or PCCM’s grievance system before making a determination on the enrollee’s request.

(ii) The grievance process, if used, must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in §438.56(e)(1).

(iii) If, as a result of the grievance process, the MCO, PIHP, PAHP, or PCCM approves the disenrollment, the State agency is not required to make a determination.

(e) Timeframe for disenrollment determinations. (1) Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the MCO, PIHP, PAHP, or PCCM files the request.
§ 438.100 Enrollee rights.

(a) General rule. The State must ensure that—
(1) Each MCO and PIHP has written policies regarding the enrollee rights specified in this section; and
(2) Each MCO, PIHP, PAHP, and PCCM complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its staff and affiliated providers take those rights into account when furnishing services to enrollees.

(b) Specific rights—
(1) Basic requirement. The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (b)(3) of this section.
(2) An enrollee of an MCO, PIHP, PAHP, or PCCM has the following rights: The right to—
(i) Receive information in accordance with §438.10.