

Total Pages: 3

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
Washington, D.C. 20503-0001

Monday, September 28, 1998

LEGISLATIVE REFERRAL MEMORANDUM

SPECIAL

TO: Legislative Liaison Officer - See Distribution below

FROM: *Janet R. Forsgren*
Janet R. Forsgren (for) Assistant Director for Legislative Reference

OMB CONTACT: Robert J. Pellicci
PHONE: (202)395-4871 FAX: (202)395-6148

SUBJECT: HHS Report on S1649 Exempt Disabled Individuals from Medicaid Managed Care

DEADLINE: NOON Tuesday, September 29, 1998

In accordance with OMB Circular A-19, OMB requests the views of your agency on the above subject before advising on its relationship to the program of the President. Please advise us if this item will affect direct spending or receipts for purposes of the "Pay-As-You-Go" provisions of Title XIII of the Omnibus Budget Reconciliation Act of 1990.

COMMENTS: HHS has requested expedited clearance - Sen. Ford is retiring at the end of this Session of Congress.

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The Honorable Wendell Ford
U.S. House of Representatives
173A Senate Russell Office Building
Washington, D.C. 20510

Dear Senator Ford:

We at the Department of Health and Human Services greatly appreciate your strong commitment to ensuring adequate health care for people with disabilities. We look forward to working closely with you to achieve this goal.

As you know, the Balanced Budget Act of 1997 specifically exempts certain groups of people including special needs children from enrollment in Medicaid managed care through the State Plan Amendment option now available to states. The legislation you propose, S. 1649, would expand the category of disabled persons who are exempted from mandatory enrollment in Medicaid managed care to include all recipients of Supplemental Security Income.

As a general matter, we believe that people with disabilities in most instances can be successfully cared for in managed care arrangements, particularly with the careful review that the Health Care Financing Administration provides for states that choose to enroll with disabilities in 1915(b) and 1115 Medicaid waivers. At the same time, we share your concern that people with disabilities receive the specialized care that is most appropriate to their individual circumstances.

We would have no objection to the passage of your legislation and would welcome the opportunity to provide any technical assistance that you require.

Sincerely,

Richard J. Tarplin



Cynthia A. Rice

08/06/98 04:54:02 PM

Record Type: Record

To: Jeanne Lambrew/OPD/EOP

cc: Cynthia Dailard/OPD/EOP, Sarah A. Bianchi/OPD/EOP

Subject: Ford amdmt re: Medicaid managed care for the disabled

Before we got sidetracked by the craziness of the 100 hour rule, I had sent you a copy of an amendment (S. 1649) that Senator Ford would like to add by UC to patients bill of rights or other legislation in September. He is seeking our views and comment.

As I'm sure you recall, the Balanced Budget Act let states put in place Medicaid managed care without waivers, but required states to get waivers for certain populations (SSI Kids, kids in foster care). This bill would require states to get waivers for anyone meeting the SSI standard, with the stated goal of protecting adults with mental retardation.

Can you check this out with HCFA? I will check with SSA.

VUF

FAX TRANSMISSION

SENATOR WENDELL H. FORD
173A RUSSELL SENATE BUILDING
WASHINGTON, D.C. 20510
202-224-4343

To: CYNTHIA RICE

Date: 7-29-98

Fax #:

Pages: 6 including cover sheet

From: ROB MANGAS

Subject:

COMMENTS:

Copy to Jeanne Lambrew

Jeanne -

Rob wants to know if we
can support this. Ford wants
to propose it as an amendment
to managed care bill when they
return in Sept. (hopes it
will be adopted by UC).

Cynthia R

MEMORANDUM

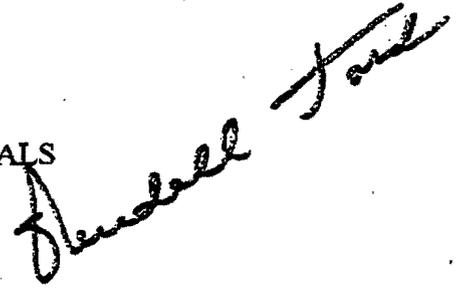
To: Rob Mangas, Office of Senator Ford
From: Jeanne De Sa and Dottie Rosenbaum, Congressional Budget Office (CBO)
Subject: Preliminary Staff Estimate of S. 1649
Date: July 28, 1998

The Balanced Budget Act (BBA) of 1997 amended Medicaid law to allow states to enroll Medicaid beneficiaries in managed care on a mandatory basis by amending their state plans rather than obtaining a waiver under sections 1915 (b) or 1115 of the Social Security Act. States are prohibited from requiring individuals dually-eligible for Medicare and Medicaid, Native Americans, and certain special needs children to enroll in managed care entities without a waiver. S. 1649 would further prohibit states from requiring disabled individuals to enroll in managed care without a waiver.

CBO estimates that this bill would have no effect on federal Medicaid spending because it would not alter current state incentives or practices related to managed care. Prior to BBA, most states had already enrolled at least a portion of their Medicaid population in mandatory managed care under waiver authority. Based on information from the Health Care Financing Administration (HCFA) and the Office of Management and Budget (OMB), few states have pursued the state plan amendment option since enactment of BBA.

States are continuing to rely primarily on the waiver process for operating current managed care programs and moving fee-for-service Medicaid enrollees to managed care arrangements for several reasons. First, the administrative burden to states of obtaining a waiver is not substantially different from amending their state plan. Because approval for managed care waivers is not difficult to obtain, states are able to carry out desired policy using this authority. Second, states prefer to rely on waiver programs, particularly for the disabled population, because they can restrict the scope of managed care enrollment (e.g., to a geographic area) rather than mandate it for all. Finally, states do not want to be bound by the BBA prohibitions on enrolling certain groups in managed care, particularly if the state is already enrolling those individuals in managed care under existing waiver authority.

STATEMENT OF SENATOR WENDELL FORD
REGARDING LEGISLATION AFFECTING MEDICAID
MANAGED CARE EXEMPTION FOR DISABLED INDIVIDUALS
February 12, 1998



Mr. President, today I am introducing legislation to exempt certain disabled individuals from mandated managed care coverage under Medicaid. During consideration of last year's budget legislation, this issue arose but was not addressed in a satisfactory manner. That legislation provided a broad grant of authority to states to require individuals eligible for Medicaid to enroll in managed care plans. Prior to this change, states were required to obtain waivers from the federal government in order to initiate such cost savings measures which would shift large portions of their Medicaid populations into managed care.

However, states have generally not been interested in shifting certain categories of individuals into managed care, such as individuals in nursing homes or special needs children. In fact, last year's legislation specifically exempted certain categories of special needs children under age nineteen.

Mr. President, I believe for certain categories of individuals it does not make sense to limit this exemption to individuals under age nineteen. For example, mentally retarded individuals receiving Medicaid benefits do not enter into a new health care category once they reach their nineteenth birthday. I believe limiting the exemption for such individuals is arbitrary and unwise policy. My legislation would simply remove the age limitation for severely disabled individuals.

I want to express my thanks to the Voice of the Retarded for their leadership on this issue and their willingness to bring it to my attention. I ask unanimous consent that a letter in support of this legislation from that organization be inserted into the *Record*. I also want to thank Louise Underwood, a constituent of mine who has been a tireless advocate over the years for the rights of mentally retarded and other disabled individuals. It is my hope that this straightforward correction to last year's legislation will be viewed as noncontroversial, and can be enacted into law in the months ahead.

Voice Of the Retarded

February 3, 1998

The Honorable Wendell H. Ford
U.S. House of Representatives
173A Senate Russell Office Building
Washington, D.C. 20510

Dear Senator Ford:

On behalf of all members of Voice of the Retarded (VOR) nationwide, I wish to thank you for your long-standing attention to the many intense needs of society's most-impaired people. More than any other public figure, you have consistently championed the causes of those who cannot speak for themselves. We, their family members and only spokespersons, are eternally grateful to you.

We come once again to seek your assistance in correcting what seems to have been an unintentional oversight in the language of the Balanced Budget Act of 1997.

As you know, the ability of traditional managed care models to meet the unique health care requirements of people with disabilities is uncertain. Congress recognized this when it exempted SSI-eligible special needs children from mandatory managed care provisions of the Balanced Budget Act of 1997. This exemption reconciled the states' interest in maintaining cost control and flexibility in program management with the disability community's concern that managed care would negatively impact access to appropriate specialized health care.

It is our belief that age is an arbitrary, artificial barrier to the provision of health care services. Mental retardation is a life-long impairment that does not disappear at age 19. We, therefore, respectfully request that you support corrective legislation to ensure that adults with mental retardation can receive the specialized health care that they need throughout their lives unimpaired by managed care.

Officers

*Polly Spare
President*

*Warren Stone
First Vice President*

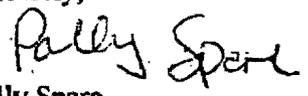
*Sandra Held
Second Vice President*

*Caroline Walsworth
Treasurer*

*Marilyn Stone
Secretary*

Thank you for your consideration.

Sincerely,



Polly Spare
President

*a national association
providing advice,
education and support
for persons with
mental retardation
and their families.*

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S.L.C.

105TH CONGRESS
2D SESSION

S. 1649

Wendell Ford

IN THE SENATE OF THE UNITED STATES

Mr. FORD introduced the following bill; which was read twice and referred to the Committee on _____

A BILL

To exempt disabled individuals from being required to enroll with a managed care entity under the medicaid program.

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. EXEMPTION OF DISABLED INDIVIDUALS FROM**
4 **REQUIRED ENROLLMENT WITH A MANAGED**
5 **CARE ENTITY UNDER THE MEDICAID PRO-**
6 **GRAM.**

7 (a) **AMENDMENT TO THE SOCIAL SECURITY ACT.—**
8 Section 1932(a)(2) of the Social Security Act (42 U.S.C.
9 1396u-2(a)(2)) is amended by adding at the end the fol-
10 lowing:

O:\ERN\ERN98.039

S.L.C.

2

1 “(D) EXEMPTION OF DISABLED INDIVID-
2 UALS.—A State may not require under para-
3 graph (1) the enrollment in a managed care en-
4 tity of an individual who is disabled (as deter-
5 mined under section 1614(a)(3)).”

6 (b) RETROACTIVITY.—The amendment made by sub-
7 section (a) takes effect as if included in the enactment
8 of the Balanced Budget Act of 1997 (Public Law 105-
9 33; 111 Stat. 251).

prepaid burial arrangements for which such amount was set aside, shall also be excluded (to such extent and subject to such conditions or limitations as such regulations may prescribe) in determining the resources (and the income) of such individual.

MEANING OF TERMS

Aged, Blind, or Disabled Individual

SEC. 1614. [42 U.S.C. 1382c] (a)(1) For purposes of this title, the term "aged, blind, or disabled individual" means an individual who—

(A) is 65 years of age or older, is blind (as determined under paragraph (2)), or is disabled (as determined under paragraph (3)), and

(B)(i) is a resident of the United States, and is either (I) a citizen or (II) an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law (including any alien who is lawfully present in the United States as a result of the application of the provisions of section 212(d)(5) of the Immigration and Nationality Act⁹⁷), or

(ii) is a child who is a citizen of the United States, who is living with a parent of the child who is a member of the Armed Forces of the United States assigned to permanent duty ashore outside the United States, and who, for the month before the parent reported for such assignment, received a benefit under this title⁹⁸

(2) An individual shall be considered to be blind for purposes of this title if he has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered for purposes of the first sentence of this subsection as having a central visual acuity of 20/200 or less. An individual shall also be considered to be blind for purposes of this title if he is blind as defined under a State plan approved under title X or XVI as in effect for October 1972 and received aid under such plan (on the basis of blindness) for December 1973, so long as he is continuously blind as so defined.

(3)(A) An individual shall be considered to be disabled for purposes of this title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months (or, in the case of an individual⁹⁹ under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).

(B) For purposes of subparagraph (A), an individual shall be determined to be under a disability only if his physical or mental

⁹⁷See Vol. II, P.L. 82-414.

⁹⁸P.L. 103-66, §13734(a), struck out "the District of Columbia, Puerto Rico, and the territories and possessions of the United States, and who, during the month before the parent reported for such assignment, was receiving benefits under this title" and substituted "and who, for the month before the parent reported for such assignment, received a benefit under this title", effective November 1, 1993.

⁹⁹P.L. 103-432, §221(a)(1), struck out "a child" and substituted "an individual"; applicable to determinations made on or after October 31, 1994.

See changes attached

impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), "work which exists in the national economy" means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

(C) For purposes of this paragraph, a physical or mental impairment is an impairment that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques.

(D) The Commissioner of Social Security¹⁰⁰ shall by regulations prescribe the criteria for determining when services performed or earnings derived from services demonstrate an individual's ability to engage in substantial gainful activity. In determining whether an individual is able to engage in substantial gainful activity by reason of his earnings, where his disability is sufficiently severe to result in a functional limitation requiring assistance in order for him to work, there shall be excluded from such earnings an amount equal to the cost (to such individual) of any attendant care services, medical devices, equipment, prostheses, and similar items and services (not including routine drugs or routine medical services unless such drugs or services are necessary for the control of the disabling condition) which are necessary (as determined by the Commissioner of Social Security¹⁰¹ in regulations) for that purpose, whether or not such assistance is also needed to enable him to carry out his normal daily functions; except that the amounts to be excluded shall be subject to such reasonable limits as the Commissioner of Social Security¹⁰² may prescribe. Notwithstanding the provisions of subparagraph (B), an individual whose services or earnings meet such criteria shall be found not to be disabled. The Secretary¹⁰³ shall make determinations under this title with respect to substantial gainful activity, without regard to the legality of the activity.¹⁰⁴

(E) Notwithstanding the provisions of subparagraphs (A) through (D), an individual shall also be considered to be disabled for purposes of this title if he is permanently and totally disabled as defined under a State plan approved under title XIV or XVI as in effect for October 1972 and received aid under such plan (on the basis of disability) for December 1973 (and for at least one month prior to July 1973), so long as he is continuously disabled as so defined.

(F) In determining whether an individual's physical or mental impairment or impairments are of a sufficient medical severity that such impairment or impairments could be the basis of eligibility

¹⁰⁰P.L. 103-296, §107(a)(4), struck out "Secretary" and substituted "Commissioner of Social Security", effective March 31, 1995.

¹⁰¹P.L. 103-296, §107(a)(4), struck out "Secretary" and substituted "Commissioner of Social Security", effective March 31, 1995.

¹⁰²P.L. 103-296, §107(a)(4), struck out "Secretary" and substituted "Commissioner of Social Security", effective March 31, 1995.

¹⁰³As in original.

¹⁰⁴P.L. 103-296, §201(b)(4)(A), added this sentence, effective August 15, 1994.

100 of 1/1/95

(b) SPECIAL RULE RELATING TO EMERGENCY ADVANCE PAYMENTS.—Section 1631(a)(4)(A) (42 U.S.C. 1383(a)(4)(A)) is amended—

(1) by inserting “for the month following the date the application is filed” after “is presumptively eligible for such benefits”; and

(2) by inserting “, which shall be repaid through proportionate reductions in such benefits over a period of not more than 6 months” before the semicolon.

(c) CONFORMING AMENDMENTS.—

(1) Section 1614(b) (42 U.S.C. 1382c(b)) is amended—

(A) by striking “or requests” and inserting “, on the first day of the month following the date the application is filed, or, in any case in which either spouse requests”; and

(B) by striking “application or”.

(2) Section 1631(g)(3) (42 U.S.C. 1382j(g)(3)) is amended by inserting “following the month” after “beginning with the month”.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to applications for benefits under title XVI of the Social Security Act filed on or after the date of the enactment of this Act, without regard to whether regulations have been issued to implement such amendments.

(2) BENEFITS UNDER TITLE XVI.—For purposes of this subsection, the term “benefits under title XVI of the Social Security Act” includes supplementary payments pursuant to an agreement for Federal administration under section 1616(a) of the Social Security Act, and payments pursuant to an agreement entered into under section 212(b) of Public Law 93-66.

Subtitle B—Benefits for Disabled Children

SEC. 211. DEFINITION AND ELIGIBILITY RULES.

(a) DEFINITION OF CHILDHOOD DISABILITY.—Section 1614(a)(3) (42 U.S.C. 1382c(a)(3)), as amended by section 105(b)(1) of the Contract with America Advancement Act of 1996, is amended—

(1) in subparagraph (A), by striking “An individual” and inserting “Except as provided in subparagraph (C), an individual”;

(2) in subparagraph (A), by striking “(or, in the case of an individual under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity)”;

(3) by redesignating subparagraphs (C) through (I) as subparagraphs (D) through (J), respectively;

(4) by inserting after subparagraph (B) the following new subparagraph:

“(C)(i) An individual under the age of 18 shall be considered disabled for the purposes of this title if that individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

42 USC 1383.

42 USC 1382
note.

“(ii) Notwithstanding clause (i), no individual under the age of 18 who engages in substantial gainful activity (determined in accordance with regulations prescribed pursuant to subparagraph (E)) may be considered to be disabled.”; and

(5) in subparagraph (F), as redesignated by paragraph (3), by striking “(D)” and inserting “(E)”.

(b) CHANGES TO CHILDHOOD SSI REGULATIONS.—

(1) MODIFICATION TO MEDICAL CRITERIA FOR EVALUATION OF MENTAL AND EMOTIONAL DISORDERS.—The Commissioner of Social Security shall modify sections 112.00C.2. and 112.02B.2.c.(2) of appendix 1 to subpart P of part 404 of title 20, Code of Federal Regulations, to eliminate references to maladaptive behavior in the domain of personal/behavioral function.

(2) DISCONTINUANCE OF INDIVIDUALIZED FUNCTIONAL ASSESSMENT.—The Commissioner of Social Security shall discontinue the individualized functional assessment for children set forth in sections 416.924d and 416.924e of title 20, Code of Federal Regulations.

(c) MEDICAL IMPROVEMENT REVIEW STANDARD AS IT APPLIES TO INDIVIDUALS UNDER THE AGE OF 18.—Section 1614(a)(4) (42 U.S.C. 1382(a)(4)) is amended—

(1) by redesignating subclauses (I) and (II) of clauses (i) and (ii) of subparagraph (B) as items (aa) and (bb), respectively;

(2) by redesignating clauses (i) and (ii) of subparagraphs (A) and (B) as subclauses (I) and (II), respectively;

(3) by redesignating subparagraphs (A) through (C) as clauses (i) through (iii), respectively;

(4) by inserting before clause (i) (as redesignated by paragraph (3)) the following new subparagraph:

“(A) in the case of an individual who is age 18 or older—”;

(5) by inserting after and below subparagraph (A)(iii) (as so redesignated) the following new subparagraph:

“(B) in the case of an individual who is under the age of 18—

“(i) substantial evidence which demonstrates that there has been medical improvement in the individual’s impairment or combination of impairments, and that such impairment or combination of impairments no longer results in marked and severe functional limitations; or

“(ii) substantial evidence which demonstrates that, as determined on the basis of new or improved diagnostic techniques or evaluations, the individual’s impairment or combination of impairments, is not as disabling as it was considered to be at the time of the most recent prior decision that the individual was under a disability or continued to be under a disability, and such impairment or combination of impairments does not result in marked and severe functional limitations; or”;

(6) by redesignating subparagraph (D) as subparagraph (C) and by inserting in such subparagraph “in the case of any individual,” before “substantial evidence”; and

(7) in the first sentence following subparagraph (C) (as redesignated by paragraph (6)), by—

(A) inserting “(i)” before “to restore”; and

42 USC 1382c.

Subtitle H—Medicaid

CHAPTER 1—MANAGED CARE

SEC. 4701. STATE OPTION OF USING MANAGED CARE; CHANGE IN TERMINOLOGY.

(a) USE OF MANAGED CARE GENERALLY.—Title XIX is amended by redesignating section 1932 as section 1933 and by inserting after section 1931 the following new section:

“PROVISIONS RELATING TO MANAGED CARE

“SEC. 1932. (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 1902(a), a State—

“(i) may require an individual who is eligible for medical assistance under the State plan under this title 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 1903(m) or section 1905(t), 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) DEFINITION OF MANAGED CARE ENTITY.—In this section, the term ‘managed care entity’ means—

“(i) a medicaid managed care organization, as defined in section 1903(m)(1)(A), that provides or arranges for services for enrollees under a contract pursuant to section 1903(m); and

“(ii) a primary care case manager, as defined in section 1905(t)(2).

“(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 title XVI;

“(ii) is described in section 501(a)(1)(D);

“(iii) is described in section 1902(e)(3);

“(iv) is receiving foster care or adoption assistance under part E of title 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 1905(p)(1)) or an individual otherwise eligible for benefits under title 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) 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. 450 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. 1601 et seq.).

“(3) CHOICE OF COVERAGE.—

“(A) IN GENERAL.—A State must permit an individual to choose a managed care entity from not less than two such entities that meet the applicable requirements of this section, and of section 1903(m) or section 1905(t).

“(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 title who is enrolled with the entity under this title to terminate (or change) such enrollment—

"(i) for cause at any time (consistent with section 1903(m)(2)(A)(vi)), 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 1903(m) or section 1905(t); and

"(ii) that takes into consideration—

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

"(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 title, inform the enrollee in a written and prominent manner of any benefits to which the enrollee may be entitled to under this title 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) CHANGE IN TERMINOLOGY.—

(1) IN GENERAL.—Section 1903(m)(1)(A) (42 U.S.C. 1396b(m)) is amended—

(A) by striking "The term" and all that follows through "and—" and inserting "The term 'medicaid managed care organization' means a health maintenance organization, an eligible organization with a contract under section 1876 or a Medicare+Choice organization with a contract under part C of title XVIII, a provider sponsored organization,