II

105TH CONGRESS
1ST SESSION

S. 864

To amend title XIX of the Social Security Act to improve the provision of managed care under the medicaid program.

IN THE SENATE OF THE UNITED STATES

JUNE 10, 1997

Mr. CHAFEE (for himself, Mr. BREAUX, Mr. KERREY, 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 improve the provision of managed care under the medicaid program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS; AMENDMENTS TO THE SOCIAL SECURITY ACT.

(a) SHORT TITLE.—This Act may be cited as the ''Medicaid Managed Care Improvement Act of 1997''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

(c) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

SEC. 2. IMPROVEMENTS IN MEDICAID MANAGED CARE PROGRAM.

Title XIX is amended—

(1) by inserting after the title heading the following:

''PART A—GENERAL PROVISIONS''; and

(2) by adding at the end the following new part:

''PART B—PROVISIONS RELATING TO MANAGED CARE

''SEC. 1941. BENEFICIARY CHOICE; ENROLLMENT.

''(a) STATE OPTIONS FOR ENROLLMENT OF BENEFICIARIES IN MANAGED CARE ARRANGEMENTS.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this part and notwithstanding paragraphs (1), (10)(B), and (23)(A) of section 1902(a), a State may require an individual who is eligible for medical assistance under the State plan under this title and who is not a special needs individual (as defined in subsection (e)) to enroll with a managed care entity (as defined in section 1950(a)(1)) 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 the following provisions are met:

''(A) ENTITY MEETS REQUIREMENTS.—The entity meets the applicable requirements of this part.

''(B) CONTRACT WITH STATE.—The entity enters into a contract with the State to provide services for the benefit of individuals eligible for benefits under this title under which prepaid payments to such entity are made on an actuarially sound basis. Such contract shall specify benefits the provision (or arrangement) for which the entity is responsible.

''(C) CHOICE OF COVERAGE.—

''(i) IN GENERAL.—The State permits an individual to choose a managed care entity from managed care organizations and primary care case providers who meet the requirements of this part but not less than from—

''(I) 2 medicaid managed care organizations,

''(II) a medicaid managed care organization and a primary care case management provider, or

''(III) a primary care case management provider as long as an individual may choose between 2 primary care case managers.

''(ii) STATE OPTION.—At the option of the State, a State shall be considered to meet the requirements of clause (i) in the case of an individual residing in a rural area, if the State—

''(I) requires the individual to enroll with a medicaid managed care organization or primary care case management provider if such organization or entity permits the individual to re-

ceive such assistance through not less than 2 physicians or case managers (to the extent that at least 2 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).

"(D) CHANGES IN ENROLLMENT.—The State provides the individual with the opportunity to change enrollment among managed care entities once annually and notifies the individual of such opportunity not later than 60 days prior to the first date on which the individual may change enrollment, permits individuals to change their enrollment for cause at any time and without cause at least every 12 months, and allows individuals to disenroll without cause within 90 days of notification of enrollment.

"(E) ENROLLMENT PRIORITIES.—The State establishes a method for establishing en-

rollment 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.

''(F) DEFAULT ENROLLMENT PROCESS.—The State establishes a default enrollment process which meets the requirements described in paragraph (2) and 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 in accordance with such process.

''(G) SANCTIONS.—The State establishes the sanctions provided for in section 1949.

''(2) DEFAULT ENROLLMENT PROCESS REQUIREMENTS.—The default enrollment process established by a State under paragraph (1)(F)—

''(A) shall provide that the State may not enroll individuals with a managed care entity which is not in compliance with the applicable requirements of this part;

''(B) shall provide (consistent with subparagraph (A)) for enrollment of such an indi-

vidual with a medicaid managed care organization—

''(i) first, that maintains existing provider-individual relationships or that has entered into contracts with providers (such as Federally qualified health centers, rural health clinics, hospitals that qualify for disproportionate share hospital payments under section 1886(d)(5)(F), and hospitals described in section 1886(d)(1)(B)(iii)) that have traditionally served beneficiaries under this title, and

''(ii) lastly, if there is no provider described in clause (i), in a manner that provides for an equitable distribution of individuals among all qualified managed care entities available to enroll individuals through such default enrollment process, consistent with the enrollment capacities of such entities;

''(C) shall permit and assist an individual enrolled with an entity under such process to change such enrollment to another managed care entity during a period (of at least 90 days) after the effective date of the enrollment; and

''(D) may provide for consideration of factors such as quality, geographic proximity, continuity of providers, and capacity of the plan when conducting such process.

''(b) REENROLLMENT OF INDIVIDUALS WHO REGAIN ELIGIBILITY.—

''(1) IN GENERAL.—If an individual eligible for medical assistance under a State plan under this title and enrolled with a managed care entity with a contract under subsection (a)(1)(B) ceases to be eligible for such assistance for a period of not greater than 2 months, the State may provide for the automatic reenrollment of the individual with the entity as of the first day of the month in which the individual is again eligible for such assistance, and may consider factors such as quality, geographic proximity, continuity of providers, and capacity of the plan when conducting such reenrollment.

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

''(A) the month for which the individual is to be reenrolled occurs during the enrollment period covered by the individual's original enrollment with the managed care entity;

''(B) the managed care entity continues to have a contract with the State agency under subsection (a)(1)(B) as of the first day of such month; and

''(C) the managed care entity complies with the applicable requirements of this part.

''(3) NOTICE OF REENROLLMENT.—The State shall provide timely notice to a managed care entity of any reenrollment of an individual under this subsection.

''(c) STATE OPTION OF MINIMUM ENROLLMENT PERIOD.—

''(1) IN GENERAL.—In the case of an individual who is enrolled with a managed care entity under this part and who would (but for this subsection) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in paragraph (2)), the State plan under this title may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but, except for benefits furnished under section 1902(a)(23)(B), only with respect to such benefits provided to the individual as an enrollee of such entity.

''(2) MINIMUM ENROLLMENT PERIOD DEFINED.—For purposes of paragraph (1), the term 'minimum enrollment period' means, with respect to an individual's enrollment with an entity under a State plan, a period, established by the State, of not more than 6 months beginning on the date the individual's enrollment with the entity becomes effective, except that a State may extend such period for up to a total of 12 months in the case of an individual's enrollment with a managed care entity (as defined in section 1950(a)(1)) so long as such extension is done uniformly for all individuals enrolled with all such entities.

''(d) OTHER ENROLLMENT-RELATED PROVISIONS.—

''(1) NONDISCRIMINATION.—A managed care entity may not discriminate on the basis of health status or anticipated need for services in the enrollment, reenrollment, or disenrollment of individuals eligible to receive medical assistance under a State plan under this title or by discouraging enrollment (except as permitted by this section) by eligible individuals.

''(2) TERMINATION OF ENROLLMENT.—

''(A) IN GENERAL.—The State, enrollment broker, and managed care entity (if any) shall

permit an individual eligible for medical assistance under the State plan under this title who is enrolled with the entity to terminate such enrollment for cause at any time, and without cause during the 90-day period beginning on the date the individual receives notice of enrollment and at least every 12 months thereafter, and shall notify each such individual of the opportunity to terminate enrollment under these conditions.

''(B) FRAUDULENT INDUCEMENT OR COERCION AS GROUNDS FOR CAUSE.—For purposes of subparagraph (A), an individual terminating enrollment with a managed care entity on the grounds that the enrollment was based on fraudulent inducement or was obtained through coercion or pursuant to the imposition against the managed care entity of the sanction described in section 1949(b)(3) shall be considered to terminate such enrollment for cause.

''(C) NOTICE OF TERMINATION.—

''(i) NOTICE TO STATE.—

''(I) BY INDIVIDUALS.—Each individual terminating enrollment with a managed care entity under subpara-

graph (A) shall do so by providing notice of the termination to an office of the State agency administering the State plan under this title, the State or local welfare agency, or an office of a managed care entity.

''(II) BY ORGANIZATIONS.—Any managed care entity which receives notice of an individual's termination of enrollment with such entity through receipt of such notice at an office of a managed care entity shall provide timely notice of the termination to the State agency administering the State plan under this title.

''(ii) NOTICE TO PLAN.—The State agency administering the State plan under this title or the State or local welfare agency which receives notice of an individual's termination of enrollment with a managed care entity under clause (i) shall provide timely notice of the termination to such entity.

''(3) PROVISION OF INFORMATION.—

"(A) IN GENERAL.—Each State, enrollment broker, or managed care organization shall provide all enrollment notices and informational and instructional materials in a manner and form which may be easily understood by enrollees of the entity who are eligible for medical assistance under the State plan under this title, including enrollees and potential enrollees who are blind, deaf, disabled, or cannot read or understand the English language.

"(B) INFORMATION TO HEALTH CARE PROVIDERS, ENROLLEES, AND POTENTIAL ENROLLEES.—Each medicaid managed care organization shall—

"(i) upon request, make the information described in section 1945(e)(1)(A) available to enrollees and potential enrollees in the organization's service area; and

"(ii) provide to enrollees and potential enrollees information regarding 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.

''(e) SPECIAL NEEDS INDIVIDUALS DESCRIBED.—In this part, the term 'special needs individual' means any of the following individuals:

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

''(A) is eligible for supplemental security income under title XVI;

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

''(C) is a child described in section 1902(e)(3);

''(D) is receiving services under a program under part B or part E of title IV; or

''(E) is not described in any preceding subparagraph but is otherwise considered a child with special health care needs who is adopted, in foster care, or otherwise in an out-of-home placement.

''(2) HOMELESS INDIVIDUALS.—An individual who is homeless (without regard to whether the individual is a member of a family), including—

''(A) an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations; or

"(B) an individual who is a resident in transitional housing.

"(3) MIGRANT AGRICULTURAL WORKERS.—A migratory agricultural worker or a seasonal agricultural worker (as such terms are defined in section 330(g)(3) of the Public Health Service Act), or the spouse or dependent of such a worker.

"(4) INDIANS.—An Indian (as defined in section 4(c) of the Indian Health Care Improvement Act (25 U.S.C. 1603(c))).

"(5) MEDICARE BENEFICIARIES.—A qualified medicare beneficiary (as defined in section 1905(p)(1)) or an individual otherwise eligible for benefits under title XVIII.

"(6) DISABLED INDIVIDUALS.—Individuals who are disabled (as determined under section 1614(a)(3)).

"(7) PERSONS WITH AIDS OR HIV INFECTION.—An individual with acquired immune deficiency syndrome (AIDS) or who has been determined to be infected with the HIV virus.

"SEC. 1942. BENEFICIARY ACCESS TO SERVICES GENERALLY.

"(a) ACCESS TO SERVICES.—

''(1) IN GENERAL.—Each managed care entity shall provide or arrange for the provision of all medically necessary medical assistance under this title which is specified in the contract entered into between such entity and the State under section 1941(a)(1)(B) for enrollees who are eligible for medical assistance under the State plan under this title.

''(2) PRIMARY-CARE-PROVIDER-TO-ENROLLEE RATIO AND MAXIMUM TRAVEL TIME.—Each such entity shall assure adequate access to primary care services by meeting standards, established by the Secretary, relating to the maximum ratio of enrollees under this title to full-time-equivalent primary care providers available to serve such enrollees and to maximum travel time for such enrollees to access such providers. The Secretary may permit such a maximum ratio to vary depending on the area and population served. Such standards shall be based on standards commonly applied in the commercial market, commonly used in accreditation of managed care organizations, and standards used in the approval of waiver applications under section 1115, and shall be consistent with the requirements under section 1876(c)(4)(A).

''(b) OBSTETRICAL AND GYNECOLOGICAL CARE.—

''(1) IN GENERAL.—A managed care entity may not require prior authorization by the individual's primary care provider or otherwise restrict the individual's access to gynecological and obstetrical care provided by a participating provider who specializes in obstetrics and gynecology to the extent such care is otherwise covered, and may treat the ordering of other obstetrical and gynecological care by such a participating provider as the prior authorization of the primary care provider with respect to such care under the coverage.

''(2) CONSTRUCTION.—Nothing in paragraph (1)(B)(ii) shall waive any requirements of coverage relating to medical necessity or appropriateness with respect to coverage of gynecological care so ordered.

''(c) SPECIALTY CARE.—

''(1) REFERRAL TO SPECIALTY CARE FOR ENROLLEES REQUIRING TREATMENT BY SPECIALISTS.—

''(A) IN GENERAL.—In the case of an enrollee under a managed care entity and who has a condition or disease of sufficient seriousness and complexity to require treatment by a specialist, the entity shall make or provide for a referral to a specialist who is available and acces-

sible to provide the treatment for such condition or disease.

''(B) SPECIALIST DEFINED.—For purposes of this subsection, the term 'specialist' means, with respect to a condition, a health care practitioner, facility, or center (such as a center of excellence) that has adequate expertise through appropriate training and experience (including, in the case of a child, an appropriate pediatric specialist) to provide high quality care in treating the condition.

''(C) CARE UNDER REFERRAL.—Care provided pursuant to such referral under subparagraph (A) shall be—

''(i) pursuant to a treatment plan (if any) developed by the specialist and approved by the entity, in consultation with the designated primary care provider or specialist and the enrollee (or the enrollee's designee), and

''(ii) in accordance with applicable quality assurance and utilization review standards of the entity.

Nothing in this subsection shall be construed as preventing such a treatment plan for an en-

rollee from requiring a specialist to provide the primary care provider with regular updates on the specialty care provided, as well as all necessary medical information.

''(D) REFERRALS TO PARTICIPATING PROVIDERS.—An entity is not required under subparagraph (A) to provide for a referral to a specialist that is not a participating provider, unless the entity does not have an appropriate specialist that is available and accessible to treat the enrollee's condition and that is a participating provider with respect to such treatment.

''(E) TREATMENT OF NONPARTICIPATING PROVIDERS.—If an entity refers an enrollee to a nonparticipating specialist, services provided pursuant to the approved treatment plan shall be provided at no additional cost to the enrollee beyond what the enrollee would otherwise pay for services received by such a specialist that is a participating provider.

''(2) SPECIALISTS AS PRIMARY CARE PROVIDERS.—

''(A) IN GENERAL.—A managed care entity shall have a procedure by which a new en-

rollee upon enrollment, or an enrollee upon diagnosis, with an ongoing special condition (as defined in subparagraph (C)) may receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the enrollee's primary and specialty care. If such an enrollee's care would most appropriately be coordinated by such a specialist, the entity shall refer the enrollee to such specialist.

''(B) TREATMENT AS PRIMARY CARE PROVIDER.—Such specialist shall be permitted to treat the enrollee without a referral from the enrollee's primary care provider and may authorize such referrals, procedures, tests, and other medical services as the enrollee's primary care provider would otherwise be permitted to provide or authorize, subject to the terms of the treatment plan (referred to in paragraph (1)(C)(i)).

''(C) ONGOING SPECIAL CONDITION DEFINED.—In this paragraph, the term 'special condition' means a physical and mental condition or disease that—

"(i) is life-threatening, degenerative, or disabling, and

"(ii) requires specialized medical care over a prolonged period of time.

"(D) TERMS OF REFERRAL.—The provisions of subparagraphs (C) through (E) of paragraph (1) shall apply with respect to referrals under subparagraph (A) of this paragraph in the same manner as they apply to referrals under paragraph (1)(A).

"(3) STANDING REFERRALS.—

"(A) IN GENERAL.—A managed care entity shall have a procedure by which an enrollee who has a condition that requires ongoing care from a specialist may receive a standing referral to such specialist for treatment of such condition. If the issuer, or the primary care provider in consultation with the medical director of the entity and the specialist (if any), determines that such a standing referral is appropriate, the entity shall make such a referral to such a specialist.

"(B) TERMS OF REFERRAL.—The provisions of subparagraphs (C) through (E) of paragraph (1) shall apply with respect to refer-

rals under subparagraph (A) of this paragraph in the same manner as they apply to referrals under paragraph (1)(A).

''(d) TIMELY DELIVERY OF SERVICES.—Each managed care entity shall respond to requests from enrollees for the delivery of medical assistance in a manner which—

''(1) makes such assistance—

''(A) available and accessible to each such individual, within the area served by the entity, with reasonable promptness and in a manner which assures continuity; and

''(B) when medically necessary, available and accessible 24 hours a day and 7 days a week; and

''(2) with respect to assistance provided to such an individual other than through the entity, or without prior authorization, in the case of a primary care case management provider, provides for reimbursement to the individual (if applicable under the contract between the State and the entity) if—

''(A) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition and meet the requirements of section 1943; and

"(B) it was not reasonable given the circumstances to obtain the services through the entity, or, in the case of a primary care case management provider, with prior authorization.

"(e) INTERNAL GRIEVANCE PROCEDURE.—Each medicaid managed care organization shall establish an internal grievance procedure under which an enrollee who is eligible for medical assistance under the State plan under this title, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such assistance.

"(f) INFORMATION ON BENEFIT CARVE OUTS.—Each managed care entity shall inform each enrollee, in a written and prominent manner, of any benefits to which the enrollee may be entitled to medical assistance 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.

"(g) DUE PROCESS REQUIREMENTS FOR MANAGED CARE ENTITIES.—

"(1) DENIAL OF OR UNREASONABLE DELAY IN DETERMINING COVERAGE AS GROUNDS FOR HEARING.—If a managed care entity (or entity acting an agreement with a managed care entity)—

"(A) denies coverage of or payment for medical assistance with respect to an enrollee who is eligible for such assistance under the State plan under this title; or

"(B) fails to make any eligibility or coverage determination sought by an enrollee or, in the case of a medicaid managed care organization, by a participating health care provider or enrollee, in a timely manner, depending upon the urgency of the situation,

the enrollee or the health care provider furnishing such assistance to the enrollee (as applicable) may obtain a fair hearing before, and shall be provided a timely decision by, the State agency administering the State plan under this title in accordance with section 1902(a)(3). Such decisions shall be rendered as soon as possible in accordance with the medical exigencies of the cases, and in no event later than 72 hours in the case of hearings on decisions regarding urgent care and 5 days in the case of all other hearings.

"(2) COMPLETION OF INTERNAL GRIEVANCE PROCEDURE.—Nothing in this subsection shall require completion of an internal grievance procedure if the procedure does not provide for timely review

of health needs considered by the enrollee's health care provider to be of an urgent nature or is not otherwise consistent with the requirements for such procedures under section 1876(c).

"(h) DEMONSTRATION OF ADEQUATE CAPACITY AND SERVICES.—

"(1) IN GENERAL.—Subject to paragraph (3), each medicaid managed care organization shall provide the State and the Secretary with adequate assurances (as determined by the Secretary) that the organization, with respect to a service area—

"(A) has the capacity to serve the expected enrollment in such service area;

"(B) offers an appropriate range of services for the population expected to be enrolled in such service area, including transportation services and translation services consisting of the principal languages spoken in the service area;

"(C) maintains a sufficient number, mix, and geographic distribution of providers of services included in the contract with the State to ensure that services are available to individuals receiving medical assistance and enrolled in the organization to the same extent that such serv-

ices are available to individuals enrolled in the organization who are not recipients of medical assistance under the State plan under this title;

"(D) maintains extended hours of operation with respect to primary care services that are beyond those maintained during a normal business day;

"(E) provides preventive and primary care services in locations that are readily accessible to members of the community;

"(F) provides information concerning educational, social, health, and nutritional services offered by other programs for which enrollees may be eligible; and

"(G) complies with such other requirements relating to access to care as the Secretary or the State may impose.

"(2) PROOF OF ADEQUATE PRIMARY CARE CAPACITY AND SERVICES.—Subject to paragraph (3), a medicaid managed care organization that contracts with a reasonable number of primary care providers (as determined by the Secretary) and whose primary care membership includes a reasonable number (as so determined) of the following providers will be

deemed to have satisfied the requirements of paragraph (1):

"(A) Rural health clinics, as defined in section 1905(l)(1).

"(B) Federally-qualified health centers, as defined in section 1905(l)(2)(B).

"(C) Clinics which are eligible to receive payment for services provided under title X of the Public Health Service Act.

"(3) SUFFICIENT PROVIDERS OF SPECIALIZED SERVICES.—Notwithstanding paragraphs (1) and (2), a medicaid managed care organization may not be considered to have satisfied the requirements of paragraph (1) if the organization does not have a sufficient number (as determined by the Secretary) of providers of specialized services, including perinatal and pediatric specialty care, to ensure that such services are available and accessible.

"(i) COMPLIANCE WITH CERTAIN MATERNITY AND MENTAL HEALTH REQUIREMENTS.—Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

''(j) TREATMENT OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—

''(1) IN GENERAL.—In the case of an enrollee of a managed care entity who is a child described in section 1941(e)(1) or who has special health care needs (as defined in paragraph (3))—

''(A) if any medical assistance specified in the contract with the State is identified in a treatment plan prepared for the enrollee by a program described in subsection (c)(1) or paragraph (3), the managed care entity shall provide (or arrange to be provided) such assistance in accordance with the treatment plan either—

''(i) by referring the enrollee to a pediatric health care provider who is trained and experienced in the provision of such assistance and who has a contract with the managed care entity to provide such assistance; or

''(ii) if appropriate services are not available through the managed care entity, permitting such enrollee to seek appropriate specialty services from pediatric health care providers outside of or apart from the managed care entity; and

''(B) the managed care entity shall require each health care provider with whom the managed care entity has entered into an agreement to provide medical assistance to enrollees to furnish the medical assistance specified in such enrollee's treatment plan to the extent the health care provider is able to carry out such treatment plan.

''(2) PRIOR AUTHORIZATION.—An enrollee referred for treatment under paragraph (1)(A)(i), or permitted to seek treatment outside of or apart from the managed care entity under paragraph (1)(A)(ii) shall be deemed to have obtained any prior authorization required by the entity.

''(3) CHILD WITH SPECIAL HEALTH CARE NEEDS.—For purposes of paragraph (1), a child has special health care needs if the child is receiving services under—

''(A) a program administered under part B or part H of the Individuals with Disabilities Education Act; or

''(B) any other program for children with special health care needs identified by the Secretary.

"SEC. 1943. BENEFICIARY ACCESS TO EMERGENCY CARE.

"(a) PROHIBITION OF CERTAIN RESTRICTIONS ON COVERAGE OF EMERGENCY SERVICES.—

"(1) IN GENERAL.—If a managed care entity provides any benefits under a State plan with respect to emergency services (as defined in paragraph (2)(B)), the entity shall cover emergency services furnished to an enrollee—

"(A) without the need for any prior authorization determination,

"(B) subject to paragraph (3), whether or not the physician or provider furnishing such services is a participating physician or provider with respect to such services, and

"(C) subject to paragraph (3), without regard to any other term or condition of such coverage (other than an exclusion of benefits).

"(2) EMERGENCY SERVICES; EMERGENCY MEDICAL CONDITION.—For purposes of this section—

"(A) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine,

could reasonably expect the absence of immediate medical attention to result in—

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

"(ii) serious impairment to bodily functions, or

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

"(B) EMERGENCY SERVICES.—The term 'emergency services' means—

"(i) a medical screening examination (as required under section 1867) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department, to evaluate an emergency medical condition (as defined in subparagraph (A)), and

"(ii) within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required under section 1867 to stabilize the patient.

"(C) TRAUMA AND BURN CENTERS.—The provisions of clause (ii) of subparagraph (B) apply to a trauma or burn center, in a hospital, that—

"(i) is designated by the State, a regional authority of the State, or by the designee of the State, or

"(ii) is in a State that has not made such designations and meets medically recognized national standards.

"(3) APPLICATION OF NETWORK RESTRICTION PERMITTED IN CERTAIN CASES.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), if a managed care entity in relation to benefits provided under this title denies, limits, or otherwise differentiates in benefits or payment for benefits other than emergency services on the basis that the physician or provider of such services is a nonparticipating physician or provider, the entity may deny, limit, or differentiate in coverage or payment for emergency services on such basis.

"(B) NETWORK RESTRICTIONS NOT PERMITTED IN CERTAIN EXCEPTIONAL CASES.—The denial or limitation of, or differentiation in,

coverage or payment of benefits for emergency services under subparagraph (A) shall not apply in the following cases:

"(i) CIRCUMSTANCES BEYOND CONTROL OF ENROLLEE.—The enrollee is unable to go to a participating hospital for such services due to circumstances beyond the control of the enrollee (as determined consistent with guidelines and subparagraph (C)).

"(ii) LIKELIHOOD OF AN ADVERSE HEALTH CONSEQUENCE BASED ON LAYPERSON'S JUDGMENT.—A prudent layperson possessing an average knowledge of health and medicine could reasonably believe that, under the circumstances and consistent with guidelines, the time required to go to a participating hospital for such services could result in any of the adverse health consequences described in a clause of subsection (a)(2)(A).

"(iii) PHYSICIAN REFERRAL.—A participating physician or other person authorized by the plan refers the enrollee to an emergency department of a hospital and

does not specify an emergency department of a hospital that is a participating hospital with respect to such services.

''(C) APPLICATION OF 'BEYOND CONTROL' STANDARDS.—For purposes of applying subparagraph (B)(i), receipt of emergency services from a nonparticipating hospital shall be treated under the guidelines as being 'due to circumstances beyond the control of the enrollee' if any of the following conditions are met:

''(i) UNCONSCIOUS.—The enrollee was unconscious or in an otherwise altered mental state at the time of initiation of the services.

''(ii) AMBULANCE DELIVERY.—The enrollee was transported by an ambulance or other emergency vehicle directed by a person other than the enrollee to the nonparticipating hospital in which the services were provided.

''(iii) NATURAL DISASTER.—A natural disaster or civil disturbance prevented the enrollee from presenting to a participating hospital for the provision of such services.

''(iv) NO GOOD FAITH EFFORT TO INFORM OF CHANGE IN PARTICIPATION DURING A CONTRACT YEAR.—The status of the hospital changed from a participating hospital to a nonparticipating hospital with respect to emergency services during a contract year and the entity failed to make a good faith effort to notify the enrollee involved of such change.

''(v) OTHER CONDITIONS.—There were other factors (such as those identified in guidelines) that prevented the enrollee from controlling selection of the hospital in which the services were provided.

''(b) ASSURING COORDINATED COVERAGE OF MAINTENANCE CARE AND POST-STABILIZATION CARE.—

''(1) IN GENERAL.—In the case of an individual who is enrolled with a managed care entity and who has received emergency services pursuant to a screening evaluation conducted (or supervised) by a treating physician at a hospital that is a nonparticipating provider with respect to emergency services, if—

''(A) pursuant to such evaluation, the physician identifies post-stabilization care (as de-

fined in paragraph (3)(B)) that is required by the enrollee,

"(B) the coverage through the entity under this title provides benefits with respect to the care so identified and the coverage requires (but for this subsection) an affirmative prior authorization determination as a condition of coverage of such care, and

"(C) the treating physician (or another individual acting on behalf of such physician) initiates, not later than 30 minutes after the time the treating physician determines that the condition of the enrollee is stabilized, a good faith effort to contact a physician or other person authorized by the entity (by telephone or other means) to obtain an affirmative prior authorization determination with respect to the care,

then, without regard to terms and conditions specified in paragraph (2) the entity shall cover maintenance care (as defined in paragraph (3)(A)) furnished to the enrollee during the period specified in paragraph (4) and shall cover post-stabilization care furnished to the enrollee during the period beginning under paragraph (5) and ending under paragraph (6).

''(2) TERMS AND CONDITIONS WAIVED.—The terms and conditions (of coverage) described in this paragraph that are waived under paragraph (1) are as follows:

''(A) The need for any prior authorization determination.

''(B) Any limitation on coverage based on whether or not the physician or provider furnishing the care is a participating physician or provider with respect to such care.

''(C) Any other term or condition of the coverage (other than an exclusion of benefits and other than a requirement relating to medical necessity for coverage of benefits).

''(3) MAINTENANCE CARE AND POST-STABILIZATION CARE DEFINED.—In this subsection:

''(A) MAINTENANCE CARE.—The term 'maintenance care' means, with respect to an individual who is stabilized after provision of emergency services, medically necessary items and services (other than emergency services) that are required by the individual to ensure that the individual remains stabilized during the period described in paragraph (4).

"(B) POST-STABILIZATION CARE.—The term 'post-stabilization care' means, with respect to an individual who is determined to be stable pursuant to a medical screening examination or who is stabilized after provision of emergency services, medically necessary items and services (other than emergency services and other than maintenance care) that are required by the individual.

"(4) PERIOD OF REQUIRED COVERAGE OF MAINTENANCE CARE.—The period of required coverage of maintenance care of an individual under this subsection begins at the time of the request (or the initiation of the good faith effort to make the request) under paragraph (1)(C) and ends when—

"(A) the individual is discharged from the hospital;

"(B) a physician (designated by the managed care entity involved) and with privileges at the hospital involved arrives at the emergency department of the hospital and assumes responsibility with respect to the treatment of the individual; or

"(C) the treating physician and the entity agree to another arrangement with respect to the care of the individual.

"(5) WHEN POST-STABILIZATION CARE REQUIRED TO BE COVERED.—

"(A) WHEN TREATING PHYSICIAN UNABLE TO COMMUNICATE REQUEST.—If the treating physician or other individual makes the good faith effort to request authorization under paragraph (1)(C) but is unable to communicate the request directly with an authorized person referred to in such paragraph within 30 minutes after the time of initiating such effort, then post-stabilization care is required to be covered under this subsection beginning at the end of such 30-minute period.

"(B) WHEN ABLE TO COMMUNICATE REQUEST, AND NO TIMELY RESPONSE.—

"(i) IN GENERAL.—If the treating physician or other individual under paragraph (1)(C) is able to communicate the request within the 30-minute period described in subparagraph (A), the post-stabilization care requested is required to be covered under this subsection beginning 30

minutes after the time when the entity receives the request unless a person authorized by the entity involved communicates (or makes a good faith effort to communicate) a denial of the request for the prior authorization determination within 30 minutes of the time when the entity receives the request and the treating physician does not request under clause (ii) to communicate directly with an authorized physician concerning the denial.

''(ii) REQUEST FOR DIRECT PHYSICIAN-TO-PHYSICIAN COMMUNICATION CONCERNING DENIAL.—If a denial of a request is communicated under clause (i), the treating physician may request to communicate respecting the denial directly with a physician who is authorized by the entity to deny or affirm such a denial.

''(C) WHEN NO TIMELY RESPONSE TO REQUEST FOR PHYSICIAN-TO-PHYSICIAN COMMUNICATION.—If a request for physician-to-physician communication is made under subparagraph (B)(ii), the post-stabilization care requested is required to be covered under this

subsection beginning 30 minutes after the time when the entity receives the request from a treating physician unless a physician, who is authorized by the entity to reverse or affirm the initial denial of the care, communicates (or makes a good faith effort to communicate) directly with the treating physician within such 30-minute period.

"(D) DISAGREEMENTS OVER POST-STABILIZATION CARE.—If, after a direct physician-to-physician communication under subparagraph (C), the denial of the request for the post-stabilization care is not reversed and the treating physician communicates to the entity involved a disagreement with such decision, the post-stabilization care requested is required to be covered under this subsection beginning as follows:

"(i) DELAY TO ALLOW FOR PROMPT ARRIVAL OF PHYSICIAN ASSUMING RESPONSIBILITY.—If the issuer communicates that a physician (designated by the entity) with privileges at the hospital involved will arrive promptly (as determined under guidelines) at the emergency depart-

ment of the hospital in order to assume responsibility with respect to the treatment of the enrollee involved, the required coverage of the post-stabilization care begins after the passage of such time period as would allow the prompt arrival of such a physician.

''(ii) OTHER CASES.—If the entity does not so communicate, the required coverage of the post-stabilization care begins immediately.

''(6) NO REQUIREMENT OF COVERAGE OF POST-STABILIZATION CARE IF ALTERNATE PLAN OF TREATMENT.—

''(A) IN GENERAL.—Coverage of post-stabilization care is not required under this subsection with respect to an individual when—

''(i) subject to subparagraph (B), a physician (designated by the entity involved) and with privileges at the hospital involved arrives at the emergency department of the hospital and assumes responsibility with respect to the treatment of the individual; or

''(ii) the treating physician and the entity agree to another arrangement with respect to the post-stabilization care (such as an appropriate transfer of the individual involved to another facility or an appointment for timely followup treatment for the individual).

''(B) SPECIAL RULE WHERE ONCE CARE INITIATED.—Required coverage of requested post-stabilization care shall not end by reason of subparagraph (A)(i) during an episode of care (as determined by guidelines) if the treating physician initiated such care (consistent with a previous paragraph) before the arrival of a physician described in such subparagraph.

''(7) CONSTRUCTION.—Nothing in this subsection shall be construed as—

''(A) preventing a managed care entity from authorizing coverage of maintenance care or post-stabilization care in advance or at any time; or

''(B) preventing a treating physician or other individual described in paragraph (1)(C) and such an entity from agreeing to modify any

of the time periods specified in paragraphs (5) as it relates to cases involving such persons.

''(c) INFORMATION ON ACCESS TO EMERGENCY SERVICES.—A managed care entity, to the extent the entity offers health insurance coverage, shall provide education to enrollees on—

''(1) coverage of emergency services (as defined in subsection (a)(2)(B)) by the entity in accordance with the provisions of this section,

''(2) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent,

''(3) any cost sharing applicable to emergency services,

''(4) the process and procedures of the plan for obtaining emergency services, and

''(5) the locations of—

''(A) emergency departments, and

''(B) other settings,

in which participating physicians and hospitals provide emergency services and post-stabilization care.

''(d) GENERAL DEFINITIONS.—For purposes of this section:

''(1) COST SHARING.—The term 'cost sharing' means any deductible, coinsurance amount, copay-

ment or other out-of-pocket payment (other than premiums or enrollment fees) that a managed care entity issuer imposes on enrollees with respect to the coverage of benefits.

''(2) GOOD FAITH EFFORT.—The term 'good faith effort' has the meaning given such term in guidelines and requires such appropriate documentation as is specified under such guidelines.

''(3) GUIDELINES.—The term 'guidelines' means guidelines established by the Secretary after consultation with an advisory panel that includes individuals representing emergency physicians, managed care entities, including at least one health maintenance organization, hospitals, employers, the States, and consumers.

''(4) PRIOR AUTHORIZATION DETERMINATION.—The term 'prior authorization determination' means, with respect to items and services for which coverage may be provided by a managed care entity, a determination (before the provision of the items and services and as a condition of coverage of the items and services under the coverage) of whether or not such items and services will be covered under the coverage.

''(5) STABILIZE.—The term 'to stabilize' means, with respect to an emergency medical condition, to provide (in complying with section 1867 of the Social Security Act) such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from the facility.

''(6) STABILIZED.—The term 'stabilized' means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur before an individual can be transferred from the facility, in compliance with the requirements of section 1867 of the Social Security Act.

''(7) TREATING PHYSICIAN.—The term 'treating physician' includes a treating health care professional who is licensed under State law to provide emergency services other than under the supervision of a physician.

''SEC. 1944. OTHER BENEFICIARY PROTECTIONS.

''(a) PROTECTING ENROLLEES AGAINST THE INSOLVENCY OF MANAGED CARE ENTITIES AND AGAINST THE

FAILURE OF THE STATE TO PAY SUCH ENTITIES.—Each managed care entity shall provide that an individual eligible for medical assistance under the State plan under this title who is enrolled with the entity may not be held liable—

''(1) for the debts of the managed care entity, in the event of the medicaid managed care organization's insolvency;

''(2) for services provided to the individual—

''(A) in the event of the medicaid managed care organization failing to receive payment from the State for such services; or

''(B) in the event of a health care provider with a contractual or other arrangement with the medicaid managed care organization failing to receive payment from the State or the managed care entity for such services; or

''(3) for the debts of any health care provider with a contractual or other arrangement with the medicaid managed care organization to provide services to the individual, in the event of the insolvency of the health care provider.

''(b) PROTECTION OF BENEFICIARIES AGAINST BALANCE BILLING THROUGH SUBCONTRACTORS.—

''(1) IN GENERAL.—Any contract between a managed care entity that has an agreement with a State under this title and another entity under which the entity (or any other entity pursuant to the contract) provides directly or indirectly for the provision of services to beneficiaries under the agreement with the State shall include such provisions as the Secretary may require in order to assure that the entity complies with balance billing limitations and other requirements of this title (such as limitation on withholding of services) as they would apply to the managed care entity if such entity provided such services directly and not through a contract with another entity.

''(2) APPLICATION OF SANCTIONS FOR VIOLATIONS.—The provisions of section 1128A(b)(2)(B) and 1128B(d)(1) shall apply with respect to entities contracting directly or indirectly with a managed care entity (with a contract with a State under this title) for the provision of services to beneficiaries under such a contract in the same manner as such provisions would apply to the managed care entity if it provided such services directly and not through a contract with another entity.

"SEC. 1945. ASSURING QUALITY CARE.

"(a) EXTERNAL INDEPENDENT REVIEW OF MANAGED CARE ENTITY ACTIVITIES.—

"(1) REVIEW OF MEDICAID MANAGED CARE ORGANIZATION CONTRACT.—

"(A) IN GENERAL.—Except as provided in paragraph (2), each medicaid managed care organization shall be subject to an annual external independent review of the quality outcomes and timeliness of, and access to, the items and services specified in such organization's contract with the State under section 1941(a)(1)(B). Such review shall specifically evaluate the extent to which the medicaid managed care organization provides such services in a timely manner.

"(B) CONTENTS OF REVIEW.—An external independent review conducted under this subsection shall include—

"(i) a review of the entity's medical care, through sampling of medical records or other appropriate methods, for indications of quality of care and inappropriate utilization (including overutilization) and treatment,

"(ii) a review of enrollee inpatient and ambulatory data, through sampling of medical records or other appropriate methods, to determine trends in quality and appropriateness of care,

"(iii) notification of the entity and the State when the review under this paragraph indicates inappropriate care, treatment, or utilization of services (including overutilization), and

"(iv) other activities as prescribed by the Secretary or the State.

"(C) USE OF PROTOCOLS.—An external independent review conducted under this subsection on and after January 1, 1999, shall use protocols that have been developed, tested, and validated by the Secretary and that are at least as rigorous as those used by the National Committee on Quality Assurance as of the date of the enactment of this section.

"(D) AVAILABILITY OF RESULTS.—The results of each external independent review conducted under this paragraph shall be available to participating health care providers, enrollees, and potential enrollees of the medicaid managed

care organization, except that the results may not be made available in a manner that discloses the identity of any individual patient.

''(2) DEEMED COMPLIANCE.—

''(A) MEDICARE ORGANIZATIONS.—The requirements of paragraph (1) shall not apply with respect to a medicaid managed care organization if the organization is an eligible organization with a contract in effect under section 1876.

''(B) PRIVATE ACCREDITATION.—

''(i) IN GENERAL.—The requirements of paragraph (1) shall not apply with respect to a medicaid managed care organization if—

''(I) the organization is accredited by an organization meeting the requirements described in subparagraph (C)); and

''(II) the standards and process under which the organization is accredited meet such requirements as are established under clause (ii), without regard to whether or not the time

requirement of such clause is satisfied.

''(ii) STANDARDS AND PROCESS.—Not later than 180 days after the date of the enactment of this section, the Secretary shall specify requirements for the standards and process under which a medicaid managed care organization is accredited by an organization meeting the requirements of subparagraph (B).

''(C) ACCREDITING ORGANIZATION.—An accrediting organization meets the requirements of this subparagraph if the organization—

''(i) is a private, nonprofit organization;

''(ii) exists for the primary purpose of accrediting managed care organizations or health care providers; and

''(iii) is independent of health care providers or associations of health care providers.

''(3) REVIEW OF PRIMARY CARE CASE MANAGEMENT PROVIDER CONTRACT.—Each primary care case management provider shall be subject to an annual external independent review of the quality and

timeliness of, and access to, the items and services specified in the contract entered into between the State and the primary care case management provider under section 1941(a)(1)(B).

''(4) USE OF VALIDATION SURVEYS.—The Secretary shall conduct surveys each year to validate external reviews of at least 5 percent of the number of managed care entities in the year. In conducting such surveys the Secretary shall use the same protocols as were used in preparing the external reviews. If an external review finds that an individual managed care entity meets applicable requirements, but the Secretary determines that the entity does not meet such requirements, the Secretary's determination as to the entity's noncompliance with such requirements is binding and supersedes that of the previous survey.

''(b) FEDERAL MONITORING RESPONSIBILITIES.—The Secretary shall review the external independent reviews conducted pursuant to subsection (a) and shall monitor the effectiveness of the State's monitoring and follow-up activities required under section 1942(b)(1). If the Secretary determines that a State's monitoring and followup activities are not adequate to ensure that the requirements of such section are met, the Secretary shall undertake ap-

propriate followup activities to ensure that the State improves its monitoring and followup activities.

''(c) PROVIDING INFORMATION ON SERVICES.—

''(1) REQUIREMENTS FOR MEDICAID MANAGED CARE ORGANIZATIONS.—

''(A) INFORMATION TO THE STATE.—Each medicaid managed care organization shall provide to the State (at least at such frequency as the Secretary may require), complete and timely information concerning the following:

''(i) The services that the organization provides to (or arranges to be provided to) individuals eligible for medical assistance under the State plan under this title.

''(ii) The identity, locations, qualifications, and availability of participating health care providers.

''(iii) The rights and responsibilities of enrollees.

''(iv) The services provided by the organization which are subject to prior authorization by the organization as a condition of coverage (in accordance with subsection (d)).

''(v) The procedures available to an enrollee and a health care provider to appeal the failure of the organization to cover a service.

''(vi) The performance of the organization in serving individuals eligible for medical assistance under the State plan under this title.

Such information shall be provided in a form consistent with the reporting of similar information by eligible organizations under section 1876.

''(2) REQUIREMENTS FOR PRIMARY CARE CASE MANAGEMENT PROVIDERS.—Each primary care case management provider shall—

''(A) provide to the State (at least at such frequency as the Secretary may require), complete and timely information concerning the services that the primary care case management provider provides to (or arranges to be provided to) individuals eligible for medical assistance under the State plan under this title;

''(B) make available to enrollees and potential enrollees information concerning services available to the enrollee for which prior author-

ization by the primary care case management provider is required;

"(C) provide enrollees and potential enrollees information regarding all items and services that are available to enrollees under the contract between the State and the primary care case management provider that are covered either directly or through a method of referral and prior authorization; and

"(D) provide assurances that such entities and their professional personnel are licensed as required by State law and qualified to provide case management services, through methods such as ongoing monitoring of compliance with applicable requirements and providing information and technical assistance.

"(3) REQUIREMENTS FOR BOTH MEDICAID MANAGED CARE ORGANIZATIONS AND PRIMARY CARE CASE MANAGEMENT PROVIDERS.—Each managed care entity shall provide the State with aggregate encounter data for all items and services, including early and periodic screening, diagnostic, and treatment services under section 1905(r) furnished to individuals under 21 years of age. Any such data pro-

vided may be audited by the State and the Secretary.

"(d) CONDITIONS FOR PRIOR AUTHORIZATION.—Subject to section 1943, a managed care entity may require the approval of medical assistance for nonemergency services before the assistance is furnished to an enrollee only if the system providing for such approval provides that such decisions are made in a timely manner, depending upon the urgency of the situation.

"(e) PATIENT ENCOUNTER DATA.—Each medicaid managed care organization shall maintain sufficient patient encounter data to identify the health care provider who delivers services to patients and to otherwise enable the State plan to meet the requirements of section 1902(a)(27) and shall submit such data to the State or the Secretary upon request. The medicaid managed care organization shall incorporate such information in the maintenance of patient encounter data with respect to such health care provider.

"(f) INCENTIVES FOR HIGH QUALITY MANAGED CARE ENTITIES.—The Secretary and the State may establish a program to reward, through public recognition, incentive payments, or enrollment of additional individuals (or combinations of such rewards), managed care entities that provide the highest quality care to individuals eligible

for medical assistance under the State plan under this title who are enrolled with such entities. For purposes of section 1903(a)(7), proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this title.

"SEC. 1946. PROTECTIONS FOR PROVIDERS.

''(a) INFORMATION TO HEALTH CARE PROVIDERS.—Each medicaid managed care organization shall upon request, make the information described in section 1945(c)(1)(A) available to participating health care providers.

''(b) TIMELINESS OF PAYMENT.—A medicaid managed care organization shall make payment to health care providers for items and services which are subject to the contract under section 1941(a)(1)(B) and which are furnished to individuals eligible for medical assistance under the State plan under this title who are enrolled with the entity on a timely basis consistent with section 1943 and under the claims payment procedures described in section 1902(a)(37)(A), unless the health care provider and the managed care entity agree to an alternate payment schedule.

''(c) APPLICATION OF MEDICARE PROHIBITION OF RESTRICTIONS ON PHYSICIANS' ADVICE AND COUNSEL TO

ENROLLEES.—A managed care entity shall comply with the same prohibitions on any restrictions relating to physicians' advice and counsel to individuals as apply to eligible organizations under section 1876.

"(d) PHYSICIAN INCENTIVE PLANS.—Each medicaid managed care organization shall require that any physician incentive plan covering physicians who are participating in the medicaid managed care organization shall meet the requirements of section 1876(i)(8).

"(e) WRITTEN PROVIDER PARTICIPATION AGREEMENTS FOR CERTAIN PROVIDERS.—Each medicaid managed care organization that enters into a written provider participation agreement with a provider described in section 1942(h)(2) shall—

"(1) include terms and conditions that are no more restrictive than the terms and conditions that the medicaid managed care organization includes in its agreements with other participating providers with respect to—

"(A) the scope of covered services for which payment is made to the provider;

"(B) the assignment of enrollees by the organization to the provider;

''(C) the limitation on financial risk or availability of financial incentives to the provider;

''(D) accessibility of care;

''(E) professional credentialing and recredentialing;

''(F) licensure;

''(G) quality and utilization management;

''(I) confidentiality of patient records;

''(J) grievance procedures; and

''(K) indemnification arrangements between the organizations and providers; and

''(2) provide for payment to the provider on a basis that is comparable to the basis on which other providers are paid.

''(f) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.—Each medicaid managed care organization that has a contract under this title with respect to the provision of services of a federally qualified health center shall provide, at the election of such center, that the organization shall provide payments to such a center for services described in 1905(a)(2)(C) at the rates of payment specified in section 1902(a)(13)(E).

"SEC. 1947. ASSURING ADEQUACY OF PAYMENTS TO MEDICAID MANAGED CARE ORGANIZATIONS AND ENTITIES.

(a) ADEQUATE RATES.—As a condition of approval of a State plan under this title, a State shall find, determine, and make assurances satisfactory to the Secretary that—

''(1) the rates it pays medicaid managed care organizations for individuals eligible under the State plan are reasonable and adequate to assure access to services meeting professionally recognized quality standards, taking into account—

''(A) the items and services to which the rate applies,

''(B) the eligible population, and

''(C) the rate the State pays providers for such items and services;

''(2) the methodology used to adjust the rate adequately reflects the varying risks associated with individuals actually enrolling in each medicaid managed care organization; and

''(3) it will provide for an annual review of the actuarial soundness of rates by an independent actuary selected by the Secretary and for a copy of the actuary's report on each such review to be transmit-

ted to the State and the Secretary and made available to the public.

''(b) ANNUAL REPORTS.—As a condition of approval of a State plan under this title, a State shall report to the Secretary, at least annually, on the rates the States pays to medicaid managed care organizations.

''SEC. 1948. FRAUD AND ABUSE.

''(a) PROVISIONS APPLICABLE TO MANAGED CARE ENTITIES.—

''(1) PROHIBITING AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES.—

''(A) IN GENERAL.—A managed care entity may not knowingly—

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

''(ii) have an employment, consulting, or other agreement with a person described in such subparagraph for the provision of items and services that are significant and material to the organization's obligations under its contract with the State.

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

''(i) shall notify the Secretary of such noncompliance;

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

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

''(C) PERSONS DESCRIBED.—A person is described in this subparagraph if such person—

''(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal ac-

quisition regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order 12549; or

''(ii) is an affiliate (within the meaning of the Federal acquisition regulation) of a person described in subparagraph (A).

''(2) RESTRICTIONS ON MARKETING.—

''(A) DISTRIBUTION OF MATERIALS.—

''(i) IN GENERAL.—A managed care entity may not distribute directly or through any agent or independent contractor marketing materials within any State—

''(I) without the prior approval of the State; and

''(II) that contain false or materially misleading information.

''(ii) CONSULTATION IN REVIEW OF MARKET MATERIALS.—In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

''(iii) PROHIBITION.—The State may not enter into or renew a contract with a

managed care entity for the provision of services to individuals enrolled under the State plan under this title if the State determines that the entity distributed directly or through any agent or independent contractor marketing materials in violation of clause (i).

''(B) SERVICE MARKET.—A managed care entity shall distribute marketing materials to the entire service area of such entity.

''(C) PROHIBITION OF TIE-INS.—A managed care entity, or any agency of such entity, may not seek to influence an individual's enrollment with the entity in conjunction with the sale of any other insurance.

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

''(E) PROHIBITION OF COLD CALL MARKETING.—Each managed care entity shall not,

directly or indirectly, conduct door-to-door, telephonic, or other 'cold call' marketing of enrollment under this title.

''(b) PROVISIONS APPLICABLE ONLY TO MEDICAID MANAGED CARE ORGANIZATIONS.—

''(1) STATE CONFLICT-OF-INTEREST SAFEGUARDS IN MEDICAID RISK CONTRACTING.—A medicaid managed care organization may not enter into a contract with any State under section 1941(a)(1)(B) unless the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations or to the default enrollment process described in section 1941(a)(1)(F) that are at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423), against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

''(2) REQUIRING DISCLOSURE OF FINANCIAL INFORMATION.—In addition to any requirements applicable under section 1902(a)(27) or 1902(a)(35), a medicaid managed care organization shall—

''(A) report to the State (and to the Secretary upon the Secretary's request) such financial information as the State or the Secretary may require to demonstrate that—

''(i) the organization has the ability to bear the risk of potential financial losses and otherwise has a fiscally sound operation;

''(ii) the organization uses the funds paid to it by the State and the Secretary for activities consistent with the requirements of this title and the contract between the State and organization; and

''(iii) the organization does not place an individual physician, physician group, or other health care provider at substantial risk (as determined by the Secretary) for services not provided by such physician, group, or health care provider, by providing adequate protection (as determined by the Secretary) to limit the liability of such physician, group, or health care provider, through measures such as stop loss insurance or appropriate risk corridors;

''(B) agree that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the organization (and of any subcontractor) relating to the information reported pursuant to subparagraph (A) and any information required to be furnished under section paragraphs (27) or (35) of section 1902(a);

''(C) make available to the Secretary and the State a description of each transaction described in subparagraphs (A) through (C) of section 1318(a)(3) of the Public Health Service Act between the organization and a party in interest (as defined in section 1318(b) of such Act);

''(D) agree to make available to its enrollees upon reasonable request—

''(i) the information reported pursuant to subparagraph (A); and

''(ii) the information required to be disclosed under sections 1124 and 1126;

''(E) comply with subsections (a) and (c) of section 1318 of the Public Health Service Act (relating to disclosure of certain financial

information) and with the requirement of section 1301(c)(8) of such Act (relating to liability arrangements to protect members); and

"(F) notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

Each State is required to conduct audits on the books and records of at least 1 percent of the number of medicaid managed care organizations operating in the State.

"(3) ADEQUATE PROVISION AGAINST RISK OF INSOLVENCY.—

"(A) ESTABLISHMENT OF STANDARDS.—The Secretary shall establish standards, including appropriate equity standards, under which each medicaid managed care organization shall make adequate provision against the risk of insolvency.

"(B) CONSIDERATION OF OTHER STANDARDS.—In establishing the standards described in subparagraph (A), the Secretary shall consider solvency standards applicable to eligible organizations with a risk-sharing contract under section 1876.

"(C) MODEL CONTRACT ON SOLVENCY.—At the earliest practicable time after the date of enactment of this section, the Secretary shall issue guidelines concerning solvency standards for risk contracting entities and subcontractors of such risk contracting entities. Such guidelines shall take into account characteristics that may differ among risk contracting entities including whether such an entity is at risk for inpatient hospital services.

"(4) REQUIRING REPORT ON NET EARNINGS AND ADDITIONAL BENEFITS.—Each medicaid managed care organization shall submit a report to the State and the Secretary not later than 12 months after the close of a contract year containing the most recent audited financial statement of the organization's net earnings and consistent with generally accepted accounting principles.

"(c) DISCLOSURE OF OWNERSHIP AND RELATED INFORMATION.—Each medicaid managed care organization shall provide for disclosure of information in accordance with section 1124.

"(d) DISCLOSURE OF TRANSACTION INFORMATION.—

''(1) IN GENERAL.—Each medicaid managed care organization which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) shall report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General a description of transactions between the organization and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

''(A) Any sale or exchange, or leasing of any property between the organization and such a party.

''(B) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

''(C) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls,

or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

''(2) Each such organization shall make the information reported pursuant to paragraph (1) available to its enrollees upon reasonable request.

''(e) CONTRACT OVERSIGHT.—

''(1) IN GENERAL.—The Secretary must provide prior review and approval for contracts under this part with a medicaid managed care organization providing for expenditures under this title in excess of $1,000,000.

''(2) INSPECTOR GENERAL REVIEW.—As part of such approval process, the Inspector General in the Department of Health and Human Services, effective October 1, 1997, shall make a determination (to the extent practicable) as to whether persons with an ownership interest (as defined in section 1124(a)(3)) or an officer, director, agent, or managing employee (as defined in section 1126(b)) of the organization are or have been described in subsection (a)(1)(C) based on a ground relating to fraud, theft, embezzlement, breach of fiduciary re-

sponsibility, or other financial misconduct or obstruction of an investigation.

''(f) LIMITATION ON AVAILABILITY OF FFP FOR USE OF ENROLLMENT BROKERS.—Amounts expended by a State for the use an enrollment broker in marketing managed care entities to eligible individuals under this title shall be considered, for purposes of section 1903(a)(7), to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

''(1) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this title) that provide coverage of services in the same State in which the broker is conducting enrollment activities.

''(2) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this title or title XVIII or debarred by any Federal agency, or subject to a civil money penalty under this Act.

''(g) USE OF UNIQUE PHYSICIAN IDENTIFIER FOR PARTICIPATING PHYSICIANS.—Each medicaid managed

care organization shall require each physician providing services to enrollees eligible for medical assistance under the State plan under this title to have a unique identifier in accordance with the system established under section 1173(b).

''(h) SECRETARIAL RECOVERY OF FFP FOR CAPITATION PAYMENTS FOR INSOLVENT MANAGED CARE ENTITIES.—The Secretary shall provide for the recovery and offset against amount owed a State under section 1903(a)(1) an amount equal to the amounts paid to the State, for medical assistance provided under such section for expenditures for capitation payments to a managed care entity that becomes insolvent, for services contracted for with, but not provided by, such organization.

''SEC. 1949. SANCTIONS FOR NONCOMPLIANCE BY MANAGED CARE ENTITIES.

''(a) USE OF INTERMEDIATE SANCTIONS BY THE STATE TO ENFORCE REQUIREMENTS.—Each State shall establish intermediate sanctions, which may include any of the types described in subsection (b) other than the termination of a contract with a managed care entity, which the State may impose against a managed care entity with a contract under section 1941(a)(1)(B) if the entity—

''(1) fails substantially to provide medically necessary items and services that are required (under

law or under such entity's contract with the State) to be provided to an enrollee covered under the contract;

''(2) imposes premiums or charges on enrollees in excess of the premiums or charges permitted under this title;

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

''(4) misrepresents or falsifies information that is furnished—

''(A) to the Secretary or the State under this part; or

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

''(5) fails to comply with the requirements of section 1876(i)(8) or this part.

''(b) INTERMEDIATE SANCTIONS.—The sanctions described in this subsection are as follows:

''(1) Civil money penalties as follows:

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

''(B) With respect to a determination under paragraph (3) or (4)(A) of subsection (a), not more than $100,000 for each such determination.

''(C) With respect to a determination under subsection (a)(2), double the excess amount charged in violation of such subsection (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

''(D) Subject to subparagraph (B), with respect to a determination under subsection (a)(3), $15,000 for each individual not enrolled as a result of a practice described in such subsection.

''(2) The appointment of temporary management to oversee the operation of the medicaid-only managed care entity upon a finding by the State that there was continued egregious behavior by the plan and to assure the health of the entity's enroll-

ees, if there is a need for temporary management while—

''(A) there is an orderly termination or reorganization of the managed care entity; or

''(B) improvements are made to remedy the violations found under subsection (a), except that temporary management under this paragraph may not be terminated until the State has determined that the managed care entity has the capability to ensure that the violations shall not recur.

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

''(4) Suspension of default or all enrollment of individuals under this title after the date the Secretary or the State notifies the entity of a determination of a violation of any requirement of this part.

''(5) Suspension of payment to the entity under this title for individuals enrolled after the date the Secretary or State notifies the entity of such a determination and until the Secretary or State is satis-

fied that the basis for such determination has been corrected and is not likely to recur.

''(c) TREATMENT OF CHRONIC SUBSTANDARD ENTITIES.—In the case of a managed care entity which has repeatedly failed to meet the requirements of sections 1942 through 1946, the State shall (regardless of what other sanctions are provided) impose the sanctions described in paragraphs (2) and (3) of subsection (b).

''(d) AUTHORITY TO TERMINATE CONTRACT.—In the case of a managed care entity which has failed to meet the requirements of this part, the State shall have the authority to terminate its contract with such entity under section 1941(a)(1)(B) and to enroll such entity's enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the State plan under this title other than through a managed care entity).

''(e) AVAILABILITY OF SANCTIONS TO THE SECRETARY.—

''(1) INTERMEDIATE SANCTIONS.—In addition to the sanctions described in paragraph (2) and any other sanctions available under law, the Secretary may provide for any of the sanctions described in subsection (b) if the Secretary determines that a managed care entity with a contract under section

1941(a)(1)(B) fails to meet any of the requirements of this part.

''(2) DENIAL OF PAYMENTS TO THE STATE.—The Secretary may deny payments to the State for medical assistance furnished under the contract under section 1941(a)(1)(B) for individuals enrolled after the date the Secretary notifies a managed care entity of a determination under subsection (a) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(f) DUE PROCESS FOR MANAGED CARE ENTITIES.—

''(1) AVAILABILITY OF HEARING PRIOR TO TERMINATION OF CONTRACT.—A State may not terminate a contract with a managed care entity under section 1941(a)(1)(B) unless the entity is provided with a hearing prior to the termination.

''(2) NOTICE TO ENROLLEES OF TERMINATION HEARING.—A State shall notify all individuals enrolled with a managed care entity which is the subject of a hearing to terminate the entity's contract with the State of the hearing and that the enrollees may immediately disenroll with the entity without cause.

''(3) OTHER PROTECTIONS FOR MANAGED CARE ENTITIES AGAINST SANCTIONS IMPOSED BY STATE.—Before imposing any sanction against a managed care entity other than termination of the entity's contract, the State shall provide the entity with notice and such other due process protections as the State may provide, except that a State may not provide a managed care entity with a pre-termination hearing before imposing the sanction described in subsection (b)(2).

''(4) IMPOSITION OF CIVIL MONETARY PENALTIES BY SECRETARY.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply with respect to a civil money penalty imposed by the Secretary under subsection (b)(1) in the same manner as such provisions apply to a penalty or proceeding under section 1128A.

''SEC. 1950. DEFINITIONS; MISCELLANEOUS PROVISIONS.

''(a) DEFINITIONS.—For purposes of this title:

''(1) MANAGED CARE ENTITY.—The term 'managed care entity' means—

''(A) a medicaid managed care organization; or

''(B) a primary care case management provider.

''(2) MEDICAID MANAGED CARE ORGANIZATION.—The term 'medicaid managed care organization' means a health maintenance organization, an eligible organization with a contract under section 1876, a provider sponsored network or any other organization which is organized under the laws of a State, has made adequate provision (as determined under standards established for purposes of eligible organizations under section 1876 and through its capitalization or otherwise) against the risk of insolvency, and provides or arranges for the provision of one or more items and services to individuals eligible for medical assistance under the State plan under this title in accordance with a contract with the State under section 1941(a)(1)(B).

''(3) PRIMARY CARE CASE MANAGEMENT PROVIDER.—

''(A) IN GENERAL.—The term 'primary care case management provider' means a health care provider that—

''(i) is a physician, group of physicians, a Federally-qualified health center, a rural health clinic, or an entity employing or having other arrangements with physicians that provides or arranges for the pro-

vision of one or more items and services to individuals eligible for medical assistance under the State plan under this title in accordance with a contract with the State under section 1941(a)(1)(B);

''(ii) receives payment on a fee-for-service basis (or, in the case of a Federally-qualified health center or a rural health clinic, on a reasonable cost per encounter basis) for the provision of health care items and services specified in such contract to enrolled individuals;

''(iii) receives an additional fixed fee per enrollee for a period specified in such contract for providing case management services (including approving and arranging for the provision of health care items and services specified in such contract on a referral basis) to enrolled individuals; and

''(iv) is not an entity that is at risk.

''(B) AT RISK.—In subparagraph (A)(iv), the term 'at risk' means an entity that—

''(i) has a contract with the State under which such entity is paid a fixed

amount for providing or arranging for the provision of health care items or services specified in such contract to an individual eligible for medical assistance under the State plan and enrolled with such entity, regardless of whether such items or services are furnished to such individual; and

''(ii) is liable for all or part of the cost of furnishing such items or services, regardless of whether such cost exceeds such fixed payment.''.

SEC. 3. STUDIES AND REPORTS.

(a) REPORT ON PUBLIC HEALTH SERVICES.—

(1) IN GENERAL.—Not later than January 1, 1998, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall report to the Committee on Finance of the Senate and the Committee on Commerce of the House of Representatives on the effect of managed care entities (as defined in section 1950(a)(1) of the Social Security Act) on the delivery of and payment for the services traditionally provided through providers described in section 1941(a)(2)(B)(i) of such Act.

(2) CONTENTS OF REPORT.—The report referred to in subsection (a) shall include—

(A) information on the extent to which enrollees with eligible managed care entities seek services at local health departments, public hospitals, and other facilities that provide care without regard to a patient's ability to pay;

(B) information on the extent to which the facilities described in such subsection provide services to enrollees with eligible managed care entities without receiving payment;

(C) information on the effectiveness of systems implemented by facilities described in such subsection for educating such enrollees on services that are available through eligible managed care entities with which such enrollees are enrolled;

(D) to the extent possible, identification of the types of services most frequently sought by such enrollees at such facilities; and

(E) recommendations about how to ensure the timely delivery of the services traditionally provided through providers described in section 1941(a)(2)(B)(i) of the Social Security Act to enrollees of managed care entities and how to ensure that local health departments, public hospitals, and other facilities are adequately

compensated for the provision of such services to such enrollees.

(b) REPORT ON PAYMENTS TO HOSPITALS.—

(1) IN GENERAL.—Not later than October 1 of each year, beginning with October 1, 1998, the Secretary and the Comptroller General shall analyze and submit a report to the Committee on Finance of the Senate and the Committee on Commerce of the House of Representatives on rates paid for hospital services under managed care entities under contracts under section 1941(a)(1)(B) of the Social Security Act.

(2) CONTENTS OF REPORT.—The information in the report described in paragraph (1) shall—

(A) be organized by State, type of hospital, type of service, and

(B) include a comparison of rates paid for hospital services under managed care entities with rates paid for hospital services furnished to individuals who are entitled to benefits under a State plan under title XIX of the Social Security Act and are not enrolled with such entities.

(c) REPORTS BY STATES.—Each State shall transmit to the Secretary, at such time and in such manner as the Secretary determines appropriate, the information on hos-

pital rates submitted to such State under section 1947(b)(2) of such Act.

(d) INDEPENDENT STUDY AND REPORT ON QUALITY ASSURANCE AND ACCREDITATION STANDARDS.—The Institute of Medicine of the National Academy of Sciences shall conduct a study and analysis of the quality assurance programs and accreditation standards applicable to managed care entities operating in the private sector or to such entities that operate under contracts under the medicare program under title XVIII of the Social Security Act to determine if such programs and standards include consideration of the accessibility and quality of the health care items and services delivered under such contracts to low-income individuals.

SEC. 4. CONFORMING AMENDMENTS.

(a) REPEAL OF CURRENT REQUIREMENTS.—

(1) IN GENERAL.—Except as provided in paragraph (2), section 1903(m) (42 U.S.C. 1396b(m)) is repealed on the date of the enactment of this Act.

(2) EXISTING CONTRACTS.—In the case of any contract under section 1903(m) of such Act which is in effect on the day before the date of the enactment of this Act, the provisions of such section shall apply to such contract until the earlier of—

(A) the day after the date of the expiration of the contract; or

(B) the date which is 1 year after the date of the enactment of this Act.

(b) FEDERAL FINANCIAL PARTICIPATION.—

(1) CLARIFICATION OF APPLICATION OF FFP DENIAL RULES TO PAYMENTS MADE PURSUANT TO MANAGED CARE ENTITIES.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended by adding at the end the following sentence: ''Paragraphs (1)(A), (1)(B), (2), (5), and (12) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1950(a)(1)) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.''.

(2) FFP FOR EXTERNAL QUALITY REVIEW ORGANIZATIONS.—Section 1903(a)(3)(C) (42 U.S.C. 1396b(a)(3)(C)) is amended—

(A) by inserting ''(i)'' after ''(C)'', and

(B) by adding at the end the following new clause:

''(ii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the

proper and efficient administration of the State plan) as are attributable to the performance of independent external reviews of managed care entities (as defined in section 1950(a)(1)) by external quality review organizations, but only if such organizations conduct such reviews under protocols approved by the Secretary and only in the case of such organizations that meet standards established by the Secretary relating to the independence of such organizations from agencies responsible for the administration of this title or eligible managed care entities; and''.

(c) EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN PROGRAM.—Section 1128(b)(6)(C) (42 U.S.C. 1320a–7(b)(6)(C)) is amended—

(1) in clause (i), by striking ''a health maintenance organization (as defined in section 1903(m))'' and inserting ''a managed care entity, as defined in section 1950(a)(1),''; and

(2) in clause (ii), by inserting ''section 1115 or'' after ''approved under''.

(d) STATE PLAN REQUIREMENTS.—Section 1902 (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(30)(C), by striking ''section 1903(m)'' and inserting ''section 1941(a)(1)(B)''; and

(2) in subsection (a)(57), by striking ''hospice program, or health maintenance organization (as defined in section 1903(m)(1)(A))'' and inserting ''or hospice program'';

(3) in subsection (e)(2)(A), by striking ''or with an entity described in paragraph (2)(B)(iii), (2)(E), (2)(G), or (6) of section 1903(m) under a contract described in section 1903(m)(2)(A)'' and inserting ''or with a managed care entity, as defined in section 1950(a)(1);

(4) in subsection (p)(2)—

(A) by striking ''a health maintenance organization (as defined in section 1903(m))'' and inserting ''a managed care entity, as defined in section 1950(a)(1),'';

(B) by striking ''an organization'' and inserting ''an entity''; and

(C) by striking ''any organization'' and inserting ''any entity''; and

(5) in subsection (w)(1), by striking ''sections 1903(m)(1)(A) and'' and inserting ''section''.

(e) PAYMENT TO STATES.—Section 1903(w)(7)(A)(viii) (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

"(viii) Services of a managed care entity with a contract under section 1941(a)(1)(B).".

(f) USE OF ENROLLMENT FEES AND OTHER CHARGES.—Section 1916 (42 U.S.C. 1396o) is amended in subsections (a)(2)(D) and (b)(2)(D) by striking "a health maintenance organization (as defined in section 1903(m))" and inserting "a managed care entity, as defined in section 1950(a)(1)," each place it appears.

(g) EXTENSION OF ELIGIBILITY FOR MEDICAL ASSISTANCE.—Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r–6(b)(4)(D)(iv)) is amended to read as follows:

"(iv) ENROLLMENT WITH MANAGED CARE ENTITY.—Enrollment of the caretaker relative and dependent children with a managed care entity, as defined in section 1950(a)(1), less than 50 percent of the membership (enrolled on a prepaid basis) of which consists of individuals who are eligible to receive benefits under this title (other than because of the option offered under this clause). The option of en-

rollment under this clause is in addition to, and not in lieu of, any enrollment option that the State might offer under subparagraph (A)(i) with respect to receiving services through a managed care entity in accordance with part B.''.

(h) PAYMENT FOR COVERED OUTPATIENT DRUGS.—Section 1927(j)(1) (42 U.S.C. 1396r–8(j)(1)) is amended by striking ''***Health Maintenance Organizations, including those organizations that contract under section 1903(m),'' and inserting ''health maintenance organizations and medicaid managed care organizations, as defined in section 1950(a)(2),''.

(i) APPLICATION OF SANCTIONS FOR BALANCED BILLING THROUGH SUBCONTRACTORS.—(1) Section 1128A(b)(2)(B) (42 U.S.C. 1320a–7a(b)) is amended by inserting '', including section 1944(b)'' after ''title XIX''.

(2) Section 1128B(d)(1) (42 U.S.C. 1320a–7b(d)(1)) is amended by inserting ''or, in the case of an individual enrolled with a managed care entity under part B of title XIX, the applicable rates established by the entity under the agreement with the State agency under such part'' after ''established by the State''.

(j) REPEAL OF CERTAIN RESTRICTIONS ON OBSTETRICAL AND PEDIATRIC PROVIDERS.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended by striking paragraph (12).

(k) DEMONSTRATION PROJECTS TO STUDY EFFECT OF ALLOWING STATES TO EXTEND MEDICAID COVERAGE FOR CERTAIN FAMILIES.—Section 4745(a)(5)(A) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1396a note) is amended by striking ''(except section 1903(m)'' and inserting ''(except part B)''.

(l) CONFORMING AMENDMENT FOR DISCLOSURE REQUIREMENTS FOR MANAGED CARE ENTITIES.—Section 1124(a)(2)(A) (42 U.S.C. 1320a–3(a)(2)(A)) is amended by inserting ''managed care entity under title XIX,'' after ''renal dialysis facility,''.

(m) ELIMINATION OF REGULATORY PAYMENT CAP.—The Secretary of Health and Human Services may not, under the authority of section 1902(a)(30)(A) of the Social Security Act or any other provision of title XIX of such Act, impose a limit by regulation on the amount of the capitation payments that a State may make to qualified entities under such title, and section 447.361 of title 42, Code of Federal Regulations (relating to upper limits of payment: risk contracts), is hereby nullified.

(n) CONTINUATION OF ELIGIBILITY.—Section 1902(e) (42 U.S.C. 1396a(e)) is amended by striking paragraph (2) and inserting the following:

''(2) For provision providing for extended liability in the case of certain beneficiaries enrolled with managed care entities, see section 1941(e).''.

(o) CONFORMING AMENDMENTS TO FREEDOM-OF-CHOICE PROVISIONS.—Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)) is amended—

(1) in the matter preceding subparagraph (A), by striking ''subsection (g) and in section 1915'' and inserting ''subsection (g), section 1915, and section 1941,''; and

(2) in subparagraph (B), by striking ''a health maintenance organization, or a'' and inserting ''or with a managed care entity, as defined in section 1950(a)(1), or''.

SEC. 5. EFFECTIVE DATE; STATUS OF WAIVERS.

(a) EFFECTIVE DATE.—Except as provided in subsection (b), the amendments made by this Act shall apply to medical assistance furnished—

(1) during quarters beginning on or after October 1, 1997; or

(2) in the case of assistance furnished under a contract described in section 4(a)(2), during quarters beginning after the earlier of—

(A) the date of the expiration of the contract; or

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

(b) APPLICATION TO WAIVERS.—

(1) EXISTING WAIVERS.—If any waiver granted to a State under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n) or otherwise which relates to the provision of medical assistance under a State plan under title XIX of the such Act (42 U.S.C. 1396 et seq.), is in effect or approved by the Secretary of Health and Human Services as of the applicable effective date described in subsection (a), the amendments made by this Act shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent such amendments are inconsistent with the terms of the waiver.

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

(A) PRIOR TO APPROVAL.—On and after the applicable effective date described in subsection (a), the Secretary, prior to extending any waiver granted under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n) or otherwise which relates to the provision of medical assistance under a State plan under title XIX of the such Act (42 U.S.C. 1396 et seq.), shall—

(i) conduct an evaluation of—

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

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

(ii) submit a report to the Congress recommending whether the extension of a waiver under such sections or provision of law should be conditioned on the State submitting the request for an extension complying with the provisions of part B of

title XIX of the Social Security Act (as added by this Act).

(B) DEEMED APPROVAL.—If the Congress has not enacted legislation based on a report submitted under subparagraph (A)(ii) within 120 days after the date such report is submitted to the Congress, the recommendations contained in such report shall be deemed to be approved by the Congress.

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