Medicaid Managed Care Model Provisions:

Enrollment and Disenrollment

Issue No. 2

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Introduction

The National Health Law Program has focused on the legal provisions governing Medicaid managed care for nearly three decades. The Medicaid program has changed significantly and now requires millions of older people, people with disabilities, and those with Limited English Proficiency to enroll in managed care. Yet, the regulations have not been updated for more than a decade and no longer reflect the needs of the covered populations, or current clinical practices and technological capabilities. To help address these deficiencies, NHeLP has developed a complete set of modernized model federal regulations.[1]

To focus advocates on areas that were significantly updated, NHeLP has prepared a series of issue briefs featuring selected model provisions governing five aspects of Medicaid managed care: beneficiary grievances and appeals, enrollment and disenrollment, network adequacy, accessibility, and quality and transparency.[2] We encourage policy makers and advocates to use these model provisions to update existing regulations, policies, and managed care contracts.

TOPIC #2: ENROLLMENT AND DISENROLLMENT

Background on Enrollment and Disenrollment:

States can require many types of beneficiaries to enroll in managed care through an amendment to their state Medicaid plan.[3] If a state does so, the state must comply with statutory requirements regarding, among other things, enrollment and disenrollment.[4] States must obtain special permission (via a federal waiver) to require mandatory enrollment into managed care of the following populations: (1) children under age 19 with special

[1] We used the current federal Medicaid managed care regulations at 42 C.F.R. part 438 as the starting point for developing our comprehensive model provisions. The regulations address state obligations, enrollee rights and responsibilities, quality assessment and improvement, external quality review, grievance systems, certification and program integrity, sanctions, and conditions for federal funding.

[2] Our issue brief on Quality and Transparency will be issued later in the fall of 2014.

needs;[5] (2) individuals who are dually eligible for Medicaid and Medicare, including Qualified Medicare Beneficiaries,[6] and (3) certain Native Americans.[7]

A properly functioning enrollment process is fundamental to ensuring access to appropriate health care and preserving continuity of care with existing providers. Generally, states must allow beneficiaries to choose between at least two managed care entities.[8] In rural areas, however, states can require enrollment in a single managed care entity so long as the individual has a choice of not less than two physicians or case managers.[9] States must establish processes for enrollment (including default enrollment), termination of enrollment, and change of enrollment, including termination or change of enrollment for cause (e.g., the enrollee moves out of the managed care plan's service area or the plan does not, because of moral or religious objections, cover the service the enrollee seeks) at any time and without cause within 90 days of first enrollment and at least every 12 months thereafter.[10] All enrollment notices and informational materials must be provided in a manner and form that is easily understood by enrollees and potential enrollees.[11] Managed care contracts must also prohibit discrimination on the basis of health status or in requirements for health services in the enrollment, disenrollment, and re-enrollment processes.[12]

A properly functioning enrollment process is fundamental to ensuring access to appropriate health care and preserving continuity of care.

Recurring Problems: Managed care enrollees have faced barriers when attempting to enroll in or disenroll from managed care plans or when seeking an exemption from mandatory managed care plan enrolment. These barriers include:

- Limited access to necessary comprehensive health care services (e.g. reproductive health or home and community-based services);
- Failure to provide enrollees with sufficient time or information to make an appropriate plan selection, resulting in default enrollment;
- Lack of clarity about prohibited grounds for requesting an enrollee disenroll from a plan;
- Inability of enrollees—especially individuals with disabilities—to disenroll when they are not receiving the care they need or to obtain an exemption from the plan enrollment altogether to protect their access to continuity of care with an existing provider for ongoing treatment of a condition;
- Delays in processing requests for disenrollment, including expedited disenrollment requests;
- Difficulty obtaining assistance from independent advocates outside the plan regarding enrollment and disenrollment and the necessary forms or process.

These model provisions address these problems by:

- Explicitly requiring, in states require Medicaid enrollees to enroll in a managed care plan, that at least one of the two entities an enrollee can choice from covers the full range of reproductive health care services covered in the State plan;
- Guaranteeing enrollees at least 45 days choose a plan when enrollees are automatically enrolled if they make no selection;
- Explicitly prohibiting a plan from requesting that an enrollee disenroll because of the enrollee's race, color, national origin, disability, age, sex, gender identity, or sexual orientation;
- Specifying situations in which a plan must disenroll an enrollee and requiring states to provide enrollees that must enroll in another plan information necessary to do so;
- Establishing criteria defining good cause for disenrollment, including when needed services are excluded from the plan's contract and when there has been a breakdown in the physician-patient relationship, and making clear that State agencies can determine other reasons as good cause;
- Establishing requirements and standards on plans and State agencies regarding expedited disenrollment requests;
- Requiring the plan to either approve a disenrollment request or refer it to the state within a specific timeframe;
- Establishing requirements to ensure availability of enrollment and disenrollment forms; and
- Imposing requirements upon plans and states to allow timely and appropriate processing of requests for exemption from mandatory enrollment.

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Medicaid Managed Care Enrollment and Disenrollment Rights

Note: These model provisions are based on NHeLP's comprehensive set of modernized Medicaid managed care regulations.

Definitions:

Prepaid Managed Care Plan (PMCP): A Medicaid managed care organization (MCO), Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PAHP), as defined by 42 C.F.R. § 438.2.

Primary Care Case Manager (PCCM): A physician, entity employing physicians, or (at state option) another health care practitioner that contracts with a State to provide case management services, as defined by 42 C.F.R. § 438.2.

Section One: Choice of PMCP and PCCMs

(a) *General rule.* Except as specified in paragraphs (b) and (c) of this Section, a State that requires Medicaid beneficiaries to enroll in a PMCP or PCCM must give those beneficiaries a choice of at least two entities. At least one of those entities must cover the full range of reproductive health services covered in the State plan, to the extent that reproductive health services fall within the scope of services for which the entity is responsible.

(b) *Exception for rural area residents.*

(1) A State that limits enrollment by rural residents to a single PMCP or PCCM must permit the beneficiary to choose from at least two physicians or case managers

(2) As used in this paragraph, "rural area" is any area other than an "urban area" as defined in 42 C.F.R. §412.62(f)(1)(ii).

(c) *Limitations on changes between primary care providers.* For an enrollee of a single PMCP or HIO under paragraph (b) or (c) of this Section, any limitation the State imposes on his or her freedom to change between primary care providers may be no more restrictive than the limitations on disenrollment under Section Two(c).

(d) *Time allotted for choice of* PMCP and PCCM. When enrollees are given a choice of plans in which to enroll and will be automatically enrolled if they make no selection, they must be allowed at least 45 days to make a plan selection.

Section Two: Disenrollment: Requirements and Limitations

(a) *Applicability*. The provisions of this Section apply to all managed care arrangements whether enrollment is mandatory or voluntary and whether the contract is with a PMCP or a PCCM.

(b) *Disenrollment requested by the PMCP or PCCM.* All PMCP and PCCM contracts must—

(1) Specify the reasons for which the PMCP or PCCM may request disenrollment of an enrollee;

(2) Provide that the PMCP or PCCM may not request disenrollment for any of the following reasons: (1) an adverse change in the enrollee's health status; (ii) the enrollee's utilization of medical services; (iii)

diminished mental capacity; or (iv) uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the PMCP or PCCM seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees);

(3) Provide that the PMCP or PCCM may not request disenrollment because of an enrollee's race, color, national origin, disability, age, sex, gender identity, or sexual orientation; and

(4) Specify the methods by which the PMCP or PCCM assures the agency that it does not request disenrollment for reasons other than those permitted under the contract.

(c) *Reasons for disenrollment.*

(1) The State agency or PMCP or PCCM shall disenroll any enrollee from a plan when one of the following conditions is met:

(i) An enrollee's Medicaid eligibility is terminated.

(ii) The State agency (or agent) incorrectly enrolled or assigned an enrollee to a plan not of his/her choosing, as indicated on the enrollment request form completed by beneficiary.

(iii) An enrollee was enrolled in the plan due to incorrect information provided by the State agency or due to prohibited marketing practices by the plan.

(iv) An enrollee's request for disenrollment is due to plan merger or reorganization.

(v) There is a change of an enrollee's place of residence to outside the plan's service area.

(vi) An enrollee requests the disenrollment for any reason and the request is not made during any restricted disenrollment period for that enrollee.

(vii) An enrollee requests disenrollment for good cause, as specified in paragraph (e)(2) below, when the request is made during any restricted disenrollment period for the enrollee.

(viii) An enrollee requests disenrollment for one of the reasons specified for exemption from plan enrollment in Section Three and meets the criteria specified in that Section.

(ix) An enrollee meets the criteria for expedited disenrollment in accordance with subsection (c).

(x) An enrollee becomes enrolled in other health coverage, except that dual enrollment is permitted if a beneficiary is enrolled in other coverage in an MCO and

(A) The Medicaid plan in which the eligible beneficiary is enrolling is the same as the MCO in which the beneficiary is enrolled, and

(B) Such enrollment is allowed in the contract between the plan and the department.

(2) In a system in which enrollment in a plan is mandatory, the State shall provide enrollees with the information necessary to change their enrollment to another plan. An enrollee who does not select the competing plan shall be assigned another plan, in accordance with Section Three(a)(2)(i) of this part. If a competing plan is at enrollment capacity, fee-for-service Medicaid shall be made available to the eligible beneficiary. Enrollees may disenroll from their plans into fee-for-service Medicaid when they: (i) meet the criteria in Section Three for exemption from plan enrollment or (ii) are eligible for voluntary enrollment.

(d) *Limits on disenrollment*. If the State chooses to limit disenrollment, its PMCP and PCCM contracts must provide that a beneficiary may request disenrollment as follows:

(1) For good cause, at any time, as described in (e)(2) below.

(2) Without good cause, at the following times:

(i) At any time during the 90 days following the date of the beneficiary's initial enrollment with the PMCP or PCCM, or the date the State sends the beneficiary notice of the enrollment, whichever is later.

(ii) At least once every 12 months thereafter.

(iii) Upon automatic reenrollment under paragraph (h) of this Section, if the temporary loss of Medicaid eligibility has caused the beneficiary to miss the annual disenrollment opportunity.

(iv) When the State imposes the intermediate sanction specified in 42 C.F.R. § 438.702(a)(3).

(e) *Procedures for disenrollment* (1) Request for disenrollment. The beneficiary (or his or her representative) must submit an oral or written request either —

(i) To the State agency (or its agent); or

(ii) To the PMCP or PCCM, if the State permits PMCP and PCCMs to process disenrollment requests.

(iii) Expedited disenrollment requests may also be submitted by facsimile, via a dedicated website, or over the telephone to the State agency (or its agent).

(2) *Good Cause for disenrollment.* The following are good cause for disenrollment:

(i) The enrollee moves out of the PMCP's or PCCM's service area.

(ii) The plan does not, because of moral or religious objections, cover the service the enrollee seeks.

(iii) The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk.

(iv) The enrollee requires Medicaid services that are excluded under the terms of the plan's contract and which can be obtained only if the member disenrolls from the plan.

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

(v) The enrollee requests the disenrollment because of an irreconcilable breakdown in the physician-patient relationship and has used the plan's problem resolution process. Documentation of the irreconcilable breakdown in the patient-physician relationship, including the use of the plan's problem resolution process, must be submitted with the disenrollment request by the beneficiary, the beneficiary's authorized representative or the plan.

(vi) The enrollee meets the criteria in Section Three for exemption from plan enrollment.

(vii) The enrollee or plan requests the disenrollment for any other reasons determined by the State agency to constitute good cause.

(3) *PMCP or PCCM action on request.*

(i) A PMCP or PCCM must either approve a request for disenrollment or refer the request to the State, including expedited disenrollment requests, within two working days of receipt if such requests meet the conditions for plan disenrollment specified in subsection (c) above.

(ii) If the PMCP, PCCM, or State agency (whichever is responsible) fails to make a disenrollment determination so that the beneficiary can be disenrolled within the timeframes specified in paragraph (f)(1) of this Section, the disenrollment is considered approved.

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

(i) Reasons cited in the request.

(ii) Information provided by the PMCP or PCCM at the agency's request.

(iii) Any of the reasons specified in paragraph (e)(2) of this Section.

(5) *Use of the PMCP or PCCM grievance procedures.*

(i) The State agency may require that the enrollee seek redress through the PMCP or PCCM's grievance system before making a determination on the enrollee's request.

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

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

(6) *Enrollment and disenrollment forms*

(i) The State agency shall make an enrollment/disenrollment form available in information packets mailed to mandatory eligible beneficiaries, at the enrollment presentations, by posting on a website that is accessible to the public, and at agency approved sites. The State agency or PMCP or PCCM shall mail the enrollment/disenrollment form to a beneficiary within three working days of receiving a telephone or written request for a form.

(ii) Plans shall make an enrollment/disenrollment form available at member services departments, by posting on a website that is accessible to the public, and shall mail the form to a beneficiary within three working days of receiving a telephone or written request for a form.

(f) *Timeframe for disenrollment determinations.*

(1) Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee or the PMCP or PCCM files the request, unless there the disenrollment request is urgent and meets the criteria for an "expedited" disenrollment under paragraph (g) .

(2) If the PMCP or PCCM or the State agency (whichever is responsible) fails to make the determination within the timeframes specified in paragraph (e)(1) of this Section, the disenrollment is considered approved.

(3) The PMCP or PCCM shall notify beneficiaries in writing of the approval or disapproval of enrollment and disenrollment requests, including expedited disenrollment requests, within seven working days of

receipt of the request. This notice shall include the effective date of the enrollment and/or disenrollment.

(g) *Expedited disenrollment*. Expedited disenrollment requests shall be effective on the first day of the month in which the request is processed. The State agency shall process all completed disenrollment requests as expedited disenrollments if they meet the following criteria and any required supporting documentation is provided:

(1) The beneficiary is an American Indian, a member of an American Indian household, or chooses to receive health care services through an Indian Health Service facility and has written acceptance from the Indian Health Service facility for care on a fee-for-service basis.

(2) The beneficiary is receiving services under a federal foster care or adoption assistance program or has been placed in the care of a child protective services agency. The disenrollment request must be submitted by the authorized foster parent, the authorized adoptive parent, or the licensed agency providing protective services.

(3) The beneficiary has a complex medical condition, specified in Section Three, and the disenrollment request is submitted with verification of the medical condition, treatment plan, and duration of treatment by the Medi-Cal fee-for-service physician.

(4) The beneficiary is enrolled in a Medicaid home and community-based waiver program under 42 U.S.C. §1396n(c) or State plan option under 42 U.S.C. §1396n(i). Verification of participation in the waiver program must be submitted with the disenrollment request by the beneficiary or the beneficiary's authorized representative as specified in (h).

(5) The State agency incorrectly enrolled or assigned the eligible beneficiary to a plan not chosen by the beneficiary, as determined by the State agency, the beneficiary or the plan and verified by the State agency. An explanation of the incorrect enrollment or assignment must be submitted with the disenrollment request by the beneficiary or the beneficiary's authorized representative.

(6) The beneficiary submitted a non-expedited disenrollment request that meets the requirements for disenrollment or a request for exemption from plan enrollment based upon a qualifying complex medical condition that was not timely processed by the State agency. An explanation of the lack of timely processing must be submitted with the disenrollment request by the beneficiary or the beneficiary's authorized representative.

(7) The beneficiary has moved or been placed outside of the plan service area and has notified his or her caseworker of the new address. If the beneficiary's new address is not yet shown in the Medicaid Eligibility Data System, the beneficiary is responsible for requesting that the caseworker provide verification of the new address to the State agency by telephone, facsimile, or in writing.

(8) The beneficiary or plan has experienced an irreconcilable breakdown in the patient-physician relationship, has used the plan's internal grievance procedure, and the State agency has approved the disenrollment. Documentation of the irreconcilable breakdown in the patient-physician relationship, including the use of the plan's problem resolution process, must be submitted with the disenrollment request by the beneficiary, the beneficiary's authorized representative as specified in (h), or the plan. Use of the plan's problem resolution process shall not be required in situations where a beneficiary's

behavior presents physical risk to plan staff, a provider, or staff at a provider site, and the plan or provider has filed a police report regarding the physical risk.

(9) The beneficiary was enrolled in the plan due to incorrect information provided by the State agency or due to prohibited marketing practices by the plan, as determined by the State agency, the beneficiary or the plan and verified by the State agency. Explanation of the incorrect information or the prohibited marketing practices must be submitted with the disenrollment request by the beneficiary or the beneficiary's authorized representative.

(10) The beneficiary requires nursing facility services, other than enrollees requesting hospice services, has been admitted to a long-term care facility and will remain in long-term care for more than two consecutive months. The name of the long-term care facility and the date of admission must be submitted with the disenrollment request by the beneficiary or the beneficiary's authorized representative.

(11) The beneficiary is deceased, and the death is not yet reflected in the Medicaid Eligibility Data System. A copy of the death certificate must be submitted with the disenrollment request by the beneficiary's authorized representative.

(h) *Notice and appeals*. A State that restricts disenrollment under this Section must take the following actions:

(1) Provide that enrollees and their representatives are given written notice of disenrollment rights at least 60 days before the start of each enrollment period.

(2) Ensure access to State fair hearing for any enrollee dissatisfied with a State agency determination that there is not good cause for disenrollment.

(i) *Automatic reenrollment*: *Contract requirement*. If the State plan so specifies, the contract must provide for automatic reenrollment of a beneficiary who is disenrolled solely because he or she loses Medicaid eligibility for a period of 30 days or less.

Section Three: Exemption from Plan Enrollment

(a) *General requirements.* In such States where mandatory enrollment in Medicaid managed care exists, an eligible beneficiary, who satisfies the requirements in (1), (2), or (3) below, may request fee-for-service Medicaid for up to 12 months as an alternative to plan enrollment, by submitting a request for exemption from plan enrollment to the State agency as specified in (b) below.

(1) An eligible beneficiary who is an American Indian as specified in Section Two(g), a member of an American Indian household, or chooses to receive health care services through an Indian Health Service facility and has written acceptance from an Indian Health Service facility for care on a fee-for-service basis.

(2) An eligible beneficiary who is receiving fee-for-service Medicaid treatment or services for a complex medical condition, from any provider who is participating in the Medicaid program but is not a contracting provider of a plan in the eligible beneficiary's county of residence, may request a medical exemption to continue fee-for-service Medicaid for purposes of continuity of care.

(i) *Complex medical conditions.* For purposes of this Section, conditions meeting the criteria for a complex medical condition include, but are not limited to, the following:

(A) An eligible beneficiary is pregnant.

(B) An eligible beneficiary is under evaluation for the need for an organ transplant; has been approved for and is awaiting an organ transplant; or has received a transplant and is currently either immediately post-operative or exhibiting significant medical problems related to the transplant. Beneficiaries who are medically stable on post-transplant therapy are not eligible for exemption under this Section.

(C) An eligible beneficiary is receiving chronic renal dialysis treatment.

(D) An eligible beneficiary has tested positive for HIV or has received a diagnosis of acquired immune deficiency syndrome (AIDS).

(E) An eligible beneficiary has been diagnosed with cancer and is currently receiving chemotherapy or radiation therapy or another course of accepted therapy for cancer that will continue for up to 12 months or has been approved for such therapy.

(F) An eligible beneficiary has been approved for a major surgical procedure by the fee-for-service Medicaid program and is awaiting surgery or is immediately post-operative.

(G) An eligible beneficiary has a complex neurological disorder, such as multiple sclerosis, a complex hematological disorder, such as hemophilia or sickle cell diseases, or a complex and/or progressive disorder not covered in (A) through (D) above, such as cardiomyopathy or amyotrophic lateral sclerosis, that requires ongoing medical supervision and/or has been approved for or is receiving complex medical treatment for the disorder, the administration of which cannot be interrupted.

(H) The beneficiary is enrolled in a Medicaid home and community-based waiver program under 1915(c) or a State plan option under 1915(i) and enrollment in a plan would jeopardize the beneficiary's ability to live in the community). Verification of participation in the waiver program or State plan option must be submitted with the disenrollment request by the beneficiary or the beneficiary's authorized representative as specified in (h).

(i) A request for exemption from plan enrollment based on complex medical conditions shall not be approved for an eligible beneficiary who has: (i) Been a enrollee of either plan on a combined basis for more than 180 consecutive calendar days, (ii) A current Medicaid provider that the beneficiary is seeking to continue care with and was a main source of Medicaid services for the beneficiary during any time in the previous year who is contracting with another plan available to the beneficiary, or (iii) Has already begun treatment after the date of plan enrollment.

(3) Except for pregnancy, any eligible beneficiary granted a medical exemption from plan enrollment shall remain with the fee-for-service provider only until the medical condition has stabilized to a level that would enable the individual to change physicians and begin receiving care from a plan provider without deleterious medical effects, as determined by a beneficiary's treating physician in the Medicaid fee-for-service program, up to 12 months from the date the medical exemption is first approved by the

State agency. A beneficiary granted a medical exemption due to pregnancy may remain with the fee-for-service Medicaid provider through delivery and the end of the month in which 90 days post-partum occurs.

(4) Any extension to the 12-month medical exemption time limit shall be requested through the State agency no earlier than 11 months after the starting date of the exemption currently in effect. The State agency will notify the beneficiary 45 days before the expiration of an approved medical exemption and will inform the beneficiary how to request an extension. An extension to the medical exemption shall be approved if the eligible beneficiary continues to meet the requirements of subsection (a)(2).

(b) *Process.*

(1) A request for exemption from plan enrollment or extension of an approved exemption due to a complex medical condition, as specified in (a)(2)(A), shall be submitted to the State agency by the Medicaid fee-for-service provider or the Indian Health Service facility treating the beneficiary and shall be submitted by mail or facsimile. Request for exemption from plan enrollment or extension of an approved exemption shall not be submitted by the plan.

(2) The State agency (or its agent), shall approve each request for exemption from plan enrollment that meets the requirements of this Section. At any time, the State agency may, at its discretion, verify the complexity, validity, and status of the medical condition and treatment plan and verify that the provider is not contracted or otherwise affiliated with a plan. State agency may deny a request for exemption from plan enrollment or revoke an approved request for exemption if a provider fails to fully cooperate with this verification. The State agency must accept the Statement of the treating physician or other qualified provider as true and valid and may not administratively overturn such a determination without evidence that it is not a valid medical exemption request.

(3) Approval of requests for exemption from plan enrollment is subject to the same processing times and effective dates specified in Section Two(f) for the processing of enrollment and disenrollment requests.

(4) The State agency may revoke an approved request for exemption from plan enrollment at any time if the agency determines that the approval was based on false or misleading information, the medical condition was not complex, treatment has been completed, or the requesting provider is not or has not been providing services to the beneficiary. The State agency shall provide written notice to the beneficiary that the approved request for exemption from plan enrollment has been revoked and shall advise the beneficiary that he or she must enroll in a Medicaid plan and how that enrollment will occur, as specified in Section 2(f)(3). The revocation of an approved request for exemption from plan enrollment shall not otherwise affect an eligible beneficiary's eligibility or ability to receive covered services as a plan enrollee.

ENDNOTES

[3] 42 U.S.C. § 1396u-2.
[4] *See id.* § 1396u-2(a)(3)(A), 42 C.F.R. §§ 438.52(a), (b) (regarding beneficiary choice); §§ 1396u-2(a)(4)(A), (B), 42 C.F.R. §§ 438.56, 438.10(f)(1) (regarding enrollment and disenrollment); §1396u-2(a)(5)(A), 42 C.F.R. §§ 438.10(b), (c) and (d) (regarding provision of information).
[5] 42 U.S.C. § 1396u-2(a)(2)(A).
[6] *Id.* § 1396u-2(a)(2)(B); CMS, *Dear State Medicaid Director* (Aug. 2, 2001) (discussing enrollment of dual eligible beneficiaries into Medicaid managed care). Qualified Medicare Beneficiaries (QMBs) are individuals with income levels that qualify for Medicaid payment of some or all of the cost of Medicare cost-sharing, including Medicare Part A and B premiums, as well as deductibles, coinsurances, and copayments.
[7] *Id.* § 1396u-2(a)(2)(C). Permission can be obtained through a waiver pursuant to 42 U.S.C. § 1396n(b) or by applying for a demonstration waiver through § 1115 of the Social Security Act. 42 U.S.C. § 1315(a).
[8] *Id.* at § 1396u-2(a)(3)(A); 42 C.F.R. § 438.52(a); HCFA, *Dear State Medicaid Director* (Jan. 14, 1998) (discussing choice of managed care entity).
[9] *Id.* at § 1396u-2(a)(3)(B); 42 C.F.R. § 438.52(b).
[10] 42 U.S.C. §§ 1396u-2(a)(4)(A), (B); 42 C.F.R. §§ 438.56, 438.10(f)(1) (regarding disenrollment). Regarding default enrollment, *see* 42 U.S.C. § 1396u-2(a)(4)(D) (requiring state to avoid default enrollment to entities which have been found out of substantial compliance with Medicaid requirements, to consider existing provider-individual relationships, and to undertake equitable distribution of individuals); 42 C.F.R. § 438.50(f).
[11] 42 U.S.C. § 1396u-2(a)(5)(A); 42 C.F.R. §§ 438.10(b), (c), and (d); HCFA, *Dear State Medicaid Director* (Feb. 20, 1998) (provision of information and effective dates).
[12] 42 U.S.C. § 1396b(m)(1)(A); 42 C.F.R. § 438.700.