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| --- | --- | --- | --- |
| STATUS1 | DOCUMENT  REVISION2 | EFFECTIVE  DATE | DESCRIPTION3 |
| Baseline | 1.0 | February 11, 2008 | Initial version of Chapter 11.6, Medicaid Managed Care Member Disenrollment Form |
| Revision | 2.0 | September 1, 2013 | Applicability is updated.  Part I is modified to remove ESRD and Ventilator Dependency.  Revision 2.0 applies to contracts issued as a result of HHSC RFP numbers 529-10-0020 and 529-12-0002. |
| Revision | 2.1 | November 15, 2015 | Revision 2.1 applies to contracts issued as a result of HHSC RFP numbers 529-10-0020, 529-12-0002, 529-13-0042, and 529-13-0071; and to Medicare-Medicaid Plans (MMPs) in the Dual Demonstration.  “Applicability of Chapter 11.6” is modified to add the Medicare-Medicaid Dual Demonstration and the STAR Kids Program. |
| Revision | 2.2 | March 1, 2024 | Revision 2.2 modifies Chapter 11.6 to update processes and department names and to include additional requirements. |
| Revision | 2.3 | March 18, 2024 | Updated with Accessibility Version. |

**Document History Log**

1 Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions.

2 Revisions should be numbered according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.

3 Brief description of the changes to the document made in the revision.

**Applicability of Chapter 11.6**

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR Program, the STAR+PLUS Program (including the Medicare-Medicaid Dual Demonstration), or the STAR Kids Program. The requirements in this chapter apply to all Programs, except where noted.

This chapter does not apply to MCOs participating in the CHIP or CHIP Perinatal or STAR Health Programs.

**MCO Disenrollment Request Form**

**Part I: (To be completed by the MCO Staff)**

|  |  |
| --- | --- |
| Date of Request | Information |
| **Member Name** |  |
| **Medicaid ID Number** |  |
| **Member Contact Information** |  |
| **MCO Name and Plan Code** |  |
| **MCO Point of Contact** |  |
| **Reason for Request** |  |
| **Summary and Timeline of MCO’s Efforts to Resolve Issues with the Member** |  |
| **Required Supporting Documentation**   1. Copy of a certified letter to the Member advising of his or her rights and responsibilities. Member correspondence must be written in plain language. See *Appendix A –Sample MCO Letter*. 2. Summary and Timeline of MCO’s Efforts to Resolve Issues with the Member. 3. List of the Member’s medications/prescriptions for a period of the last three (3) years. 4. List of diagnoses. 5. Service Plan and current services being provided by the MCO to the Member. 6. A list of services/benefits that will be lost if the Member is disenrolled. |  |
| **Submitted by (MCO Medical Director):** |  |
| **Signature:** |  |
| **Printed Name:** |  |
| **Title:** |  |

**Part II: (To be completed by HHSC MCCO Staff)**

|  |  |
| --- | --- |
| MCCO Health Plan Manager (HPM) Verified Reason for Disenrollment |  |
| **MCCO HPM Verified Conditions for Disenrollment Met** | MCCO HPM Approval \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Director of MCCO Approval \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Date Forwarded to Disenrollment Committee** |  |
| **Date Response due from Disenrollment Committee** |  |
| **Date Response Received from Disenrollment Committee** |  |

**Part III: (To be completed by HHSC Disenrollment Committee)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Rationale |
| Approved? |  |  |  |

**Part IV: (To be completed by HHSC MCCO Staff)**

|  |  |  |  |
| --- | --- | --- | --- |
| Date Decision Letter Sent to MCO | Date Decision Letter Sent to Member | Date Change Request Sent to Program Enrollment and Support | Date TIERS Updated |
| **MCCO Staff** | **MCCO Staff** | **MCCO Staff** | **MCCO Staff** |

**Appendix A –Sample MCO Letter**

Date

***Sent Via Certified Mail***

[Member Name]

[Member Address]

[Member city state]

Dear [Member name]:

As you are aware, you are enrolled in STAR+PLUS. STAR+PLUS is a Texas Medicaid managed care program. In STAR+PLUS you get:

* Basic medical care, like primary care and specialty doctor visits and hospital visits
* Long-term services like attendant care
* A service coordinator. This is someone who will work with you, your family, and your doctors to make sure you get the services you need
* Unlimited medically necessary prescription drugs
* "Value-added" or extra services not offered in traditional Medicaid

[MCO Name], the STAR+PLUS plan you are currently enrolled in, has several value-added services that help you. Some of [MCO]’s value-added services for non-STAR+PLUS Home and Community-Based Services (HCBS) members 21 and older include: [List examples as per examples below]

* Emergency Response Services
* Up to ten (10) home-delivered meals each year after getting out of the hospital or nursing facility
* Up to an extra eight (8) hours of respite services each calendar year

We have included a complete list of the value-added services you may be able to get from [MCO].

You have rights and responsibilities in Medicaid managed care.

Your rights include:

* Being treated fairly and with respect
* having a provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated
* Being told why care or services were denied and not given
* Change to another plan or provider in a reasonably easy manner

**The other health plans available in [service area] service area are: [list names of other MCOs] Healthcare. Should you wish to change your health plan, you may call the STAR+PLUS Helpline at 1-877-782-6440.**

Along with your rights as a member of Medicaid managed care, you also have responsibilities. Your responsibilities include:

* Learn and follow your health plan’s rules and Medicaid rules
* Keep your scheduled appointments
* Work as a team with your provider in deciding what health care is best for you
* Treat providers and health plan staff with respect

We have included a complete list of your rights and responsibilities as a member of Medicaid managed care.

In limited circumstances, Medicaid managed care health plans may ask Texas Health and Human Services Commission (HHSC) to dis-enroll a member. The health plan does not need the member’s consent. The health plan must get approval from HHSC. HHSC may dis-enroll a member based on the following:

* Member does not follow rules or the member’s actions are disruptive
* Doctors and/or the health plan cannot safely provide care because of the member’s actions
* The way the member acts is not because of a disability
* The member does not have a mental health condition

[MCO] has asked that you stop the following behaviors:

* Using offensive language during phone calls and/or face-to-face visits with provider and/or health plan staff
* Threatening physical harm to provider and/or health plan staff, preventing [MCO]’s providers from providing care for you

However, you have not stopped the above behavior. If you do not stop the above behavior, [MCO] will seek approval from HHSC to dis-enroll you from its health plan. Should you become dis-enrolled from [MCO], you may be placed back into traditional Medicaid and no longer receive Medicaid managed care benefits.

For example, if you are placed back into traditional Medicaid:

* You will have a limit of three (3) prescriptions per month
* You will not have a service coordinator
* You will not have access to value-added services

[MCO] would like you to remain enrolled in its health plan by accepting your responsibilities as a member of Medicaid managed care and correcting the above behavior immediately. Otherwise, [MCO] will proceed with the dis-enrollment process.

If you have any questions, please contact me at [MCO designated signature direct contact phone number].

Sincerely,

[direct contact designee]

[Title]

[MCO]