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<b>Medicaid Managed Care Member Disenrollment Policy</b>	<b>November 15, 2015</b>	
	<b>Version 2.1</b>	

### DOCUMENT HISTORY LOG

STATUS <sup>1</sup>	DOCUMENT REVISION <sup>2</sup>	EFFECTIVE DATE	DESCRIPTION <sup>3</sup>
Baseline	1.0	February 11, 2008	Initial version of Chapter 11.5, Medicaid Managed Care Member Disenrollment Policy
Revision	1.1	March 15, 2009	Chapter 11.5 is revised to correct the applicability of the chapter in Section I and omit erroneous information in Section III.
Revision	2.0	September 1, 2013	Applicability is updated. Section III is modified to remove ESRD and Ventilator Dependency. Section IV 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. Section I "Applicability of Chapter 11.5" is modified to add the Medicare-Medicaid Dual Demonstration and the STAR Kids Program.
<sup>1</sup> Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions <sup>2</sup> 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. <sup>3</sup> Brief description of the changes to the document made in the revision.			



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## I. Applicability of Chapter 11.5

Section I  
Applicability is  
modified by  
Versions 1.1,  
2.0, and 2.1

This chapter applies to the 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 term “MCO” includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers, Medicare-Medicaid Plans (MMPs), and any other entities licensed or approved by the Texas Department of Insurance. 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.

## II. Purpose

This policy is to clarify the limited conditions under which MCOs may request disenrollment of Members as provided in Attachment A to the HHSC Managed Care Contract, Uniform Managed Care Contract Terms & Conditions, Section 5.02, Member Enrollment & Disenrollment.

## III. Policy

Section III  
Policy  
modified by  
Versions 1.1  
and 2.0

MCOs may request disenrollment of Members for the following reasons of non-compliance.

### Non-compliance

- (1) the Member misuses or loans the Member’s MCO membership card to another person to obtain services;
- (2) the Member is disruptive, unruly, threatening or uncooperative to the extent that the Member’s membership seriously impairs the MCO’s or Provider’s ability to provide services to the Member or to obtain new Members and the Member’s behavior is not caused by a physical or behavioral health condition;
- (3) the Member is steadfastly refusing to comply with managed care restrictions (e.g., repeatedly using emergency room in combination



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with refusing to allow the MCO to treat the underlying medical condition);

#### IV. Procedures

Section IV  
Procedures  
modified by  
Version 2.0

#### Non-compliance

MCOs will follow these procedures for requesting the involuntary disenrollment of Members.

1. The MCO completes Part I of the MCO Disenrollment Request Form and forwards to Health Plan Management (HPM) staff along with a signed letter from the MCO's Medical Director attesting to the basis for the MCO's request. The information may be sent by mail, fax or secure site.

Mail address: HHSC MC-H320  
P. O. Box 85200  
Austin, Texas 78708

Fax number: 512-491-1969

Secure site: Tex MedNet Central

After posting, send an email to the Health Plan Manager to notify of the file location (folder) and the file name.

2. HPM staff will, within two (2) Business Days of receipt of a complete disenrollment request, forward the information to the Disenrollment Committee.
3. The Disenrollment Committee will review the information provided by the MCO. The information must demonstrate that the MCO has made reasonable efforts to remedy the problem. The Disenrollment Committee may request additional information from the MCO, HHSC, or the Member to complete the review. Within five (5) Business Days of receipt of all information necessary to complete the review, the Disenrollment Committee will make a final determination regarding the disenrollment request, complete



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the Disenrollment Request Form, and forward the completed form to HPM staff.

4. Within two (2) Business Days of receiving the Disenrollment Committee's decision, HPM staff will notify the Member and MCO of the disenrollment decision and the Member's right to request an Appeal from the Disenrollment Committee. HHSC will inform the Member that he or she must request an Appeal within thirty (30) days of receipt of the disenrollment letter.
5. HPM staff will notify Data Integrity to place a "never enroll client again" segment on the Member's managed care record.

**Note:** Medicaid Members age 21 and older may also appeal a disenrollment decision through the Fair Hearing process due to a reduction in benefits (i.e. loss of unlimited prescriptions, reinstatement of spell of illness, loss of annual adult exam).

**Note:** Members disenrolled from an MCO at the MCO's request will not subsequently be enrolled in a different MCO.