

## ***Chapter 5*** ***Enrollment, Disenrollment and Member Transfers***

### **A. Medicaid Managed Care (STAR & STAR+Plus) Enrollment & Disenrollment**

**The state of Texas has selected certain counties to have a Medicaid Managed Care Program called STAR (which stands for State of Texas Access Reform) The information covered in this section will address eligibility, enrollment, and disenrollment from the STAR program.**

#### ***Medicaid (STAR and STAR+Plus) Eligibility***

Providers are responsible for requesting and verifying current Medicaid eligibility information about the member by asking for the Member's Medicaid Identification Form, and their Molina HealthCare of Texas Identification Card (ID card). The Member's Medicaid Identification Form takes precedence over their Molina HealthCare of Texas ID Card.

#### **Medicaid Forms include:**

- Form 3087, Medicaid Identification Form
- Form 1027-A, Temporary Medicaid Identification Form

#### **Providers can verify eligibility by:**

- Calling Molina HealthCare of Texas at 1-866-449-6849
- Accessing the Molina HealthCare of Texas web site at [www.Molinahealthcare.com](http://www.Molinahealthcare.com)
- Contacting Automated Inquiry Systems (AIS) at 1-800-925-9126

#### **For more information:**

Members interested in receiving more information on the STAR program can call:

- STAR Help Line at 1-800-964-2777
- Molina Member Services at 1-866-449-6849

#### **Span of Eligibility:**

Members can change health plans by calling the Texas MEDICAID MANAGED CARE Program Helpline at 1-800-964-2777. However, a member **cannot** change from one health plan to another health plan during an inpatient hospital stay.

If a member calls to change health plans on or before the 15<sup>th</sup> of the month, the change will take place on the first day of the next month. If they call after the 15<sup>th</sup> of the month, the change will take place the first day of the second month after that. For example:

- *If a request for plan change is made on or before April 15, the change will take place on May 1.*
- *If a request for plan change is made after April 15, the change will take place on June 1.*

**STAR Program Targeted Client Groups:**

HHSC has targeted specific client groups within the Texas Medicaid program for STAR program enrollment:

<b>Type</b>	<b>Program</b>	<b>Enrollment Code</b>
1	Regular TANF	M
3	MAO RSDI Increase - No Medicare	M*
7	12 Month Medicaid Denied Due to earnings	M
12	SSI Manually Certified - No Medicare	M*
13	SSI Recipient – No Medicare	M*
18	Disabled Adult Children denied SSI due to increase in SS benefits – No Medicare	M*
19	Transitional SSI – No Medicare	V
20	04 months Medicaid – TANF	M
22	Early Age Widows/Widowers – No Medicare	M*
29	12 months transitional Medicaid – limited TANF	M
37	12 months transitional Medicaid denied due to earned income; disregards ending	M
40	Pregnant Women	M
43	Children under 1 year of age with income below 185% FPIL	M
44	Children aged 6-19 yrs. with income below 100% FPIL	M
45	Children up to age 1 year, born to Medicaid eligible mothers	M
47	Medicaid for deprived children with step-grandparent income	M
48	Children aged 1-5 years with income below 133% FPIL	M
61	TANF state program	M
M – Mandatory V –Voluntary M* - Mandatory Adults aged 21 and older		

***STAR Member Enrollment***

A member is free to choose a STAR health plan and PCP. The member will not begin to receive benefits under a Medicaid Managed Care program until the first day of the following month (provided enrollment takes place before the cut-off date for the following month). The cut-off date is generally the 15<sup>th</sup> of the month.

<b>Example; if enrollment takes place <i>PRIOR</i> to cut-off</b>	
Member certified for Texas Medicaid	January 1
Medicaid Benefits Begin	January 1
Member selects health plan and PCP	January 1
Managed care benefits begin	February 1

<b>Example; if enrollment takes place <i>AFTER</i> to cut-off</b>	
Member certified for Texas Medicaid	January 1
Medicaid benefits begin	January 1
Member selects health plan and PCP	January 20
Managed care benefits begin	March 1

**Enrollment of Pregnant Women:**

Women who are on Medicaid type program 40 may be retroactively enrolled in STAR. Women who are certified for Medicaid type program 40 on or before the 10<sup>th</sup> of the month will be enrolled in STAR beginning the first of the month of certification. Women who are certified after the 10<sup>th</sup> of the month will be on fee-for-service Medicaid the month of certification and will be enrolled in STAR beginning the first of the month following the month of certification.

***There are two exceptions to this rule:***

- Women who are certified at any time in their estimated month of delivery will be enrolled in STAR the first of the following month (prospective enrollment).
- Women who are certified at any time in their actual month of delivery (if known by HHSC before certification) will be enrolled in STAR the first of the following month (prospective enrollment).

**Enrollment of Newborns:**

Newborns are covered under their mother’s Health Plan up to 90 days from the date of birth. Mothers are encouraged to contact the STAR Help Line at 1-800-964-2777 to enroll the newborn in the STAR program. Mothers can choose to select another health plan for their newborn at the time of enrollment. Mothers are also encouraged to select a PCP for the newborn prior to birth. The PCP assignment can be done by calling Molina HealthCare of Texas Member Services at 1-866-449-6849.

It is important that providers call the number listed on the Medicaid Identification Form (Form H3087) for plan and provider information (STAR Help Line at 1-800-964-2777 or the STAR health plan number listed on the Medicaid Identification Form [Form H3087]).

### ***Health Plan Changes***

#### **Member initiated change/Span of Eligibility:**

Members can change health plans by calling the STAR Help Line at 1-800-964-2777. However, a member cannot change from one health plan to another health plan during an inpatient hospital stay.

If a member calls to change their health plan on or before the 15<sup>th</sup> of the month, the change will take place on the first day of the following month. If they call after the 15<sup>th</sup> of the month, the change will take place the first day of the second month after the request has been made. For Example:

- If a request for plan change is made on or before April 15, the change will take place on May 1.
- If a request for plan change is made after April 15, the change will take place on June 1.

Members can change their health plan as often as monthly. If a member chooses to change their health plan, retaliatory action can not be taken against the member by the Health Plan or provider.

#### **Health Plan Initiated Change (Disenrollment):**

Molina has a limited right to request a Member be disenrolled from HMO without the Member's consent. HHSC must approve any HMO request for disenrollment of a Member for cause. HHSC would consider disenrollment under the following circumstances:

- Member misuses or loans Member's Molina membership card to another person to obtain services.
- Member is disruptive, unruly, threatening or uncooperative to the extent that Member's membership seriously impairs Molina's or Provider's ability to provide services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.
- Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow Molina to treat the underlying medical condition).
- Molina must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the Member's behavior. The request with supporting documentation is sent to HHSC, the final decision will be made by HHSC.

Molina must notify the Member of Molina's decision to disenroll the Member if all reasonable measures have failed to remedy the problem. If the Member disagrees with the decision to disenroll the Member from Molina, Molina must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process.

Molina cannot request a disenrollment based on adverse change in the member's health status or utilization of services that are Medically Necessary for treatment of a member's condition.

### ***Disenrollment***

If a Member makes a request for disenrollment, Molina must give the Member information on the disenrollment process and direct the Member to the HHSC Administrative Services Contractor. If the request for disenrollment includes a Complaint by the Member, the Complaint will be processed separately from the disenrollment request, through the Complaint process.

### **Automatic Disenrollment/Re-enrollment:**

When a member no longer meets the criteria for Managed Care enrollment, the state will automatically disenroll the member. The disenrollment will be effective the first of the following month in which HMO eligibility changes.

Examples for loss of Medicaid managed Care eligibility are:

- The Member has left the service area Molina is contracted to provide HMO coverage in.
- The Member qualifies for DADS hospice services
- The Member begins Medicare coverage

If a member loses Medicaid eligibility and then regains eligibility within six months, the member is automatically reassigned to their previous health plan and PCP. The member will have the right to request a plan change or PCP change by following the process outlined in the previous pages.

Member's disenrollment request from managed care will require medical documentation from the PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment from managed care.

**Note:** Providers are prohibited from taking retaliatory action against a member for any reason.

## **B. CHIP Enrollment and Disenrollment**

**Children's Health Insurance Program (CHIP)** is a health insurance program for children under the age of 19. CHIP is available to children whose families have low to moderate income, but have earned too much money to qualify for Medicaid and do not qualify for private insurance.

### ***CHIP Eligibility***

Providers are responsible for requesting and verifying current CHIP eligibility information about the member by asking for the Member's Molina HealthCare of Texas Identification Card (ID Card), and calling Molina Member Services Department or accessing eligibility information on the Molina HealthCare of Texas web site.

#### **Verifying Eligibility:**

Members and providers can verify CHIP eligibility by:

- Calling Molina HealthCare of Texas at 1-866-449-6849
- Accessing the Molina HealthCare of Texas web site at [www.molinahealthcare.com](http://www.molinahealthcare.com)

### ***CHIP Enrollment***

#### **Applying for CHIP:**

Families can apply for the CHIP program in one of three ways:

- Complete and mail in a printed application.
- Call 1-800-647-6558 and complete the application over the phone.
- Download, complete and mail in an application from <http://www.hhsc.state.tx.us/chip>

***Mail Applications to:***  
P.O. Box 149276  
Austin, TX 78714-9983

Children enrolling in CHIP for the first time, or returning to CHIP after disenrollment, will be subject to a waiting period before coverage actually begins. The waiting period for a child is determined by the date on which he/she is found eligible for CHIP, and extends for the duration of three (3) months. If the child is found eligible for CHIP on or before the fifteenth (15<sup>th</sup>) day of a month, then the waiting period begins on the first day of that same month. If the child is found eligible on or after the 16th day of a month, then the waiting period begins on the first day of the next month.

Please refer to the table below for examples of how the waiting period affects the beginning of coverage. A child will remain covered for a term of twelve (12) continuous months. Families must re-enroll their children every twelve (12) months.

### **Sample Enrollment Timeline**

<b>Action</b>	<b>A</b>	<b>B</b>
Eligibility determination date	January 1-15	January 16-31
1 <sup>st</sup> day of waiting period	January 1	February 1
Family completes enrollment in CHIP program	Before March CHIP enrollment cut-off (Usually around March 20 <sup>th</sup> )	Before April CHIP enrollment cut-off (Usually around April 20 <sup>th</sup> )
First possible date coverage can begin	April 1	May 1

**Note:** Auto-enrollment of newborns is not permitted. Newborns eligible for Medicaid will not be able to enroll in CHIP.

#### **Enrollment/Disenrollment for Pregnant Members and Infants:**

The Administrative Services Contractor will refer pregnant CHIP members, with the exception of Legal Permanent Residents and other legally qualified aliens barred from Medicaid due to federal eligibility restrictions, to Medicaid for eligibility determinations. Those CHIP members who are determined to be Medicaid Eligible will be disenrolled from Molina’s CHIP plan. Medicaid coverage will be coordinated to begin after CHIP eligibility ends to avoid gaps in health care coverage.

In the event Molina remains unaware of a member’s pregnancy until delivery, the delivery will be covered by CHIP. The Administrative Services contractor will then set the member’s eligibility expiration date at the later of (1) the end of the second month following the month of the baby’s birth or (2) the Member’s original eligibility expiration date. Most newborns born to CHIP Members or CHIP heads of household will be Medicaid eligible. Eligibility of newborns must be determined for CHIP before enrollment can occur. For newborns determined to be CHIP-eligible, the baby will be covered from the beginning of the month of birth for the period of six (6) months.

**Note: Providers are required to notify the Health Plan immediately when a pregnant CHIP member is identified.**

#### **Re-enrollment:**

Children’s Insurance Program will send the Member a notice two (2) months before it is time to renew that child’s coverage. To continue enrollment in CHIP the member must reapply for coverage. Members

can call the Children's Health Insurance program at 1-800-647-6558 for more information on re-enrollment.

### ***Health Plan Changes***

#### **Member Initiated:**

A Member can ask to change their health plan during the first (initial) three (3) months they are enrolled in Molina HealthCare of Texas, or during the one open enrollment month every year in their county. To request a plan change the member can call the Children's Health Insurance program at 1-800-647-6558.

After the first (initial) three (3) months of enrollment in the health plan or when it is not open enrollment in a Member's county, a Member may with good reason disenroll for the following reasons:

- The Primary Care Provider (PCP) that has been automatically selected no longer is in the Molina Network of Providers and there are no other doctors in the health plan that will accept that Member's family or that is close to their home.
- The Primary Care Provider (PCP) that the Member picked is no longer in their health plan and he/she was the only doctor in the health plan that spoke the Member's language.
- The Primary Care Provider (PCP) that a family member needs to see because of a special medical need is not a provider for Molina HealthCare of Texas.
- The Member no longer lives near any of the Primary Care Providers (PCP) in Molina HealthCare of Texas's Provider Network.
- Other - If the Member believes that staying enrolled with Molina HealthCare of Texas is harmful and not in their best interest.

***Reminder:*** Members are only allowed to make plan changes once a year. Members may request to change health plans for exceptional reasons or good cause. HHSC will make the final decision.

#### **Health Plan Initiated (Disenrollment):**

Molina has a limited right to request a Member be disenrolled from Molina without the Member's consent. HHSC must approve any Molina request for disenrollment of a Member for cause. HHSC may permit disenrollment of a Member under the following circumstances:

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

- Molina must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

Before a request for disenrollment can be initiated, reasonable measures must be taken to correct the Member's behavior. The request with supporting documentation is sent to HHSC, the final decision will be made by HHSC.

Molina must notify the Member of Molina's decision to disenroll the Member if all reasonable measures have failed to remedy the problem. If the Member disagrees with the decision to disenroll the Member from Molina, Molina must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process. Molina cannot request a disenrollment based on adverse change in the member's health status or utilization of services that are Medically Necessary for treatment of a member's condition.

Molina will not disenroll a child based on a change in the child's health status or because of the amount of Medically Necessary Services that are used to treat the child's condition.

**Note: Providers are prohibited from taking retaliatory action against a Member for choosing to disenroll or for any other reason whatsoever.**

### ***Disenrollment***

Disenrollment may also occur if the Member's child loses CHIP eligibility. A child may lose CHIP eligibility for the following reasons:

- "Aging-out" when CHILD turns nineteen;
- Failure to re-enroll by the end of the 6-month coverage period;
- Failure to pay enrollment fee when due or within the grace period;
- Change in health insurance status, i.e., a CHILD enrolls in an employer-sponsored health plan;
- Death of a CHILD;
- CHILD permanently moves out of the state;
- CHILD is enrolled in Medicaid.
- Failure to drop current insurance if child was determined to be CHIP-eligible because cost sharing under the current health plan totaled 10% or more of the family's gross income.
- Child's parent or Authorized Representative reports a non-qualifying alien status for a non-citizen child, thereby disqualifying the child from CHIP
- Child's parent or Authorized Representative requests (in writing) the voluntary disenrollment of a child.