Chapter 19

Enrollment and Marketing Rules

Physician and Other Professional Provider Roles in Star and CHIP Marketing and Enrollment

Limitations

Trusted physicians and other professional providers may be in a unique position to influence patients on the selection of a health plan. For that reason, the Texas Health and Human Services Commission (HHSC) have created policies for marketing practices by physicians and other professional providers for state programs.

Policies prohibit network providers from making false or misleading claims that:

• The primary care provider (PCP) office staffs are employees or representatives of the state, county or federal government.
• BCBSTX is recommended or endorsed by any state agency, county agency or any other organization.
• The state or county recommends that a prospective member enroll with a specific health plan.
A prospective member or medical recipient loses benefits under the Medicaid Managed Care (STAR) program or the Children’s Health Insurance Program (CHIP), or other welfare benefits if the prospective member does not enroll with a specific health plan.

Policies prohibit network providers from:

- Making marketing presentations or advising or recommending to an eligible individual that he or she select membership in a specific managed care plan.
- Offering or giving away any form of compensation, reward or loan to a prospective member to induce or procure member enrollment in a specific health plan.
- Engaging in direct marketing to members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.
- Using any list of members obtained originally for enrollment purposes from confidential state or county data sources, or from the data sources of other contractors.
- Marketing practices that discriminate against potential members based on marital status, age, religion, sex, national origin, language, sexual orientation, ancestry, pre-existing psychiatric problem or medical condition (such as pregnancy, disability or acquired immune deficiency syndrome), other than those specifically excluded from coverage under our contract.
- Reproducing or signing an enrollment application for the member.
- Displaying materials from certain managed care organizations that the provider holds a contract with and not others.
- Marketing activities that involve unsolicited personal contact, including door-to-door solicitation at a child-care facility or other type of facility, direct mail or telephone, with a Medicaid client or a parent whose child is enrolled in Medicaid.
- Marketing activities directed at the client or parent solely because the client or the parent’s child is receiving Medicaid.
- Marketing materials intended to influence the client’s or parent’s choice of provider.

Providers may:

- Help the member apply for benefits; direct him or her to call the Texas State Medicaid Managed Care Program Help Line at 800-964-2777 for enrollment information.
- File a complaint with BCBSTX if a provider or member objects to any member marketing, either by other providers or our representatives. Please refer to the Complaints and Appeals chapter of this manual for more information on the complaint process.

For more information regarding Provider Marketing Guidelines, visit the TMHP website at:

- http://www.tmhp.com/Pages/Topics/Marketing.aspx
PROGRAM ENROLLMENT PROCESS

HHSC determines the eligibility and enrollment for STAR and CHIP members.

CHIP eligibility is for 12 continuous months. HHSC or Maximus, the Administrative Services Contractor, presents health plan options to individuals and families eligible for STAR or CHIP. STAR or CHIP eligible members enroll in the managed care plan of their choice and select a primary care provider or primary care site (PCS). If HHSC does not receive this enrollment information within 45 days, it assigns the member to a STAR plan, and then submits the member information to BCBSTX. We then assign a PCP or PCS for the member.

CHIP eligible members must enroll in a CHIP health maintenance organization (HMO) plan in 90 days or they will not be eligible for CHIP services. CHIP eligible members are not defaulted into a plan.

HHSC or Maximus informs BCBSTX of new member enrollment, and notifies BCBSTX after enrollment of any changes in member eligibility, status or contact information (such as change of address).

Physicians and other professional providers will be given notice of new members signed up or assigned to their care through monthly eligibility reports mailed to them by BCBSTX.

BCBSTX sends each new member an enrollment kit within five business days after receiving the HHSC monthly membership file. This includes a member identification (ID) card, letter and PCP choice or assignment. The ID card includes PCP contact information as well as the procedures for changing a PCP or PCS.

HHSC will automatically re-enroll any member who loses STAR or CHIP eligibility but becomes eligible again within six months or less. Members will automatically return to the same health plan and PCP as they had prior to disenrollment, if available. Members may choose to switch plans.

To support the member enrollment process, PCPs are encouraged to maintain open panels. The state requires that 90 percent of BCBSTX’s PCPs have open panels, and your open panel will assist us in meeting this requirement.

CHIP Plan Changes

CHIP members may request a change:

- For any reason within 90 days of CHIP enrollment and once thereafter
- For cause at any time
- If the member moves to a different service delivery area
- During the annual re-election period

**HHSC will make the final decision.**

CHIP Member Enrollment Renewal

Around the ninth month of the 12-month coverage period, the vendor mails a renewal packet to families enrolled in CHIP. The packet contains a CHIP renewal form; a letter requesting current income and deduction verification and instructing the family how to renew for another term of coverage immediately following the expiration of the current term of coverage; and a postage paid, return addressed envelope. The letter instructs the family to complete and return the renewal form within seven days of receipt.
The CHIP renewal form is the CHIP application pre-populated with all currently available and most recent data except for income and deduction information. Additionally, a separate enrollment/transfer form is included for the family to indicate whether they wish to reconsider their health plan choice and a line for signature and date. The instructions on both the letter and the CHIP renewal form direct the family to review and to update the form by either completing any missing information or correcting pre-populated information.

CHIP PERINATAL PROGRAM MEMBER ENROLLMENT AND DISENROLLMENT FROM HEALTH PLAN

CHIP Perinatal Member Enrollment:
- 12-Month eligibility for CHIP and CHIP Perinatal members (newborn).
- The mother of the CHIP Perinatal has 15 calendar days from the time the enrollment packet is sent by the enrollment broker to enroll in a Managed Care Organization.

When a member of a household enrolls in the CHIP Perinatal Program, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal Program member’s health plan if those health plans are different. All members of the household must remain in the same health plan until the latter of (1) the end of the CHIP Perinatal Program member’s enrollment period or (2) the end of the traditional CHIP program members’ enrollment period. Copayments, cost sharing, and enrollment fees still apply to children enrolled in CHIP.

In the ninth month of the CHIP Perinatal Newborn’s coverage, the family will receive a CHIP renewal form, which will be pre-populated to include the CHIP Perinatal Newborn’s and the CHIP members’ information. Once the child’s CHIP perinatal coverage expires, the child will be added to his or her siblings’ existing CHIP case.

Maximus, the State’s Administrative Services Contractor, is responsible for providing Blue Cross and Blue Shield of Texas with new member and member change information within five days of the beginning of the month, for that month’s eligibility information. However, HHSC makes the final decision of enrollment for all CHIP members.

Disenrollment occurs due to loss of eligibility, including, but not limited to the following events:
- Failure to re-enroll at the conclusion of the 12-month eligibility period
- Change in health insurance status, such as a child enrolling in an employer sponsored insurance plan
- Permanent move out of the state
- Enrollment in Medicaid

A provider cannot take retaliatory action against a member for disenrollment.

The switch of the CHIP members from their Managed Care Organization to the Managed Care Organization providing CHIP Perinatal coverage does not count as their one Managed Care Organization plan change per year. Members may request to change Managed Care Organizations for exceptional reasons or good cause.
CHIP Perinate Plan Changes

A CHIP Perinate (unborn child) who lives in a family with an income at or below the Medicaid eligibility threshold (an unborn child who will qualify for Medicaid once born) will be deemed eligible for Medicaid and will receive 12 months of continuous Medicaid coverage (effective on the date of birth) after the birth is reported to HHSC’s enrollment broker.

A CHIP Perinate mother in a family with an income at or below the Medicaid eligibility threshold may be eligible to have the costs of the birth covered through Emergency Medicaid. Clients under the Medicaid eligibility threshold will receive a Form H3038 with their enrollment confirmation. Form H3038 must be filled out by the doctor at the time of birth and returned to HHSC’s enrollment broker.

A CHIP Perinate will continue to receive coverage through CHIP as a ‘CHIP Perinate Newborn’ if born to a family with an income above the Medicaid eligibility threshold and the birth is reported to HHSC’s enrollment broker.

A CHIP Perinate Newborn is eligible for 12 months’ continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment as an unborn child plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

CHIP Perinate mothers must select an MCO within 15 calendar days of receiving the enrollment packet or the CHIP Perinate is defaulted into an MCO and the mother is notified of the plan choice. When this occurs, the mother has 90 days to select another MCO.

When a member of a household enrolls in CHIP Perinatal, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal member’s health plan if the plan is different. All members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinatal member’s enrollment period, or (2) the end of the traditional CHIP members’ enrollment period. In the 10th month of the CHIP Perinate Newborn’s coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn’s and the CHIP members’ information. Once the child’s CHIP perinatal coverage expires, the child will be added to his or her siblings’ existing CHIP case.

CHIP Perinatal members may request to change health plans under the following circumstances:

- For any reason within 90 days of enrollment in CHIP Perinatal;
- If the member moves into a different service delivery area, or
- For cause at any time.
ENROLLING NEWBORNS

Encourage your patients to call a Texas Department of State Health Services (DSHS) social worker to let them know about the pregnancy.

STAR

For hospitals: At the time of delivery, please complete the HHSC form 7484, Hospital Report (Newborn Child or Children), and mail to the address identified on the form within five days of the birth. Prompt submission of this form to HHSC will expedite the process of assigning the newborn the Medicaid identification number needed for submission of claims to the assigned plan.

For members: After the baby is born, the member will receive a Medicaid ID Form 3087 that says Newborn Call Plan. The baby is part of the mother’s health plan for 90 days following the date of birth if the mother applies for Medicaid. The state will retroactively, to the date of birth, enroll newborns in BCBSTX designated by the mother.

Once enrolled, if the member hasn’t called BCBSTX to choose a primary care provider (PCP) or other professional provider for their baby, they can call 888-657-6061 to choose one. If the parent does not choose, one will be chosen for the newborn member.

CHIP

When seeing a member who is pregnant, remind her of the importance of calling both DSHS and BCBSTX to report the pregnancy. We offer a prenatal program that will assist her during pregnancy.

Pregnant CHIP members should be referred to Medicaid for eligibility determination. For eligible members, the baby will be enrolled in the mother’s plan unless the mother asks for an exception. If CHIP members do not qualify for Medicaid, the mother is covered through delivery until eligibility is terminated. The baby is not covered under CHIP or STAR in this case.

Newborn Process

When a member of a household enrolls in the CHIP Perinatal Program, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal member’s health plan if those health plans are different. All members of the household must remain in the same health plan until the latter of (1) The end of the CHIP Perinatal Member’s enrollment period, or (2) the end of the traditional CHIP members’ enrollment period. Copayments, cost-sharing, and enrollment fees still apply to children enrolled in CHIP.

In the ninth month of the CHIP Perinate newborn’s coverage, the family will receive a CHIP Renewal form, which will be pre-populated to include the CHIP Perinate newborn’s and the CHIP members’ information. Once the child’s CHIP perinatal coverage expires, the child will be added to his or her siblings’ existing CHIP case.
Maximus, the State’s Administrative Services Contractor is responsible for providers BCBSTX new member and member change information within five days of the beginning of the month for that month’s eligibility information. However, HHSC makes the final decision of enrollment for all CHIP members.

Disenrollment occurs due to loss of eligibility, including, but not limited to the following events:

- Failure to re-enroll at the conclusion of the 12-month eligibility period
- Change in health insurance status, such as a child enrolling in an employer sponsored insurance plan
- Permanent move out of the state
- Enrollment in Medicaid

The switch of CHIP members from their Managed Care Organization to the Managed Care Organization providing CHIP Perinatal coverage does not count as their one Managed Care Organization plan change per year. Members may request changing Managed Care Organizations for exceptional reasons or good cause.

PREGNANT TEENS

Provider Responsibility

Network providers are required to notify us immediately upon identification of a pregnant CHIP member for Medicaid eligibility determinations. A CHIP member who is potentially eligible for Medicaid must apply for Medicaid. A pregnant CHIP member who is determined to be Medicaid-eligible will no longer be eligible for CHIP and will be disenrolled from the program. Medicaid coverage will be coordinated to avoid gaps in health care coverage.

If BCBSTX remains unaware of a CHIP member’s pregnancy until delivery, the delivery will be covered by CHIP. 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 time specified in the Member Handbook.

Since Medicaid provides a much more comprehensive scope of services for both the pregnant teen and her newborn, it is in the best interest of the pregnant teen to receive Medicaid coverage as early as possible. For this reason, it is critical that providers notify BCBSTX immediately upon learning about a CHIP member’s pregnancy and/or delivery.

PHYSICIANS AND OTHER PROFESSIONAL PROVIDERS’ ROLE IN STAR AND CHIP MARKETING AND ENROLLMENT

As network physicians and other professional providers who serve STAR or CHIP members, you may not provide prospective members with an enrollment form. Moreover, you may not assist prospective members (who are patients) in completing the enrollment form.

If someone expresses interest in our plan during a medical visit, you may help that person preliminarily find out what program he or she may qualify for, then provide resources for more information.