MEMBER-INITIATED PRIMARY CARE PROVIDER AND OTHER PROFESSIONAL PROVIDER TRANSFERS

Members have the right to change their primary care provider or other professional provider at any time. When a member enrolls in any of our programs, we provide instructions to call our Customer Service Department (CSD) if the member wants to choose another PCP. Our CSD staff will consider special needs when changing a PCP and will work with the member to make a new selection. We accommodate member requests for transfers whenever possible, and have policies to maintain continued access to care/continuity of care during the transfer process.

STAR and CHIP members may request a PCP transfer by calling Customer Service at: 888-657-6061.
When a member calls to request a PCP change:

1. The Customer Service Representative (CSR) checks the availability of the member’s choice. If the member can be assigned to the selected PCP, the CSR will reassign the member. If the PCP is not available, the CSR will assist the member in finding an available PCP. If the member advises the CSR that he/she is hospitalized, the PCP change will take effect upon discharge.

2. BCBSTX notifies PCPs of member transfers through monthly enrollment reports. PCPs can find these reports by calling our Customer Service Department.

3. The effective date of a PCP transfer will be the same as the date of the member request. We may assign a member retroactively.

4. To support member transfers between PCPs, 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.

TRANSFERS TO OTHER PLANS

STAR Members

Members can change health plans by calling the Texas Medicaid Managed Care program help line at: 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 15th of the month, the change will take effect on the first day of the next month. If the members call after the 15th of the month, the change will take effect the first day of the second month after the request. For example:

1. If a request for plan change is made on or before April 15, the change will take effect May 1.
2. If a request for plan change is made between April 16 and April 30, the change will take effect on June 1.

CHIP Members

Effective October 1, 2009, the CHIP Reauthorization Act (CHIPRA) requires the state, enrollment broker and managed care entities to allow CHIP enrollees to terminate and/or change enrollment without cause during the 90-day period beginning on the date the individual receives notice of enrollment.

DISENROLLMENT FROM BCBSTX

Medicaid Managed Care Member Disenrollment from BCBSTX

If a member requests disenrollment from the managed care program, BCBSTX will provide the member with information on the disenrollment process and direct the member to Maximus, the HHSC Administrative Services Contractor. If the request for disenrollment includes a member complaint, the complaint will be processed separately from the disenrollment request through the complaint process.

Members’ disenrollment requests from managed care will require medical documentation from the PCP or documentation that indicates sufficiently compelling circumstances that merit disenrollment from managed care. HHSC will make the final determination.
CHIP/CHIP Perinatal Program Member Disenrollment

Disenrollment from the CHIP/CHIP Perinatal Program 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

HHSC will make the final decision.

Physicians and other professional providers may not take retaliatory action against STAR or CHIP members for requesting transfer or disenrollment.

When a CHIP member switches from his or her Managed Care Organization to the Managed Care Organization providing CHIP Perinatal coverage, it does not count as their one Managed Care Organization plan change per year. Members may request a change in their Managed Care Organization for exceptional reasons or good cause.

Who Can Initiate Disenrollment?

Two sources may initiate a disenrollment:

1. The member
2. Blue Cross and Blue Shield of Texas

Member-Initiated Disenrollment

Members can voluntarily disenrolled and choose another managed care health plan at any time, except during an inpatient stay. When members enroll in our plan, we provide instructions on where to call or write to disenrolled and choose another managed care health plan. Disenrollment become effective the first day of the second month after Texas Health and Human Services Commission (HHSC) or a contractor receives all documentation necessary as determined by HHSC. Physicians and other professional providers may not take retaliatory action against STAR or CHIP members for requesting transfer or disenrollment.

Disenrollment may result in any of the following:

- Enrollment with another plan
- Termination of eligibility

If a member asks a physician or other professional how to disenroll from BCBTX, the physician or other professional provider can direct the member to call the Customer Service phone number on the back of the member’s identification (ID) card: 888-657-6061.
BCBSTX Response to Member Disenrollment Calls

When BCBSTX’s Customer Service Department (CSD) receives a call from a member who wants to disenroll from us, the Customer Service Representative (CSR) follows these steps:

1. The CSR will attempt to find out the reason for the request.

2. If the situation is something that the CSR can address and resolve, the CSR reminds the member that he or she has the right to request disenrollment, but also offers to resolve the issue. The CSR also asks the member if he or she wants to delay the disenrollment process pending the resolution.

3. If a member agrees to allow us to attempt resolution, BCBSTX’s CSR initiates the process that would properly address the situation.

4. If the member declines, the CSR will refer the member to the Texas Medicaid Managed Care program help line at 800-964-2777.

5. The CSR informs the member that the disenrollment process will take 15 to 45 days.

Physician and other professional provider Request for Termination of Professional Relationship with Member

A physician or other professional provider may request the termination of the professional relationship between the provider and the member. The request for termination must be approved by BCBSTX. For continuity of care, if the physician requesting the termination is the member’s PCP, that physician must continue to manage the member’s care until we can reassign the member to another PCP, or 30 days from the day we receive the Provider Request for Member Deletion from PCP Assignment form, whichever comes first. This form is available on our website at http://bcbstx.com/provider/medicaid/index.html. Upon completion of this form, providers must mail it to BCBSTX at:

Blue Cross and Blue Shield of Texas
Attn: Membership
P.O. Box 51422
Amarillo, TX 79159-1422

The reasons a provider may terminate his/her professional relationship with a member include, but are not limited to, the following:

- Fraudulent use of services or benefits
- Threats of physical harm to a physician or office staff
- Uncooperative or disruptive behavior on the part of the member/patient or member’s/patient’s family
- Member/patient continuously misses appointments
- Medical needs that could be better met by a different provider
- Evidence of receipt of prescription medications or health services in a quantity or manner which is not medically beneficial or necessary
The member accesses care from providers other than the selected or assigned provider

Breakdown in provider and member relationship

Previously approved termination

Reasons a provider may not terminate his/her professional relationship with a member include, but are not limited, to the following:

- Discriminating against a member or potential member because of race, creed, age, color, religion, natural origin, ancestry, marital status, sexual orientation, physical or mental disability, health status or existing need for medical care
- Amount, variety, or cost of covered health services required by the member
- Patterns of high utilization, either known or experienced

Once we receive a request for termination from the physician and/or other professional provider, we will contact the physician and/or other professional provider to determine if the request meets the performance standards allowed for termination. If the performance standards for termination are not met, we will explain why the physician/member relationship may not be terminated.

If the termination request meets the performance standards, a termination date of the physician/member relationship will be given to the provider. The term date must be the last day of the month following the initial 30 calendar day timeframe. Immediate termination may be considered if a safety issue or gross misconduct is involved and must be reviewed and approved by BCBSTX.

The provider is required to send a notification letter to the member. The notification letter must include:

- Name of the member – (if terming a family, list all members affected)
- Member identification number(s)
- Group number
- Effective date of termination

A copy of the letter sent to the member must be sent simultaneously to BCBSTX Network Management via email, fax, or regular mail. The provider must continue to provide medical services for the member until the termination date stated in the provider’s letter. Once we receive the letter from the provider, we will notify the provider of receipt of the letter.

BCBSTX will send a letter to the member, 30 days prior to the termination date, outlining the steps the member must take to select a new physician or other professional provider.

Prior to disenrollment, BCBSTX makes every attempt to resolve any issues and keep the member in our plan. If these attempts fail, BCBSTX will either reassign the patient to another PCP or forward the disenrollment request form to the appropriate state agency requesting member reassignment to another health plan.

For more information, please call our Provider Services Department at 877-560-8055.
Plan-Initiated Member Disenrollment

BCBSTX may request disenrollment for a member who has moved out of the service area. If members move out of the service area, they are responsible for notifying their state eligibility worker of the address change. After that, HHSC will disenroll the member from the health plan.

BCBSTX may also request disenrollment if:
- The member misuses or loans their membership card to another person
- The member is disruptive, unruly, threatening or uncooperative
- The member refuses to comply with managed care restrictions

State Agency–Initiated Member Disenrollment

BCBSTX receives daily changes and monthly full replacement files from HHSC and contracted agencies containing all active membership data and incremental changes to eligibility records. BCBSTX disenrolls member who are not listed on the monthly full replacement file effective as of the designated disenrollment date with consideration of the following disenrollment reasons:
- Death
- Permanent change of residence out of service area
- County changes
- Loss of benefits
- Voluntary disenrollment
- Change in eligibility status
- Incarceration
- Admission to a long-term care or intermediate care facility beyond the month of admission and the following month
- Member has other non-government or government sponsored health coverage