



ADMINISTRATIVE RULES OF MONTANA



37.86.5006 HEALTH MAINTENANCE ORGANIZATIONS: DISENROLLMENT

- (1) An enrollee may request, without good cause, disenrollment from an HMO at any time, except that an individual required to enroll in an HMO per ARM 37.86.5005(1) (a) may disenroll only for good cause as defined in (11) of this rule.
- (2) A disenrollment request must be accompanied by a choice for another managed health care provider.
- (3) Disenrollment is requested by either completing a form designated by the administrative contractor for managed care or by a written or oral request to the administrative contractor for managed care.
 - (a) The form must be available through the same locations as specified in ARM 37.86.5005 for the enrollment form.
 - (b) An HMO or any other entity responsible for making the form available upon receiving a form or a request, must forward the form or request to the administrative contractor for managed care within 3 working days.
- (4) An HMO, based on good cause, may request that the department disenroll a recipient. The request with the basis for the request must be in writing.
 - (a) Good cause does not include an adverse change in health status.
 - (b) An enrollee may be terminated from medical assistance for good cause if the enrollee:
 - (i) has committed acts of physical or verbal abuse that pose a threat to providers or other enrollees of the HMO;
 - (ii) has allowed a non-enrollee to use the HMO certification card to obtain services or has knowingly provided fraudulent information in applying for coverage;
 - (iii) has violated rules of the HMO stated in the evidence of coverage;
 - (iv) has violated rules adopted by the commissioner of insurance for enrollment in an HMO; or
 - (v) is unable to establish or maintain a satisfactory physician-patient relationship with the physician responsible for the enrollee's care. Disenrollment of an enrollee for this reason must be permitted only if the HMO can demonstrate that it provided the enrollee with the opportunity to select an alternate primary care physician, made a reasonable effort to assist the enrollee in establishing a satisfactory physician-patient relationship, and informed the enrollee that the enrollee may file a grievance on this matter.

- (5) Disenrollment takes effect, at the earliest, the first day of the month after the month in which the administrative contractor for managed care receives the request for disenrollment, but no later than the first day of the second calendar month after the month in which the administrative contractor for managed care receives a request for disenrollment. The enrollee remains enrolled with the HMO and the HMO is responsible for services covered under the contract until the effective date of disenrollment which is always the first day of a month.
- (6) The department will disenroll an enrollee from a particular HMO if:
 - (a) the contract between the department and the HMO is terminated; or
 - (b) the enrollee permanently moves outside the HMO's enrollment area.
- (7) The department will disenroll an enrollee from an HMO if:
 - (a) the enrollee enters a medicaid eligibility group excluded from HMO enrollment; or
 - (b) the enrollee becomes ineligible for medicaid; or
 - (c) the enrollee moves outside the HMO's enrollment area.
- (8) If an enrollee becomes ineligible for medicaid and is reinstated into medicaid within 1 month, the enrollee may be reenrolled with the same HMO.
- (9) A recipient disenrolling or disenrolled from an HMO who remains medicaid eligible is eligible for regular medicaid.
- (10) A person participating in the FAIM project who is required to enroll in an HMO under ARM 37.86.5005 is considered to have good cause to disenroll if the person:
 - (a) has a terminal illness;
 - (b) meets one of the conditions for exemption from or is ineligible for the passport to health program as defined in ARM 37.86.5103; or
 - (c) is under treatment by a physician or mid-level practitioner who is not affiliated with a medicaid HMO and the patient, provider, and department believe that a disruption of the patient/provider relationship may adversely affect treatment or cause unnecessary hardship to the patient.

Authorizing statute(s): Sec. 53-2-201 and 53-6-113, MCA

Implementing statute(s): Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-116 and 53-6-117, MCA

History: NEW, 1995 MAR p. 2155, Eff. 9/29/95; AMD, 1996 MAR p. 284, Eff. 1/26/96; AMD, 1997 MAR p. 503, Eff. 3/11/97; AMD, 1997 MAR p. 1210, Eff. 7/8/97; TRANS, from SRS, 2000 MAR p. 481; AMD, 2000 MAR p. 866, Eff. 3/31/00.