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SECTION 6: ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

MEDI-CAL ELIGIBILITY

Under Medi-Cal, HPSJ offers a managed care plan (Medi-Cal HMO) for low-income adults, children, seniors, and persons with disabilities. This program is regulated under the provisions of Title 22 of the California Code of Regulations and the Department of Health Care Services (DHCS). Under this oversight, HPSJ's Medi-Cal HMO program must comply with federal and State requirements. HPSJ's Medi-Cal HMO program provides general acute and preventative medical services required by the federal government under the federal Medicaid program as well as the State Medi-Cal program. Some services are carved out and not managed by HPSJ.

Eligibility for Medi-Cal is month-to-month so Members participating in this program must re-certify their eligibility annually. Because of this, Members may lose Medi-Cal eligibility and then regain it at a later date or become effective for services retroactively. Please be aware that not all Medi-Cal beneficiaries participate in the HPSJ Medi-Cal HMO plan. Those patients who are not affiliated with HPSJ may be participating through another Medi-Cal HMO or be Medi-Cal fee-for-service (FFS).

MEMBER IDENTIFICATION CARDS

HPSJ issues all new Members an Identification Card that must be presented to providers at the time Covered Services are requested. Please note that the HPSJ Identification Card (ID Card) alone should not be considered verification of Member eligibility with our health care programs. The ID Card is issued for identification purposes only and does not guarantee eligibility. All providers should verify eligibility on the date that the service is rendered. A referral or Authorization is also not enough to guarantee that the patient is eligible on the date of service.

Members:
Some of your care may need approval. Please look in your Evidence of Coverage or call us.
If you have a medical emergency, call 911 or go to the nearest hospital.
You do not need to get an approval ahead of time for your emergency care.

Customer Service: 1-888-936-PLAN(7526)

Mental Health Services and Inquiries: 1-888-581-PLAN(7526)
Routine Vision Care: 1-888-321-7526
TDD/TTY Users: 711
Providers:
Authorization, Benefits and Eligibility: (209) 942-6320
Mail Claims To:
Health Plan of San Joaquin
P.O. Box 839, El Cerrito, CA 94530

Pharmacy Administrator: ProCare Rx
Submit prescription claims to ProCare's online system for immediate adjucation.
1-855-828-1486 RxBin: 07043
www.hpsj.com

VERIFICATION OF ELIGIBILITY

There are several ways to verify eligibility with HPSJ. The methods listed below will provide various levels of detail about Members including, but not limited to:

- Name
- HPSJ identification number
- Birth date
- Gender (female or male)
- Language preference
- Eligibility status (eligible or termed) and effective dates
- PCP name and phone number
- PCP assignment effective date

Interactive Voice Response System (IVR)

IVR is another tool that is available 24/7 to verify a Member's eligibility. To use IVR, please call (209) 942-6303 and provide the Member's 9-digit identification number. A confirmation number will be provided which should be maintained to document the verification of eligibility.

Customer Service Department

Eligibility can also be verified by calling the Customer Service Department. Representatives are available to assist with eligibility verification inquiries Monday through Friday from 8:00 am to 5:00 pm. To contact Customer Service, call (209) 942-6320 or (888) 936-7526.

HealthReach

HPSJ's Advice Nurse **HealthReach** is available 24/7 to assist you with eligibility inquiries and to assist in triaging Members in need of Covered Services. To access **HealthReach**, please call (800) 655-8294.

PRIMARY CARE PHYSICIAN (PCP) ASSIGNMENT

PCPs are the primary provider of Covered Services for Members, so they play a central role in coordinating care. For this reason, the selection or assignment of each Member to a PCP is of critical importance. The PCP is the center of a multidisciplinary team and coordinates all medical care for their assigned Members while acting as their key contact and advocate.

PCP Selection and Change

The first and most important decision that a Member makes is the selection of a PCP. HPSJ

encourages individual PCP selection because it creates a better opportunity for a Member to develop a one-on-one relationship with a physician who can personally engage with them in coordinating their care. This relationship creates continuity and improved quality and helps avoid confusion and duplication of services. Members can find available PCPs on the HPSJ website and are directed to choose PCPs for themselves and for each family member.

Members can change PCPs by using the Member portal on the HPSJ website or by calling the Customer Service Department at (209) 942-6320 or (888) 936-7526.

- PCP change requests made between the first (1st) and the fifteenth (15th) of the month will become effective the first (1st) day of the current month, providing that the Member has not received Covered Services from their current PCP during this month.
- Change requests during the first fifteen (15) days of the month will become effective on the first day of the following month if the Member has accessed services through their current PCP.
- Requests made from the sixteenth (16th) through the end of the month will become effective the 1st day of the following month.
- Requests for retroactive PCP assignments received after the fifteenth (15th) of the month must be reviewed and approved.
- Changes after the fifteenth (15th) of the month will not be effective until the first day of the following month unless:
    - Members have not seen their current PCP in the current month of the request, and the Member is ill and needing immediate attention
    - The Member does not approve of a previous auto-assignment
    - The Member previously requested a change, and it was not administratively processed

GROUP/CLINIC ASSIGNMENT

HPSJ Members can be assigned to either an individual PCP within a Group or clinic, or directly to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs).

PRIMARY CARE PHYSICIAN (PCP) AUTO-ASSIGNMENT

Upon Enrollment with HPSJ, Members are notified that they have thirty (30) days to select a PCP. In the event Members fail to respond with a selection, the Member will be assigned to a PCP by HPSJ. In making an auto-assignment, HPSJ will take several factors into consideration, including but not limited to:

- Language, age and gender of Member
- Language, age and gender restrictions for potential PCPs
- Current report of PCPs accepting new Members
- Panel capacity of current PCPs
- Geographic accessibility (travel time and distance) based on Member's zip code
- Availability of traditional safety net PCPs
- Culture and ethnicity of Member and PCPs
- PCPs with whom Member has had a previous relationship

HPSJ will notify the Member of the auto-assignment. They will have the option of changing PCPs if they do not wish to receive care from the auto-assigned PCP.

PCPs are notified of newly assigned Medi-Cal Members on the monthly roster which is available through the secure provider portal (DRE) on the HPSJ website, www.hpsj.com.

MEMBER DISENROLLMENT

HPSJ does not make Medi-Cal eligibility determinations for Members. The responsibility for the determination of Medi-Cal eligibility resides with the State and the County Human Services Agency; it is subject to retroactive adjustment in accordance with the terms and conditions of coverage described in the *Medi-Cal Combined Evidence of Coverage and Disclosure Form*. Providers should verify eligibility on the date that the service is rendered (see section 6-1).

- Disenrollment is effective on the 1st day of the 2nd month following receipt by Department of Health Care Services (DHCS) of all documentation necessary to process the disenrollment – provided disenrollment was requested at least thirty (30) calendar days prior to that date.
- During this time period, the Member remains active and Covered Services should be continued until the effective date of disenrollment.
- Administering disenrollment requests is the responsibility of HPSJ's Utilization Management Department.

Voluntary Disenrollment

Members can elect to discontinue participation in the HPSJ Medi-Cal plan as often as monthly. This disenrollment decision can be made for any reason. If a Member requests disenrollment, the Customer Service Representative (CSR) will refer member to HCO for further assistance.

However, if a reason is given, HPSJ may be able to resolve the situation by explaining how participation with HPSJ works, facilitating appointments or resolving service issues.

Involuntary Disenrollment

Under certain circumstances, HPSJ may request the disenrollment of a Member under specific guidelines set by DHCS. In addition, HPSJ providers may, under specific circumstances, request that HPSJ review a given Member situation for possible disenrollment consideration. Please note that final disenrollment decisions are handled entirely by DHCS. According to 42 CFR 460.164, Members can be disenrolled for any of the following reasons:

- Member moves outside of the HPSJ Service Area
- Member no longer qualifies for Medi-Cal benefits as determined by DHCS
- Member has changed to a Medi-Cal Aid Code which is not covered under HPSJ
- Member is (or will be) incarcerated for more than one (1) month
- Member becomes enrolled in one of the following forms of other health coverage:
- Medicare HMO
- CHAMPUS Prime HMO
- Any other HMO/prepaid health plan in which the enrollee is limited to a prescribed panel of providers for comprehensive service

Medi-Cal Disenrollment for Complex Medical Conditions

An HPSJ Medi-Cal Member is eligible for disenrollment for complex medical conditions (as defined by State law) if they have been an HPSJ Medi-Cal Member for ninety (90) days or less, are under treatment by a non-HPSJ provider, and started or were scheduled for treatment before their HPSJ effective date.

Medi-Cal Member Disenrollment for Long Term Acute Care

An HPSJ Medi-Cal Member may be disenrolled from Medi-Cal HMO to receive Long Term Care (LTC) through fee-for-service Medi-Cal, if the LTC admission exceeds the month of

admission and the following month. Disenrollment, if requested and approved, may become effective on the first day of the second month following the Member's month of admission to an LTC facility. Please note that hospice services are Covered Services and are not considered LTC services, regardless of the Member's expected or actual length of stay in a nursing facility. Administering disenrollment requests is the responsibility of HPSJ's Utilization Management Department. Requests are directed to Health Care Options at (800) 430-4263. Until the date of disenrollment, HPSJ retains responsibility for the payment of LTC costs.