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SECTION 6: ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

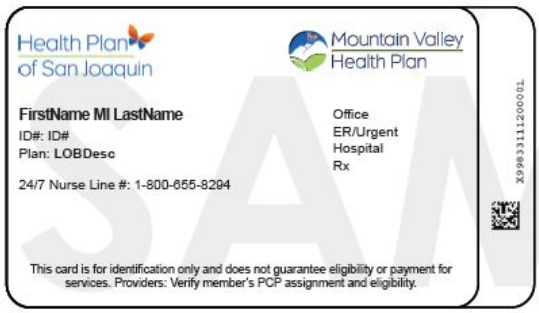
MEDI-CAL ELIGIBILITY

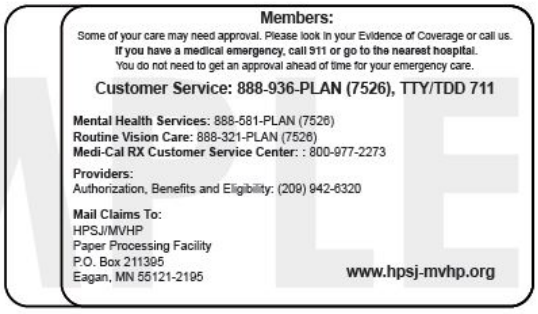
Under Medi-Cal, Health Plan offers a managed care plan (Medi-Cal HMO) for low-income adults, children, seniors, and persons with disabilities. This program is regulated under the provisions of Title 22 of the California Code of Regulations and the Department of Health Care Services (DHCS). Under this oversight, Health Plan's Medi-Cal HMO program must comply with federal and State requirements. Health Plan'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 Health Plan.

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 later or become effective for services retroactively. Please be aware that not all Medi-Cal beneficiaries participate in Health Plan's Medi-Cal HMO plan. Those patients who are not affiliated with Health Plan may be participating through another Medi-Cal HMO or be Medi- Cal fee-for-service (FFS).

MEMBER IDENTIFICATION CARDS

Health Plan issues all new Members an Identification Card that must be presented to Providers at the time Covered Services are requested. Please note that the Health Plan 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 must 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.





SECTION 6: ELIGIBILITY, ENROLLMENT, AND DISENROLLMENT

VERIFICATION OF ELIGIBILITY

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

- Name
- Health Plan 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 Member eligibility. To use IVR, please call (209) 942-6303 and provide the Member's 9-digit Health Plan 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 Advice Nurse Line

Health Plan'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. 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. Health Plan 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 Health Plan 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 Health Plan website or by calling the Customer Service Department at (209) 942-6320 or (888) 936-7526. Providers can also submit Member PCP selections to Health Plan by using the PCP Selection Form Request via secure Provider portal (DRE).

- 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 (15^{th}) 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

Health Plan 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 Health Plan, 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 Health Plan. In making an auto-assignment, Health Plan 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

Health Plan 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-mvhp.org.

MEMBER DISENROLLMENT

Health Plan 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 must 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 Health Plan's Utilization Management Department.

Voluntary Disenrollment

Members can elect to discontinue participation in the Health Plan 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, Health Plan may be able to resolve the situation by explaining how participation with Health Plan works, facilitating appointments or resolving service issues.

Involuntary Disenrollment

Under certain circumstances, Health Plan may request the disenrollment of a Member under specific guidelines set by DHCS. In addition, Health Plan Providers may, under specific circumstances, request that Health Plan 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 Health Plan 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 Health Plan
- 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