Molina Healthcare of California
Provider/Practitioner Manual

Eligibility, Enrollment, and Disenrollment

SECTION 3: ELIGIBILITY, ENROLLMENT, DISENROLLMENT

ELIGIBILITY FOR MANAGED CARE

Mandatory Aid Categories

Under the Geographic Managed Care (GMC) and Two-Plan Model, enrollment is mandatory for the following aid categories eligible for Medi-Cal without a share-of-cost:

- CalWorks - formerly Aid to Families with Dependent Children (AFDC)
- CalWorks - formerly Medically Needy, Family (AFDC)
- Medically Indigent Children
- Refugee/Entrant
- Public Assistance, Family

Voluntary Aid Categories

Beneficiaries who fall into these aid categories may enroll but are not required to do so:

- Public Assistance, Aged
- Public Assistance, Blind/Disabled
- Medically Needy, Aged (no share-of-cost)
- Medically Needy, Blind/Disabled (no share-of-cost)
- Medically Indigent Adult

Exemptions from Mandatory Enrollment

Medi-Cal beneficiaries meeting the following criteria are exempt from mandatory enrollment:

- Individuals with a complex or high-risk medical condition who are in an established treatment relationship with a provider(s)/practitioner(s) or who are not participating in the GMC or Two-Plan Model provider/practitioner network.
- Children in Foster Care or the Adoptions Assistance Program.*
- Native Americans, their household members, and other persons who qualify for services from an Indian Health Center.*

* These individuals are exempt from mandatory enrollment, although if they wish to enroll they may do so.

Not Permitted to Enroll

Medi-Cal beneficiaries meeting the following criteria are not permitted to enroll under the GMC Program and Two-Plan Model:

- Individuals in a skilled nursing facility.
- Individuals with the following other health coverage:
    - Kaiser HMO
    - CHAMPUS
    - Other HMO coded K, F, C, or P
    - Medicare HMO (unless Medicare HMO is also a Geographic Managed Care Plan, and the Department of Health Care Services (DHCS) allows this plan to enroll beneficiaries in both the contractor's Medicare HMO and Medi-Cal managed care plan)

NEW MEMBERS

Molina Healthcare receives a weekly enrollment tape from Health Care Options (HCO) and a monthly Central Insurance Division (CID) Medical Eligibility Data System (MEDS) tape from DHCS. The data received from HCO is loaded into Molina Healthcare's computer system on a weekly basis to create a prospective member enrollment record. The CID MEDS tape is loaded monthly into Molina Healthcare's computer system in order for the new member enrollment record to receive eligibility.

This process creates a new member file for eligibility purposes and production of member identification cards.

Each new member receives a Molina Healthcare Welcome Packet that includes a Molina Healthcare identification card. This identification card will contain the name of the member's Primary Care Practitioner (PCP). To identify a member's assigned PCP, you may also refer to Molina Healthcare's Interactive Voice Response system or the Plan's Member Services Department. The identification card issued by Molina Healthcare is for Plan Identification only. Although the member eligibility is verified at the time the card is issued, possession of the card does not guarantee eligibility. In case a member has lost the identification card or his/her eligibility is in question, eligibility may be verified using one of the following options:

- PCP eligibility roster
- Molina Healthcare Interactive Voice Response at (800) 357-0172 (also accessible through 888-665-4621)
- Automated Eligibility Verification System (AEVS) at (800) 456-2387 [1]
- Point of Service Device (POS) [2]
- Data entry through C.E.R.T.S. software (Claims & Eligibility Real Time System) [3]
- Molina Healthcare's Member Services Department at (888) 665- 4621,
- Molina Healthcare's Provider Resolution Department at (888) 665-4621
- ePortal (www.molinahealthcare.com)

[1] Providers/Practitioners who would like to obtain a PIN number in order to access AEVS may call (800) 541-5555.
[2] Providers/Practitioners who would like to obtain a POS Device may call (800) 541-5555.
[3] Providers/Practitioners who wish to obtain C.E.R.T.S. software may call (800) 541-5555.

If the member does not appear on the current eligibility roster, the Provider/Practitioner should contact Molina Healthcare's Provider Services Department at (888) 665-4621.

At no time should a member be denied services because his/her name does not appear on the eligibility roster. Please remember that a member may access emergency services without prior authorization.

Remember, the card is for identification purposes only. Eligibility to receive services depends on verification from Molina Healthcare. There will be at least two (2) phone numbers on the front of the card. The first number is for members to use. If a member has questions that you are unable to answer, suggest a call to Molina Healthcare's Member Services Department.

ELIGIBILITY VERIFICATION

Ask the member for his/her plastic Medi-Cal Benefits Identification Card (BIC) issued by DHCS with the magnetic strip. Providers/Practitioners who have access to POS devices may swipe the member's Medi-Cal BIC card through the device to get information about the member's current or past eligibility status, the current or past PCP's name and phone number, or capitated IPA/Medical Group and phone number. The CERTS software and AEVS verification systems provide the same information.

If help is needed in using the POS Device, call the POS Help Desk at (800) 541-5555.

The Molina Healthcare Interactive Voice Response (IVR) system notifies both Providers/Practitioners and members of member eligibility status and PCP assignment. The system has a dedicated phone line at (800) 357-0172 and is available twenty four (24) hours a day, three hundred sixty five (365) days a year. The system provides members' last name, first name, date of birth, eligibility status, and PCP information, as well as IPA/Medical Group affiliation and subcontract health plan affiliation as applicable.

In the event that the IVR System is not working, the Plan's alternative is Molina Healthcare's Member Services Department. The Provider/Practitioner may verify eligibility directly with Molina Healthcare staff at (888) 665-4621. The Eligibility Department is staffed Monday through Friday, 7:00 a.m. to 7:00 p.m. Any calls made during non-business hours go directly to Molina Healthcare's after hour service, with the same access to current member eligibility status.

ELIGIBILITY REPORTS

Molina Healthcare distributes eligibility reports monthly to provide information on member enrollment in an IPA/Medical Group or with a directly contracted PCP or Direct PCP Groups. The reports are generated the first week of each month and mailed to IPAs/Medical Groups, PCPs, and to Direct PCP Groups.

Molina Healthcare members who have changed Providers/Practitioners by the 25th of a month will be listed on the next month's eligibility reports. Members who have changed Providers/Practitioners after the 25th of a month will be listed on the month following the next month's eligibility listing.

Molina Healthcare's hard copy (paper) eligibility reports are titled "Eligibility Listing-IPA Roster." This report is mailed to IPA/Medical Groups, Providers/Practitioners, and/or staff model facilities on a monthly basis, on or before the 10th of the mid-month.

Molina Healthcare's electronic export file of the eligibility report is titled "Molina Healthcare Eligibility Listing: <IPA Name> Roster - <Month> and <Year>". As directed by the IPA/Medical Group, the electronic file is sent via electronic mail, diskette, or via US mail to the IPA/Medical Group designee by the 10th of each month. These files are password protected and can only be accessed by the IPA/Medical group designee.

The reports include the following information:

Member First and Last Name/ Telephone Number, Social Security Number and Client Identification Number (CIN), MEDS ID, Date of Birth, enrollment effective date, enrollment termination date, PCP effective date, PCP termination date, county/project code, member's complete address, member's change or drop reason, and status of enrollment (each (*) asterisk represents thirty (30) days in the health plan. For example, a member has two asterisks (**) - this equals sixty (60) days the member has been on plan. When a member reaches one hundred twenty (120) days on plan, the asterisks will no longer appear on eligibility report).

The report contains the following sections:

NEW MEMBER - list of all NEW members assigned.

MEMBERS WHO TRANSFERRED IN - list of members who have requested a PCP change to your facility along with the name and phone number of the previous PCP to assist you in obtaining the member's medical record.

MEMBERS WHO TRANSFERRED OUT - list of members who requested a change of PCP.

MEMBERS WITH AN ENROLLMENT RESTRICTION - list of members assigned to your facility, BUT NOT eligible at the time the eligibility roster was printed. IT IS IMPORTANT THAT YOU VERIFY CURRENT DAY ELIGIBILITY for these members on your POS SYSTEM, AEVS, or by telephoning Molina Healthcare's automated eligibility system at (800) 357-0172.

MEMBERS DROPPED FROM THE PLAN - list of members who have dropped from the plan.

MEMBER MODIFICATION - list of members who have a change of address, Medical Identification Number, or 14-digit MEDS ID number.

CONTINUING MEMBERS - list of members who have continuously been assigned

MEMBER ENROLLMENT Initial Health Assessment (IHA) - identifies the time-frame that a member has been on the Plan for up to four (4) months from his/her initial date of eligibility. An asterisk (*) is equal to each month the member has been on the Plan. The asterisk will assist you in identifying members in need of his/her Initial Health Assessment. Molina Healthcare's IHA access standards are as follows:

- Within sixty (60) days for members under 18 months
- Within ninety (<90) days for members over 18 months

If a member arrives at a PCP's office to receive care, but does not appear on the current month's eligibility report, the office should contact Molina Healthcare to verify eligibility. However, a member must not be denied services because his/her name does not appear on the eligibility roster.

ENROLLMENT

Health Care Options (HCO) is responsible for providing Medi-Cal beneficiaries information pertaining to the benefits of health care services through a managed care plan. HCO also assists the beneficiary in making a choice among the different managed care plans. HCO is responsible for assigning beneficiaries who fail to choose a health plan to a managed care plan within each beneficiary's county.

HCO is responsible for the distribution of enrollment forms to beneficiaries as well as to the various managed care health plans. The health plans then distribute the forms to their prospective members upon request. The health plans and their affiliated Providers/Practitioners are no longer allowed to submit the Medi-Cal Enrollment Forms on behalf of their patients.

ENROLLMENT PROCESS

Initial Eligibility and Annual Re-Determination

The following process was created to ensure a smooth transition for all Medi-Cal beneficiaries:

- HCO mails an enrollment packet to each beneficiary who did not attend an HCO presentation. The packet includes an Enrollment Form, Provider Directories, Health Plan Comparison/Feature Charts, and a Medi-Cal Choice Booklet.
- Beneficiaries must select a health plan within their county and complete and mail the enrollment form to HCO within thirty (30) days from the date on which they received the packet.
- Once HCO receives the enrollment form, the beneficiaries' information is entered into their system. If the beneficiary failed to select a health plan, HCO will assign a health plan to the member.
- A beneficiary will be notified by HCO in writing of the auto assignment to a managed care health plan at least thirty (30) days prior to the final submission of documents to DHCS. If the beneficiary wishes to enroll in a different managed care health plan after the submission has been made to DHCS, he/she must contact HCO at (800) 430-4263 to enroll into the managed care health plan of his/her choice.
- If a beneficiary selects a health plan, but not a Primary Care Practitioner (PCP), the health plan will automatically assign a PCP to him/her through the auto assignment process described below.

If beneficiaries have questions regarding the enrollment process, they should be directly referred to HCO at (800) 430-4263.

PCP AUTO ASSIGNMENT

Upon initial enrollment, if the member did not select a PCP, Molina Healthcare will assign a PCP to the member and mail out an ID card with the Welcome Packet indicating PCP assignment. The Welcome letter explains to the member that they may select a different PCP if they are dissatisfied with the choice made for them. The letter also advises members of the importance of scheduling an appointment with their PCP within the first ninety (90) days of initial enrollment.

The following criteria is followed when processing auto assignment of a PCP:

- The proximity of the provider/practitioner must be within ten (10) miles or thirty (30) minutes of member's residence.
- The member's language preference.
- The member's age, gender, and special PCP needs (i.e., Pediatrician, Obstetrician, etc.)
- The existence of established relationships and family linkages.
- Molina Healthcare makes every attempt to assign members to the PCP of their choice. Molina Healthcare is limited to the information that is on the HCO tape, which is neither always complete nor correct.

DISENROLLMENT PROCESS

Any member of Molina Healthcare may at any time, without cause, request to be disenrolled from the plan. The member must contact HCO at (800) 430-4263. A HCO representative will mail a disenrollment form to the member's residence.

A member with a mandatory aid code must simultaneously re-enroll into another managed care health plan. If the member fails to select a health plan, HCO will automatically assign him/her to one. Members who have a voluntary aid code may elect to remain in the Medi-Cal Fee-for-Service program or select a new health plan.

The disenrollment process takes fifteen (15) to forty five (45) days to complete. During this time period, Molina Healthcare will be responsible for the member's health care until the disenrollment is approved by DHCS and processed by HCO.

Disenrollment of a member is mandatory under the following conditions:

- Member requests to be disenrolled.
- Member loses Medi-Cal eligibility.
- Member moves out of the Plan's approved service area.
- Member's Medi-Cal aid code changes to an aid code not covered.
- Member's enrollment violates the State's marketing and enrollment regulations.
- Member requests disenrollment as a result of a Plan merger or reorganization.
- Member is eligible for those carve-out services that require disenrollment. (See Additional Services or Carve-Out Services).

Members disenrolled because of any of the above conditions will be allowed to return to the Fee-for-Service Medi-Cal Program unless their Medi-Cal eligibility is a mandatory managed care aid code or eligibility is terminated by DHCS. Molina Healthcare does not determine eligibility for the Medi-Cal program.

DHCS allows for certain beneficiaries to remain in Fee-for-Service Medi-Cal as described above, under the Heading, Exemptions From Mandatory Enrollment. Such exemptions are granted by HCO and DHCS, not Molina Healthcare. For more information, contact HCO at (800) 430-4263.

PROVIDER/PRACTITIONER PLAN INITIATED DISENROLLMENTS (PID)

A Provider/Practitioner may request to DHCS that a Plan Initiated Disenrollment (PID) be processed for any of its members. However, the health plan is responsible to initiate the process with DHCS.

All written communication letters sent to the members must be prior approved by the Plan and/or DHCS.

The Provider/Practitioner contracted with Molina Healthcare must make its requests in writing and forward such requests to Molina Healthcare's Member Services Department, Attn: Member Services Director. These requests must include a detailed description of the circumstances prompting the Provider/Practitioner to initiate the request for disenrollment. Included should be any documentation and detailed description of corrective action taken by the Provider/Practitioner in an effort to resolve the matter. The detailed description should include:

- Statement of the specific issue
- Dates of occurrence
- Frequency of occurrence

Upon receipt of such request from the Provider/Practitioner, the Member Services Department Director or designee will make an effort to contact the member to provide education and counseling. Member Services will involve a Medical Case Manager RN to attempt to coordinate care. The member may be transferred to another PCP within the plan. In every case, the member is notified in writing of the intent to disenroll and given a thirty (30) day opportunity to appeal to the Member Services Department or DHCS fair hearing via telephone or in writing. At no time should the Provider/Practitioner contact the member without approval of the Member Services Department Director or designee. The Member Services Department Director or designee will then review the request with the Plan's Medical Director and process a PID request to DHCS for approval. Once DHCS reviews the request, the member is mailed a letter, via U.S. mail, notifying him/her of the outcome.

Molina Healthcare is responsible to notify the member via certified mail that the Plan has been notified of their behavior. The member will be warned that further non-compliance may result in transferring the member to an alternate Provider/Practitioner or termination of membership from the plan based on the severity of the issue. If the member fails to comply and behavior is repeated, the Provider/Practitioner must immediately send documentation of repeated offense to Molina Healthcare Member Services. The Provider/Practitioner is responsible for sending final documentation to the Plan. Molina Healthcare must notify the member again (second and final notification) in writing via U.S. certified mail of Molina Healthcare's intent to request a PID or transfer to an alternate Provider/Practitioner. The provider will receive a cc copy of the letter for their medical records.

A PID is evaluated on the severity and cause of the breakdown of the Provider/Practitioner/member relationship. Below are examples of circumstances that could result in a PID. To initiate a PID, the documentation process outlined above must be followed. DHCS will approve a request only if one or more of the following circumstances have occurred:

- The member is repeatedly verbally abusive to Plan Providers/Practitioners, ancillary or administrative staff, or to other Plan members.
- The member physically assaults a Plan Provider/Practitioner, staff member, or Plan member, or the member threatens any individual with any type of weapon on the Plan premises. In such cases, appropriate charges must be brought against the member, and a copy of the police report should be submitted along with the request.
- The member is disruptive to Provider/Practitioner operations in general with potential limitation of access to care by other patients.
- The member habitually uses non-contracted Providers/Practitioners for non-emergency services without prior authorization.
- The member has allowed the fraudulent use of his or her health plan identification card.

- The member refuses to transfer from a non-Plan hospital to a Plan hospital when it is medically safe to do so.
- Other inappropriate use of out-of-Plan services that results in degradation in the Plan's relations with community Providers/Practitioners thereby threatening the access of other Plan members.

A member's failure to follow prescribed medical care treatment, including failure to keep established medical appointments, does not warrant a request for a PID unless Molina Healthcare can demonstrate to DHCS that, as a result of such failure, the Plan or Provider/Practitioner is exposed to greater and unforeseeable risk. In this event, a temporary PID may be requested by the Plan and granted by DHCS.

Expedited Disenrollment Requests

The Plan may request for an expedited disenrollment for the following:

- **Continuity of Care** - If the treating Provider/Practitioner is not part of Molina Healthcare's network of Providers/Practitioners, the member may be eligible for disenrollment. The member is only eligible for disenrollment within the first ninety (90) days of initial enrollment with Molina Healthcare. A medical exemption form signed by the treating Provider/Practitioner and member is required for processing.
- **Long Term Care** - The member must be in a Skilled Nursing Facility (SNF) longer than the month of admission and one month after. Molina Healthcare must have the date of admission, name, address, telephone, and fax number of the facility.
- **Incarceration** - The name of the facility and the date the member entered the facility is required for processing.
- **Resides Outside-of-the-Service Area -** The member moved outside of the service area. The member's new address and move date is required. The member must report their change of address to their eligibility worker within ten (10) days. Failing to do so will result in delaying the disenrollment from Molina Healthcare.
- **Native American** - If the member is a Native American the member may be exempted from being in a health plan. A Non-Medical Exemption form must be completed by an Indian Health Service Provider/Practitioner. The form is required for processing.
- **Major Organ Transplant** - The member must be approved for a transplant and the Treatment Authorization Form (TAR) must be provided to Molina Healthcare's Member Services Department for processing.

All requests for expedited disenrollments along with any required documentation must be submitted to Molina Healthcare's Member Eligibility/Outreach Supervisor via facsimile or US Mail. The member may also initiate a request by calling Molina Healthcare's Member Services Department at (888) 665-4621.

If you need copies of the exemption forms mentioned, please contact HCO at (800) 430-4263.

Molina Healthcare of California
Attn: Member Eligibility/Outreach Supervisor
200 Oceangate, Suite 100
Long Beach, CA 90802
Fax: (562) 901-9632

Related Policies

For more information or a copy of the complete PID policy, contact Molina Healthcare's Member Services Department at (888) 665-4621.