13. Managed Care, Health Care Options, and OHC

13.1 Overview of the Managed Care Two-Plan Model

Santa Clara County has two managed care plans:

- SANTA CLARA FAMILY HEALTH PLAN - Local Initiative
- ANTHEM BLUE CROSS OF CALIFORNIA - Commercial plan

Medi-Cal (MC) recipients who enroll in a MC Managed Care Plan (MCP) must seek medical care from a participating physician and cannot go outside the plan for medical care with the exception of life-threatening emergency room care and non-covered services (i.e. dental care).

13.1.1 Fee-For-Service

Health care is provided to certain MC recipients through Fee-For-Service benefits. This means that some MC clients may receive medical care from an individual doctor, dentist, pharmacy, etc. of choice who accepts the client as a MC patient.

MC Fee-For-Service benefits do not restrict or require that clients receive their medical care from specified health care providers. Fee-for-Service medical providers are individually reimbursed by MC for specific services or procedures performed.

Not all providers accept Fee-for-Service MC. It is the clients responsibility to determine whether a provider accepts Fee-for-Service MC before treatment.

Medi-Cal Rx

Effective April 1, 2021, the Department of Health Care Services (DHCS) is transitioning all Medi-Cal Pharmacy services to the Fee for Service (FFS) delivery system – Medi-Cal Managed Care health plans will no longer manage the pharmacy part of the Medi-Cal benefit package. This new model of delivering Medi-Cal pharmacy benefits and services (administered by DHCS and contractor Magellan) will be identified collectively as “Medi-Cal Rx”. Medi-Cal Rx does not affect Programs of All-Inclusive Care for the Elderly (PACE) plans, Senior Care Action Network (SCAN) and Cal MediConnect health plans, or the Major Risk Medical Insurance Program (MRMIP). Individuals will need to present their Medi-Cal Beneficiary Identification Card (BIC) to access pharmacy services.

Medi-Cal Rx Customer Service Center line: 1-800-977-2273 or 711 for TTY.

13.1.2 Managed Care Enrollment

Mandatory Enrollment

Enrollment in one of the two Managed Care Plans (MCP) is mandatory for individuals who:

- Reside in the county,
- Receive full scope benefits, and
- Are not required to pay a share-of-cost (SOC).

Voluntary Enrollment

Enrollment is voluntary for MC recipients in the following aid codes:

- Children: Aid Codes 03, 04, 40, 42, 45, 4A, 4C, 4F, 4G, 4K, 4M, 5K, 7J
- Pregnant Individuals: 86
- Breast and Cervical Cancer Treatment Program (BCCTP): 0M, 0N, 0P, 0U, 0V.

Note:

Individuals who choose not to enroll in a managed care plan will only be eligible for Fee-for-Service MC.

Exemptions from Enrollment

The following MC Recipients are exempt from mandatory enrollment and will remain in Fee-for-Service:

- Foster Care, Adoption Assistance Program (AAP) or Kinship Guardianship Assistance Payment (KinGAP) program
- Recipients with a Share of Cost (SOC)
- Recipients who are dually eligible for Medicare and MC
- *Individuals with Other Health Coverage (cannot enroll in MCP at all)
- Individuals in skilled nursing facilities (Long Term Care)
- Individuals eligible for emergency and/or pregnancy-related services only
- Individuals with a complex or high-risk medical condition (this includes ANY PREGNANCY) who must continue to be treated by a provider or providers who are not affiliated with either Two-Plan Model program.
- Native Americans, their household members and other people who qualify for services from an Indian Health Clinic.

- Individuals accepted for case management under an AIDS Waiver or other Home and Community Based Services (HCBS) program (except for the Developmentally Disabled Services Waiver)
- Individuals requiring services relating to a major organ transplant.

Individuals with a Medicare HMO (OHC code “F”) may not enroll in the Two-Model Plan in Santa Clara County at this time.

See DHCS website for additional information on mandatory enrollment and exemptions.

13.1.3 Managed Care Plan Providers are Not Other Health Coverage

The provider under an MCP should not be listed as Other Health Coverage in CalWIN. For example, the client may have selected Kaiser as a Provider under Santa Clara Family Health Plan, however, the OHC code is still “N”. The only time that Kaiser information should be entered into CalWIN is when it is a private or group health insurance plan.

13.2 Health Care Options Enrollment Contractor

All Two-Plan Model enrollment and disenrollment functions are handled by the Health Care Options (HCO) contractor. The current HCO contractor is Maximus. MC recipients who need assistance with selecting, enrolling in or disenrolling from a plan can contact the HCO contractor at 1-800-430-4263, There are also HCO representatives stationed at BAC, North County and South County District Offices to answer questions and provide assistance with enrollment and disenrollment.

Health Care Options Flyer

The HCO Flyer explains that certain MC individuals are required to enroll in one of the two Managed Care Plans. It also explains that if the client does not choose a plan within the required time frame, one will be chosen for them. The HCO flyer must be placed in all CalWORKs and MC Intake packets.

13.2.1 EW Role in the Managed Care Enrollment Process

In order to reduce plan defaults and client confusion, EWs must inform applicants and recipients of the MC Managed Care process and requirements at Intake and at Redetermination.

EWs must inform all applicants/recipients in mandatory CalWORKs and MC Aid Codes that:

- They are required to enroll in one of the two MCPs in Santa Clara County,
- There are HCO representatives located in certain Intake office lobbies to answer questions and assist clients in making a choice,

- If they do not attend the HCO presentation and choose a plan at that time, an enrollment packet will be mailed to them,

- They must make a choice between the two plans within 30 days, otherwise a plan will be selected for them.

13.2.2 Urgent Disenrollment

The DHCS Medi-Cal Managed Care Office of the Ombudsman developed an online fillable form for counties to use for urgent requests including:

- Enrollment
- Disenrollment
- Removal of 59 holds.

Client's can contact the Managed Care Ombudsman Office for emergency disenrollment at 1-888-452-8609 or email to MMCDOmbudsmanOffice@dhcs.ca.gov.

All standard non-urgent changes need to be submitted by the recipient or their authorized representative through Health Care Options at 1-800-430-4263.

Online Form Completion Criteria

The following criteria must be met before an online request for disenrollment can be made:

- MEDS must reflect all current information (i.e. residence address, county code)
- MEDS must show active coverage for the recipient.

If the information above is not correct in MEDS, the request may be denied.

Client-Initiated Disenrollment

Clients have the option to request disenrollment by phone to the Medi-Cal Managed Care Ombudsman at 1-888-452-8609. Requests made by phone before 5pm will be processed no later than two business days after the request is made. Requests made by phone after 5 pm will be processed the following business day and be effective no later than two business days after the request is processed.

13.2.3 Automatic Default Into a Managed Care Plan

After 30 days, individuals who do not return enrollment forms are automatically assigned to a plan. There are several criteria by which the plans are automatically assigned:

- The plan must have a primary care service site within the individuals zip code area (time and distance for travel does not exceed 30 minutes or ten miles),

- Family members are usually assigned to a plan as a group, and
- The plan must include a primary care provider with the capacity to accept new patients and the language capacity to meet the individual needs.

13.2.4 Disenrollment

HCO representatives are responsible for disenrolling clients from their MCP. Disenrollment, whether to another health plan or to Fee-for-Service, normally takes 15 to 45 days. [Refer to "Urgent Disenrollment," page 13-4].

13.2.5 Two-Plan Model Identification Cards

Both the Santa Clara Family Health Plan and Blue Cross of California will issue an identification card to the plan participant.

Santa Clara Family Health Plan's card includes the client's name, an ID number, the date coverage started, and the Primary Care Provider's name, address, and telephone number. On the back are instructions on what to do in case of an emergency.

The Blue Cross of California plan card also has identifying information, subscriber's name and address, effective date of coverage, the name, address and telephone number for the primary care doctor, Blue Cross 24 hour nurse advice line, and Blue Cross toll free service line.

MC recipients must always carry BOTH their plastic MC BIC and their managed care plan ID card with them in order to receive medical services.

13.3 HCO Referrals

Individual who complete a face-to-face interview and are required to enroll in a managed care plan can be referred to an HCO representative for a consultation providing information on managed care health plans/providers and assistance in completing the enrollment choice form.

The completed Enrollment Choice form can be held by HCO staff up to 120 days prior to approval of benefits if the client chooses to meet with a representative prior to their MC being approved.

HCO Referral Form

The "Health Care Options Referral Form" (SCD 31) is used to refer clients who are completing a face-to-face interview at BAC, North County and South County district offices to HCO staff for a consultation. This includes both mandatory and voluntary recipients.

Enrollment Information Packet

MC recipients also have the option to enroll by mail and phone. Individuals who are required to enroll in one of the MC MCPs are mailed a packet of information that includes:

- An enrollment form with written notice of the requirement to select one of the two available MCPs
- The 800 number for enrolling by phone
- Information about requesting an exemption from the mandatory enrollment requirement under certain conditions. [Refer to "Exemptions from Enrollment," page 13-2]
- A list of health care providers affiliated with each managed care network

This information will help recipients determine whether their personal doctor or clinic is affiliated with one of the two plans.

Choosing a Primary Care Provider (PCP)

MC recipients must select a Primary Care Provider (PCP) in addition to selecting a plan. If the individual does not make a selection within a specified time, the plan will assign a PCP.

HCP Information on MEDS

Both the Santa Clara Family Health Plan and Blue Cross of California plans are reflected in the [HCP-NO] field on various MEDS screens as a three-digit numeric code as follows:

- Managed Care Plan Code for Santa Clara Family Health Plan: 309
- Managed Care Plan Code for Blue Cross of California: 345

A two-digit numeric or alpha/numeric code in the [HCP-STAT] identifies a recipient's enrollment status in the associated managed care plan. [Refer to "HCP-STAT," page 12-45]

13.3.1 Cost of Care in Managed Care Plans

Covered benefits are provided at no charge to the recipient when enrolled in one of the managed care plans.

13.3.2 Transportation Services for Managed Care Recipients

Transportation services are available to Managed Care recipients through each of the two managed care plans.

Recipients can request transportation services via the process below:

- **Santa Clara Family Health Plan**: Contact customer service at 1-800-260-2055 at least 7 days before the appointment. The appointment must be for services covered through the health plan, and the doctor must be an SCFHP provider. When requesting transportation, clients should be prepared to provide the date and time of appointment, address of appointment, pick up location, member ID number and name of the doctor they are seeing.
- **Anthem Blue Cross of California**: Request transportation services through their doctor prior to the appointment. Contact transportation reservations at 1-877-931-4755 (TTY 711) at least 7 days before the appointment. When requesting transportation, clients should be prepared to provide the date and time of appointment, address of appointment, pick up location, member ID number and name of the doctor they are seeing.

13.3.3 MCP and HCO Contact Information Updates

MCPs and HCOs provide the County with a list of clients who have reported a change in contact information. This listing is distributed to District Office for processing. The HCO or MCP is responsible for obtaining the client's consent to share information and then inform the County that it has the client's consent. This will allow EWs to maintain the most up-to-date contact information for clients.

13.4 Managed Care for Mental Health Services

The MC Specialty Mental Health Service Consolidation Program provides mental health services to all MC recipients in the county through single managed care Mental Health Plan (MHP). Individuals are automatically enrolled upon MC approval.

The MHP for Santa Clara County is:

Santa Clara County Mental Health Department
645 South Bascom Avenue
San Jose, CA 95128

The toll free telephone number is: 1-800-704-0900

Individuals may call the mental health plan to get information about:

- Mental health plan services offered
- How to access mental health services
- A list of the mental health plan's psychiatrists, therapists, clinics

13.4.1 Mental Health Services

Most mental health services must be pre-approved by the MHP before the psychiatrist or therapist can be reimbursed by MC. Prior approval is not required for hospital services when an individual needs hospital admission for emergency mental health treatment.

When an MC recipient needs mental health services, he/she should contact his/her family doctor, clinic, or the MHP for approval.

13.5 Coordinated Care Initiative - Cal MediConnect

The federal Medicare program and the state MC program have partnered to start the Coordinated Care Initiative (CCI) to improve care for California's seniors and people with disabilities who are dually eligible for both of the public health insurance programs, MC and Medicare. These individuals are referred to as dual eligibles.

The CCI includes two parts, Cal MediConnect and Managed Medi-Cal Long-Term Services and Supports (MLTSS).

13.5.1 Cal MediConnect

Optional enrollment into an integrated managed care that combines Medicare and MC benefits. A client's medical, some behavioral health, long-term institutional, and home and community-based services will be combined into a single health plan.

13.5.2 MLTSS

Mandatory enrollment of all MC clients (including those dually eligible for both MC and Medicare (Duals) who have opted out of Cal MediConnect or who are not eligible for Cal MediConnect) into a MC managed care health plan to receive all their MC benefits, including Long-Term Services and Supports (LTSS), one of which is In-Home Supportive Services (IHSS).

Note:

All recipients of IHSS will receive their benefits as a MC managed care benefit.

13.5.3 CCI Implementation

The Cal MediConnect program is a three-year Duals Demonstration Project which will be implemented in the following eight counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

Dual Eligible Enrollment

The state will automatically enroll all dually eligible clients (Medicare and MC) into a Cal MediConnect health plan unless the client actively chooses not to join (i.e. opt out) and notifies the state of this choice. The state will send eligible clients multiple notices describing their choices, including a Guidebook and Choice Form that allows those individuals to make a decision.

Opting out

This is when an eligible client chooses not to join a coordinated health plan and decides to keep his/her Medicare benefits separate by choosing a MC health plan only. Clients who enroll in a Cal MediConnect health plan may change health plans at any time.

Note:

Opting out applies only to Medicare benefits. Clients must still get their MC benefits through a managed care health plan.

13.5.4 Dual Eligibles Who Do Not Enroll into a Cal MediConnect Health Plan

For dually eligible clients (Medicare and MC) who do not enroll into a Cal MediConnect Health Plan, the state will require enrollment into a MC managed care health plan for all MC LTSS and any Medicare deductibles or costs. These dual eligible clients who enroll in a MC managed care health plan only will not have a change to their Medicare benefits. They can still go to their Medicare doctors, hospitals, and providers.

13.5.5 MC ONLY Clients

The state requires mandatory enrollment into a MC managed care health plan. MC ONLY clients MUST get all their MC benefits, including LTSS, through a MC managed care health plan.

Most people with only MC already are enrolled in a MC managed care health plan, which will now include LTSS through their health plan.

13.5.6 CCI Health Plan Providers

In Santa Clara County, there are two CCI health plan providers:

Santa Clara Family Health Plan

New Members: 1-877-723-4795

TTY: 1-800-735-2929

Anthem Blue Cross

New Members: 1-855-817-5785

TTY: 1-800-855-2880

Cal MediConnect Ombudsman

Clients enrolled in Cal MediConnect who need:

- Help with their services or plan,
- Assistance with resolving enrollee problems/complaints,
- Assistance with filing appeals,

can reach the Cal MediConnect Ombudsman services by calling:

Phone: 1-855-501-3077

TTY: 1-855-847-7914

Monday - Friday, 9am - 5pm

13.5.7 Program of All-Inclusive Care for the Elderly (PACE)

PACE provides all Medicare and MC benefits plus extra services to help seniors who have chronic conditions live at home. If clients are 55 years old or older and they need a higher level of care to live at home, they may be able to join PACE. The Santa Clara County PACE plan is On Lok Lifeways.

On Lok Lifeways

1333 Bush Street

San Francisco, CA 94109

Main Phone: (415) 292 - 8888

Fax: (415) 292 - 8745

Toll Free: 1-888-886-6565

TTY: 1-415-292-8898

Website: www.onlok.org

13.5.8 Client Questions and Answers

The following are questions and answers that staff can refer to when clients have questions regarding Cal MediConnect:

Q1. How do I know if I am eligible?

A1. Most people with full Medicare and MC benefits (Dual Eligibles) can join a Cal MediConnect health plan. MC recipients in participating counties who receive LTSS, such as Multipurpose Senior Service Program (MSSP), Community-Based Adult Services (CBAS), IHSS, or who live in a nursing facility, will need to enroll in a managed care plan for those benefits. This applies both to those who opt out of Cal MediConnect and those who are not eligible.

The following are not eligible for Cal MediConnect:

- Dual Eligible clients under 21.
- Dual Eligibles with partial benefits or other health coverage.
- Home and Community Based Services waiver enrollees (except MSSP; all others must disenroll from those programs to be eligible for the Cal MediConnect; will not be passively enrolled).
- Dual Eligibles with developmental disabilities.
- Dual Eligibles with End-Stage Renal Disease (exception for San Mateo & Orange).
- PACE and AIDS Health Care Foundation enrollees (who must disenroll from those programs to be eligible for the Cal MediConnect; will not be passively enrolled).
- Individuals receiving services through California's regional centers or State developmental centers or intermediate care facilities for the developmentally disabled.
- Individuals residing in one of the Veterans Homes of California.

Q2. How will I be notified?

A2. If you need to select a new plan, you will receive three different notices, sent 90, 60 and 30 days ahead of your enrollment date. This is the same for clients in Cal MediConnect and clients in MC fee-for-service who need to choose a managed care plan for their LTSS.

The first notice (90-day notice) will alert you to the coming change.

The second notice (60-day notice) will come with a packet that has information about plan benefits and provider networks to help you select a plan. This will include a plan that is the best match for you based on how many of your current providers are included in a plan¡¦s provider network.

The third notice (30-day notice) will provide you with information about your specific plan. This will be the plan you have chosen based on the 60-day notice. If you did not make a selection, it will be the plan that is the best match.

Those clients who are NOT eligible for Cal MediConnect and who are already enrolled in a MC managed care plan will receive one notice prior to the change in their benefit package. This change is the LTSS program, which adds long-term services and supports to clients' existing plan.

Q3. What are my options?

A3. Your enrollment date will depend on several factors, including which county you live in and whether you are already in a MC managed care plan. You will receive a choice form in your 60-day packet that you can use to select a plan. You can also call Health Care Options to enroll in a plan at 1-844-580-7272 or 1-800-430-7077 (TTY).

If you are eligible for Cal MediConnect, here are your options:

1. Enroll in Cal MediConnect. Combine your Medicare and MC benefits under one plan. Clients can access the same Medicare benefits that they could through a fee-for-service or Medicare Advantage plan.

2. Join a MC plan only. Your fee-for-service Medicare or Medicare Advantage plan remains as it is; however, you must enroll in a MC plan for your MC benefits.

3. Enroll in PACE. Only certain dual eligible clients are eligible for PACE; you must be 55 or older, live in your home or community setting, need a high level of care, and in a zip code served by a PACE health plan with openings.

Note: Those who are not eligible for Cal MediConnect or who opt out still must enroll in a MC managed care plan or PACE.

Q4. When do I need to enroll?

A4. Enrollment dates will vary. You do not need to do anything until you receive your notices.

Q5. Can I keep my providers?

A5. Your new Cal MediConnect or MC health plan is required to make sure your care continues and is not disrupted. Your health plan will work with you and your doctors to make sure you get all the care you need.

You have the right to continue to receive needed services, even if you may no longer be able to receive them from the same provider. Eventually, you must get all your covered services from providers who work with your plan. These are in-network providers.

If your primary care or specialist doctor is not in your plan, you may be able to continue to see them for 6 months for Medicare services and 12 months for MC services as long as:

- You have seen the doctor twice in the 12 months before enrolling in the plan,
- Your doctor is willing to work with the plan and accept payment from them, and
- Your doctor is not excluded from your plan for quality or other reasons.

You have the right to stay in your current nursing home under Cal MediConnect, unless it is excluded from the plan's network for quality or other concerns.

You will not have to change IHSS, CBAS, and MSSP providers.

Continuity of care protections do not apply to suppliers of medical equipment, medical supplies, and transportation. They also do not apply to home health or physical therapy providers.

Q6. Why did I receive a letter that says I will be disenrolled from my prescription (Part D) coverage?

A6. If you qualify for both Medicare and MC, you will be automatically matched with (and eventually enrolled into) a Cal MediConnect plan, unless you otherwise choose to keep your Medicare they way it is now and choose a plan for your MC benefits, or if you choose a PACE plan. Since you can only be in one Medicare plan at a time, your enrollment in Cal MediConnect will automatically end your enrollment in any other Medicare prescription drug plan. Your Part D prescription drug coverage will then be covered by a Cal MediConnect plan.

You receive the disenrollment notice because your current Medicare program recognizes that you are scheduled to join Cal MediConnect, and is alerting you that your coverage will switch to that new plan once your new coverage begins. You will not lose your prescription drug coverage at any time.

If you do not want to be in Cal MediConnect, you may keep your Medicare the same and stay in your current prescription drug plan. You will still have to select a MC plan for your MC benefits. You just need to let Health Care Options know your decision.

Q7. What information should I consider in making this decision?

A7. Your 60-day packet will contain information to help you make your decision, including identifying health plans that may be the best fit with your current doctors and other health care providers. You should contact this health plan's member services phone number to be sure your doctor(s) and other health care providers that you use are in the plan's network. If you want to find a new doctor, the health plan can help you find one.

You will also want to make sure that the Cal MediConnect health plan's Medicare Prescription Drug formulary includes the medications that you need to take. Be sure to have the exact name of the prescription drug when calling the plan(s).

You may also want to talk with family members, your doctor(s) or other people you rely on in making this decision. Individual counseling is also available from the local Health Insurance Counseling and Advocacy Program (HICAP).

Q8. Where can I get more information? How can I exercise my options?

A8. Health Care Options staff can also help you to understand these new options and MC changes, and to enroll in the managed care of your choice. They can be reached at 1-844-580-7272.

The Cal MediConnect Ombudsman Program helps clients voice complaints and solve problems with Cal MediConnect. If you need help with your services or your plan, you can call 1-855-501-3077 (TTY 1-855-874-7914) from Monday - Friday, 9am - 5pm.

HICAP is available to help you understand these changes and new options. HICAP provides workshops on Medicare issues, including Cal MediConnect, and also provides individual counseling to assist individuals in understanding their options. You can call 1-800-434-0222 to talk with someone at your local HICAP.

13.6 Other Health Coverage (OHC)

MC recipients are required to report and utilize any other health insurance that is available. Federal law prohibits MC from paying for services which are covered by the client's private or group health insurance or health plan. The California Department of Health Care Services (DHCS) Third Party Liability and Recovery Division (TPLRD) has implemented electronic health data exchanges among the health care providers, consumers of health care and government agencies to obtain other health coverage information for MC recipients through an automated data match process.

OHC is defined as benefits for health related services or entitlements for which a MC recipient is eligible under any:

- Private, group or indemnification insurance program
- Other state or federal medical care program
- Other contractual or legal entitlement

Note:

Individuals can be approved for MC and OHC; the OHC will be billed as the primary coverage and MC will be billed as secondary coverage.

Due to the confidentiality of Minor Consent Services, MC will not report OHC nor bill private insurance carriers for such services

13.7 Client Responsibility

13.7.1 Reporting

All MC clients have the responsibility to report:

- Current OHC information. This includes not only current health insurance, but also health insurance which is available, but not applied for.
- The availability of employer related health benefits.
- OHC changes within ten days (for example, termination, lapses, or a different insurance carrier).
- OHC information to their doctors and other health care providers.

Note:

The client must utilize private health insurance prior to using MC.

If the beneficiary refuses to cooperate in the State's purchase of health insurance under the HIPP program, when it is found to be cost effective, DHCS may decline payment for medical services which would otherwise be covered by the insurance policy.

13.7.2 Fraud Referrals

If the EW suspects that an MC recpient is withholding information about OHC, the client's name, CIN and any available OHC information must be communicated to:

Department Of Health Care Services
Medi-Cal Investigations Unit - North
P.O. Box 977413 - MS 2201
Sacramento, CA 95899

Main Line: 916-650-6630
Fax: 916-324-0772

13.8 EW Responsibility

13.8.1 Informing

EWs must inform MC applicants and recipients that:

- Reporting OHC does not interfere with their eligibility for or use of MC benefits.
- If health insurance coverage is available from any source, at no cost to the recipient, the applicant/recipient must enroll. If the applicant/recipient fails to cooperate by not enrolling in the plan, the EW must deny or discontinue MC eligibility.

  Note: Individuals who do not apply for available coverage that meets Minimum Essential Coverage (MEC) are not eligible for Advanced Premium Tax Credits (APTC).

- Employer related health benefits which are available to an individual must be reported. If there is no cost, the benefits must be applied for and retained. The MC program may pay the health insurance premiums if it is determined to be cost effective. ["Treat the discontinued person as an ineligible member of the MFBU. MC benefits must continue for members of the family unit who are unable to enroll on their own behalf.," page 13-26.]
- Any health insurance payments received for health care services paid by MC must be reported and repaid.
- Due to the confidentiality of Minor Consent Services, MC will not report OHC nor bill private insurance carriers for such services.

Note:

Federal law requires that EWs inform Medi-Cal beneficiaries and applicants that they are not required to purchase Medigap insurance.

13.8.2 Identification

EWs must ask applicants and recipients if they have other health insurance when:

- Interviewing CalWORKs or MC only applicants during the Intake process.

- Completing a CalWORKs or MC only redetermination.
- A CalWORKs or MC only client is or was recently employed.
- A CalWORKs or MC only client obtains, loses or changes employment.
- It is reported that an absent parent is employed, obtains, loses or changes jobs (OHC may be available for the dependents).
- Child support payments are being made, as employment of the absent parent is strongly indicated.
- A client reports veteran status, military service or union membership of a family member or an absent parent.
- The client or absent parent is a student (who may have insurance through a school health plan).
- Work history indicates national organization membership (such as the American Association of Retired Persons or National Retired Teachers Association, which offer health plans).
- Earnings statements indicate health coverage deductions.
- Other evidence indicates the client may have other health insurance.

13.8.3 EW Actions

EWs are required to determine the availability of OHC by reviewing the application and asking key questions.

The chart below describes the actions EWs must take to identify OHC:

If the Client...	Then the EW Must...
Indicates either on the application or verbally that other health insurance is available,	Interview the client further to determine if the health insurance policy is one listed. [Refer to "OHC Changes and EW Actions," page 13-19]
Indicates the absent parent is: employed, was recently employed, retired, serving in the military, a veteran, a union member, or a student,	• Ask the client additional questions to determine if other health insurance is available.

If the Client...	Then the EW Must...
Has one of the health insurance policies listed in the following table, [Refer to "OHC Changes and EW Actions," page 13-19]],	• Complete the **Collect Individual Attributes Detail** and the **Collect Health Care Coverage Detail** windows for each eligible person with other health coverage. • Record premium paid by the client, if any, on the **Collect Health Care Coverage Detail** window. The ***premium paid by, premium amount*** and ***frequency*** fields must be completed in order for CalWIN to properly allow the premium payment as a deduction in the budget.

13.8.4 Good Cause

There may be instances where the applicant/recipient may have other health coverage available but is unable to access this coverage. The EW must explore good cause and obtain an affidavit about the situation. Good cause exists when:

- There are geographic barriers to accessing the health coverage. OHC is considered unavailable when the health plan is limited to a specific geographic service area and the recipient lives outside that area or the health plan requires use of specified provider(s) and the beneficiary lives more than 60 miles or 60 minutes travel time from the specified provider(s).

- There are domestic abuse issues. [Refer to "Removal of OHC Codes for Victims of Domestic Violence," page 13-29]]

If good cause exists, the EW must inform the Third Party Liability (TPL) OHC Unit to remove the OHC indicator and indicate the reason. The "Other Health Coverage Transmittal" (SCD 2265) was developed for this purpose.

DHCS cannot correct or remove the health insurance records that come through the Local Child Support Agency (LCSA) OHC data match or entered by Healthy Families (HF). In these situations, the EW should work with CS or HF to have the OHC record removed from the CS Administration OHC data match or HF. To communicate with the LCSA staff may complete and send the "Social Services Agency/Local Child Support Agency Communication Form" (SCD 1603) or call (866) 901-3212. For issues regarding HF on MEDS or HF carrier information, staff may call (800) 880-5305.

13.8.5 OHC Priority

The goal of DHCS Third Party Liability is to complete an OHC request within 30 days of receipt. However, due to staffing shortages it may take up to 60 days. Priority is given to victims of domestic violence, cases where the OHC information is preventing immediate access to care, and cases where the client has signed an affidavit that he/she never had OHC.

If the client never had the OHC, request the OHC record be put on the "no carrier match list" to prevent the next OHC tape match from resetting the OHC code. The OHC removal request must indicate "Attention Manager" and the reason for the urgent request.

DHCS will attempt to process these requests within 48 hours of receipt.

Note:

Complete the SCD 2265 when faxing the requests. Do not submit multiple requests for the same person as this may add to the delay.

13.8.6 Adding (Or Changing) OHC

EWs must update CalWIN when a new OHC coverage policy is reported or there are subsequent changes to the current health coverage information.

The Social Security office is responsible for collecting OHC information ONLY when making an initial SSI/SSP determination or redetermination. Any corrections of or updates to OHC information for SSI/SSP recipients must be completed by the EW.

The recipient's MEDS record must be updated for each month affected to ensure proper claims processing.

The chart below describes the types of OHC changes and the EW actions:

Table 13-1: OHC Changes and EW Actions

OHC Change	EW Action
• Client's name • Address • Carrier contact information • Scope of coverage • Policy information • Dependents • Gender	Update the **Collect Individual Attributes Detail** and the **Collect Health Care Coverage Detail** windows with the proper OHC information, as needed.

Table 13-1: OHC Changes and EW Actions

OHC Change	EW Action
Different OHC Policy	• To report termination of old OHC, refer to [Refer to Chapter 13, Section 13.8 "Removing OHC," page-21]. • Update CalWIN with the proper OHC information on the **Collect Individual Attributes Detail**, the **Collect Health Care Coverage Detail** and the **Collect Insured Individual Detail** windows.
Additional or New policy	Update CalWIN with the new OHC information on the **Collect Individual Attributes Detail** and the **Collect Health Care Coverage Detail** windows. The following health plans are automatically reported to DHCS. Any other health plan must be manually reported to DHCS using the OHC Additions tool. NOTE: The user will be prompted to enter a security code on the screen before proceeding to the online form. • Aetna • Anthem Blue Cross • Arcadian Health Plan • Blue Shield of California • Care 1st Health Plan • Central Health Plan of California, Inc. • Chinese Community Health Plan • Easy Choice Health Plan • GEMCare Health Plan • Health net of California, Inc. • Health Net Life Insurance • Health Net Community Solutions, Inc. • Inter Valley Health Plan • Kaiser Foundation Health Plan, Inc. • MD Care Health Plan • PacifiCare of California • SCAN Health Plan • Social Services Coordinators, LLC • Unicare • United Healthcare Services, Inc, Wellcare Health Plan, Inc.

Exceptions

The following types of OHC should not be entered in the **Display Health Care Coverage Summary** window:

- Accident benefits
- Automobile, Burial, and Life Insurance benefits
- Casualty Workers Compensation benefits
- Disability benefits

- Medicare
- Healthy Kids
- Veteran's Administration (VA) benefits
- Coverage under a PHP or HMO which the client has chosen as a Health Care Option (HCO).

Coverage under one of the mandatory two-plan model managed care plans: Anthem Blue Cross of California or Santa Clara Family Health Plan.

13.8.7 Removing OHC

A request to remove the OHC code from MEDS must be made when there is termination of coverage, or the individual does not have the coverage reported by other sources (i.e. MEDS shows coverage the client never had).

The Social Security office is responsible for collecting OHC information ONLY when making an initial SSI/SSP determination or redetermination. Any corrections of or updates to OHC information for SSI/SSP recipients must be completed by the EW.

The recipient's MEDS record must be updated for each month affected to ensure proper claims processing.

Verification

In order to ensure that MC is the payer of last resort, termination of OHC must be verified prior to removing the OHC code from MEDS for individuals whose OHC has ended (or for individuals who never had OHC).

Acceptable verifications include:

- A payroll or pension check stub which shows that health insurance deductions have stopped.
- An Explanation of Benefits from the insurance carrier showing the policy termination date.
- A termination letter from the health insurance carrier or employer showing the policy termination date.

Note: If the termination letter indicates COBRA eligibility and the client has a high cost medical condition, refer the client to the Health Insurance Premium Payment program. [Refer to “Health Insurance Premium Payment (HIPP) Program,” page 13-23]

- A “Sworn Statement” (SCD 101) by the client or representative stating he/she no longer has, or never had the OHC. The affidavit must include the coverage termination date, if known. The affidavit may be used when an erroneous OHC code appears on a client’s MC record after DHCS conducts a data match with an insurance carrier, domestic violence situations, or in any other situation where the client cannot verify termination. The affidavit may also be used when a custodial parent or guardian cannot verify termination of an absent parent’s insurance.

Scan the verification of OHC termination in IDM under F-1.

OHC Termination/Removal Process

To report termination or request removal of OHC the following steps must be taken:

Step	Action
1.	Enter the correct information and insurance termination date (if applicable) on the **Collect Individual Attributes Detail** and the **Collect Health Care Coverage Detail** windows.
2.	Complete the online form to request the removal of OHC. Note: For website submissions, DHCS will send a generic e-mail to confirm that the request has been entered. The EW must check MEDS to verify that the changes are complete and correct.

13.8.8 Temporary OHC Removal

To remove OHC for immediate need cases, staff may use an EW15 or EW55 (for SSI/SSP cases) immediate need transaction to update the OHC Code for the current month to a value of “N.” Do not use other OHC values as this will display the incorrect OHC information to providers.

Do not use EW15 or EW55 transaction to change OHC carrier information (e.g. scope of coverage changes).

13.9 Unavailable OHC

Unavailable OHC should not be entered in CalWIN, and if the information is already in MEDS, it must be removed. OHC is considered unavailable in the following situations:

- Any coverage to which a child may be entitled, if the child is applying for Minor Consent Services.
- Coverage to which a child may be entitled when:
  - The parent or guardian refuses to provide the necessary insurance information due to a “good cause” claim in the medical referral process. [Refer to “Adding (Or Changing) OHC,” page 13-19]

  - The absent parent cannot be located, and
  - The child is applying for MC independently and would be in a separate MFBU from the custodial parent or guardian, or
  - The child is applying for MC independently and has no custodial parent or guardian (i.e., child under age 18 applying as an adult).
- Any private PHP/HMO plan which is limited to a specific geographical service area and the client must travel more than 60 miles or 60 minutes to receive care.

13.10 Health Insurance Premium Payment (HIPP) Program

DHCS may elect to pay health insurance premiums on behalf of MC recipients. The objective of the Health Insurance Premium Payment (HIPP) program is to reduce MC expenditures by continuing to pay an individual's health insurance coverage when the cost of the premium would be less than the cost of MC benefits (as determined by DHCS).

13.10.1 HIPP Qualifications

An individual qualifies for HIPP when all of the following requirements are met:

- The individual is active on Fee-for-Service MC.
- The individual is **not** Medicare eligible.
- The individual is **not** enrolled in a MC Managed Care Plan.
- The premiums are not the court ordered responsibility of the absent parent.
- The applicant or family member has a high-cost medical condition.
- The expected MC program savings are greater than the amount of the premium cost.
- The client has health insurance coverage, COBRA continuation, a conversion policy in effect or available, or coverage available through another source.
  - If the health insurance lapsed within the last 60 days, submit an HIPP Program application. If the case appears cost effective, DHCS will contact the insurance company and find out if it is possible to reobtain the insurance.
- For COBRA applicants, there is enough time for the State to process the application and get the premium paid to meet insurance company deadlines.

A timely application is defined as follows:

When Coverage Is Under	And HIPP Application Is Made Within
COBRA continuation	30 days of the insurance termination date.
A conversion policy	20 days of the insurance termination date.

- The policy must cover the individual's high cost medical condition.
- The policy was not issued through the California Major Risk Medical Insurance Board.
- There is no enrollment in a Medi-Cal related pre-paid health plan, County Health Initiative or Geographic Managed Care Plan.
- There is no retro or past due payments due on the policy.

Note:

Eligibility for HIPP begins the month the application is received.

13.10.2 EW Action

The "HIPP Application Form - Fillable" form acts as a referral to the HIPP Program. Follow the online instructions to complete it. The online form can be completed by the applicant/recipient or the EW.

Completing the Online Application

The online HIPP application must include the following information:

Online Form Fields	What to Enter
MC BIC Number	Client's CIN
Name (last, first middle)	Client's Name
Address (street, apartment no.	Client's complete address
City, State, Zip Code	
Contact Telephone Number	10-digit telephone number
E-Mail Address	The online application submission process requires a valid e-mail address. If the EW is completing the application for the client, the EW's e-mail address should be entered
Are you currently on Medicare?	Yes or No
Is This a COBRA policy?	Yes or No

Online Form Fields	What to Enter
If Yes, please enter the policy start and stop dates: • Start Date • End Date	Enter the start & end dates (mm/dd/yyyy) of the COBRA coverage
How are insurance premiums currently paid: • Paid by policyholder directly to insurance carrier • paid by policyholder through payroll deduction • Other	Must select the appropriate method of payment If "Other" is selected, must provide explanation in free-form text box.
Insurance Company	Name of the OHC Insurance (e.g. Kaiser)
Insurance Company Telephone Number	Business telephone number for the OHC Insurance company
Policyholder Name	Name of person who holds the OHC coverage policy (e.g. if insurance provided by employer, name of the employee)
Policy holder Address	Policyholder's complete address
City State, Zip Code	
Policy Number	OHC policy number
Group Number	OHC group number
Current Premium Amount	Out of pocket costs for insurance
Number of individuals covered under this policy	total number of individuals who have coverage
File Upload	This section requires that the following documents be uploaded with the application: • Explanation of Benefits- at least 1 year of medical and pharmaceutical services • Insurance Rate Sheet Breakdown or Current Premium Statement • payee Data record • HIPP Forms (located on the main HIPP website) •DHCS 9114 (if applicable) •DHCS 9119 •DHCS 9120 •DHCS 9121

It is vital that all potential HIPP applications be sent immediately. Timing in making the first premium payment to the insurance carrier is critical to the carrier's obligation to accept coverage.

Although it may appear that a client qualifies for HIPP, DHCS may/may not approve the HIPP application.

13.10.3 DHCS Responsibility

DHCS (HIPP Program) will:

- Process the HIPP Application.
- Initiate premium payments to the insurance carrier, employer, or recipient, if approved. (The premium payment is paid beginning the month the HIPP application is received).
- Update MEDS with appropriate OHC code.
- Reevaluate the premium payment cases annually. The EW and the client will be notified of any changes.

13.10.4 HIPP Approved

EWs must delete the private health insurance premium in CalWIN (allowing for a 10-day notice if the SOC will be increased) and check to make sure the OHC is already entered in CalWIN and that MEDS is coded correctly.

Note:

There are no California Department of Social Services Administrative Adjudications Division hearings on appeals for denial of enrollment to the HIPP Program as of January 1, 1996.

HIPP eligibility can be viewed on the [HIAR] screen in MEDS. If the MC recipient is enrolled in the HIPP, the "Source" field will indicate "HIPP." [Refer to "HIAR - Health Insurance Action Request," page 1-73].

13.10.5 Client Disenrolls from OHC voluntarily

If the EW learns that the client has voluntarily disenrolled from OHC for which the State is paying the premium, notify DHCS immediately by calling 1-866-298-8443.

After disenrollment is verified, DHCS will notify the EW to discontinue the client from MC with a timely 10-day Notice of Action (NOA).

Upon notification, the EW must:

- Discontinue the person responsible for withdrawing from the State-paid health plan,
- Issue a timely discontinuance NOA, and
- Treat the discontinued person as an ineligible member of the MFBU. MC benefits must continue for members of the family unit who are unable to enroll on their own behalf.

13.11 OHC Identification by DHCS

DHCS currently receives OHC data from over 20 health insurance carriers, the Department of Child Support Services, the Social Security Administration, California Children's Services, and other automated systems.

13.11.1 Discrepancies

When DHCS discovers a discrepancy, MEDS is updated with the insurance information and scope of coverage codes (cost avoidance OHC codes).

Affected individuals are sent a letter explaining cost avoidance and informed that their providers must bill the other health coverage carrier prior to billing MC. Individuals are instructed to contact their EW if they no longer have the coverage.

Clients who have further questions about the health insurance coverage may call the DHCS, OHC Section's toll-free number, **1 (800) 541-5555**.

13.12 Cost Avoidance

This type of OHC code requires the provider to bill the other health coverage carrier prior to billing MC. An Explanation of Benefits (EOB) from the private coverage carrier, indicating either a denial of payment or partial payment, must be attached to the provider's claim to MC.

Exception:

The provider is not required to bill the private carrier first when a person is in Long Term Care or is receiving prenatal or preventative pediatric services when the individual has a cost avoidance type of coverage.

Other Health Coverage (OHC) provided by absent parents through the Department of Child Support Services (DCSS) should **not** be subject to cost avoidance. This OHC information can be viewed on the **View HIS Information** screen in MEDS, under **ABS-PARENT-INS** data field (known as ABS Flag):

- ABS Flag "Y" = OHC provided by the absent parent
- ABS Flag "G" = Good cause is granted
- ABS Flag "C" = OHC provided by the custodial parent

13.12.1 Cost Avoidance Coverage Identification

Private health insurance coverage which must be coded with the cost avoidance OHC code may be identified by either DHCS or by the EW. DHCS will place the cost avoidance code directly on MEDS when an individual is identified as having OHC. The EW must update the OHC information in CalWIN.

OHC information. An ABS flag value of 'Y' indicates OHC provided by the absent parent and if a good cause is granted, ABS flag value of ‘G’ displays

13.12.2 Effective Date of Cost Avoidance

Applicants - The first month of eligibility.

Recipients - The first of the future month.

13.13 PHP, HMO, Triwest

PHP, HMO, Triwest, and other comprehensive health plans (for example, Kaiser, Secure Horizons) must be billed prior to billing MC. MC will reject bills for services provided to beneficiaries with OHC codes “F”,”K”, “C”, or “P” with the exception of the following:

- The service is not a covered benefit under the designated plan (e.g., eye glasses, dental, prescriptions)
- The service is determined to be a medical emergency and occurs outside of the plan's geographic service area (i.e., individuals with Kaiser must use their Kaiser coverage when within a 30-mile radius of any Kaiser facility).

Note:

For either of these situations, the provider must attach the OHC denial letter to the claim when submitting a bill for MC payment.

13.14 OHC Information in MEDS

13.14.1 OHC/HIAR

When there is private health insurance coverage, the following information will appear on the individual’s [HIAR] screen on MEDS. [Refer to “HIAR - Health Insurance Action Request,” page 1-71]

- Name of carrier
- Policyholder name
- Policy number
- Policy start and stop dates
- Employer name and address
- Scope of coverage
- Whether dependent coverage is available.

Note:

The information may be useful in responding to individual's inquiries and in identifying insurance carriers. **The worker must ensure personal information found in MEDS pertaining to the absent parent is NOT disclosed.**

13.14.2 Information Lacking

If the client has private health insurance, but the MC program lacks information about the coverage, the word "COMPREHENSIVE" will appear on the record instead of the codes. This will alert providers to bill all services to the insurance company.

Clients will be notified to call their EW if the health insurance information on the MC record is incorrect.

13.15 Removal of OHC Codes for Victims of Domestic Violence

When MC benefits are used, the OHC policyholder will be provided an Explanation of Benefits which indicates where and when the benefits were used. This can be an issue when victims of domestic abuse flee the home and need to utilize the services of an OHC policy held by the abuser. The EW must remove the OHC code from MEDS to ensure the safety of the victims when they are made aware of the situation.

Written verification to support the domestic violence claim is not necessary. However, the EW must document the reason for the OHC removal in the **Maintain Case Comments** window in CalWIN.

[Refer to "Removing OHC," page 13-21]

13.16 OHC for Foster Care/Adoption Assistance Children

The current process of posting OHC codes to MEDS does not take into consideration access to care and inappropriate disclosure issues for children in Foster Care (FC) and the Adoption Assistance Program (AAP).

13.16.1 OHC Coding Changes

In May 2010, the State made modifications behind the scenes to prevent the OHC code from being overlaid when OHC information is reported for a child receiving MC benefits under a FC or AAP Aid Code.

The new logic will automatically change the OHC code to "N" on MEDS to indicate no coverage and enter "Y" as the OHC-SOURCE. The reported OHC code will be posted in the ORIGINAL-OHC code fields on the [INQC] screen until the child becomes ineligible for MC benefits under either the FC or AAP program.

13.16.2 SSI Children

For FC/AAP children who are on SSI, staff must request the Third Party Liability Branch-OHC Unit to modify the OHC for these children.

13.16.3 Recording OHC in CalWIN

The OHC information reported by the FC/AAP child must be entered in CalWIN on the **Collect Individual Attributes Detail** and **Collect Health Care Coverage Detail** windows to ensure the OHC data is interfaced to MEDS ORIGINAL-OHC fields.

This is necessary so that when the child leaves FC/AAP and transitions into a regular MC program, MEDS will already have the OHC data and can update the code to reflect the appropriate OHC without delay.

13.17 Repayment for Medical Services

Individuals must be advised that if they receive insurance payments from their private coverage for a service which has been paid by MC, they must repay MC.

13.17.1 Provider Overpayments (OP) Program

Any health insurance payments received by individuals for services covered by Medi-Cal must be reported and repaid to DHCS. [Refer to "Health Insurance Premium Payment (HIPP) Program," page 4-8]

Individuals should provide the following information in the endorse section of any checks from insurance carriers as follows:

- Name of Payee—Name and signature of the individual who received the check.

- Medi-Cal Identification Number of Recipient—This may be a different person than the one who received the check.
- “For Deposit Only to Health Care Deposit Fund”—This will ensure that the check will be properly applied to the state fund only.
- Date(s) of service, the provider's name, and a daytime phone number where the individual can be reached.

13.17.2 DHCS Recovery

DHCS will recover payments made for MC services that should be paid by the client's OHC.

DHCS distributes OHC payments collected which exceed both the MC payments for the service and the administrative costs in collecting the payment as follows:

- The difference between the provider's billing and the amount paid by MC must be paid to the provider, subject to the amount of the excess available.
- Funds remaining must be paid to the legally entitled person or entity.

13.18 Third Party Liability (TPL)

An applicant/recipient who receives or will receive health care services as a result of an accident or injury caused by someone else, must assign the right to receive payment for these services to the Department of Health Care Services (DHCS), if those services will be billed to Medi-Cal. If the client is unable to make the assignment, the client's guardian, attorney or the person acting on the client's behalf must make the assignment.

The potential for a third party liability claim exists when:

- The third party has liability insurance, or
- Client has Workers' Compensation insurance, or
- Client has filed or intends to file a claim or lawsuit.

Potential third party liability claims include, but are not limited to:

- Insurance claims
- Workers' compensation claims
- Wrongful death suits
- Malpractice suits
- Other civil suits for injury

13.18.1 Workers' Compensation

Workers' Compensation covers health costs related to injuries on the job. If the client is receiving Workers' Compensation from a work-related injury, the EW must notify DHCS using the Workers Compensation Notification (New Case) online fillable form. DHCS will recover the cost of any money paid out for services that were paid by MC.

13.18.2 EW Responsibility

When the Eligibility Worker (EW) is made aware of a potential third party liability claim or a client is receiving Workers' Compensation from a work-related injury, they must notify the Department of Health Care Services (DHCS) within 10 days using the Personal Injury Notification (New Case) or Workers Compensation Notification (New Case) online fillable form as appropriate. For both instances, the EW will need to request the following information from the injured individual:

- First and last name
- Date of birth
- Client Identification Number (CIN)
- Date of injury
- Type of injury
- Third party's insurance information
- Final date of treatment (if known)
- Date of settlement (if known)
- Client's attorney information (if applicable)

The EW must also take the following actions:

Step	Action
1	Advise the applicant/client of the requirement to report potential third party liability information.
2	Complete the [Collect Third Party Liability Detail] window in CalWIN.
3	Deny the Medi-Cal application if an applicant refuses to supply the information requested. OR Advise any recipient who fails to provide the requested information that: • DHCS may file a lien against his/her property to recover the costs of health care services, and • His/her Medi-Cal benefits may be discontinued.

13.19 When DHCS Receives a Third Party Payment

When DHCS receives payment on an account, notification of the payment is sent to the county in which the client resides to:

- Alert the county that a cash settlement from a personal injury case may have been received,
- Instruct the EW to:
  - Contact the client to inquire about a possible settlement,
  - Discontinue aid if the client is over the property limit.

13.20 Kaiser Dues Subsidy Program

The Kaiser Dues Subsidy Program provides Kaiser health care coverage for a sliding-scale fee to former CalWORKs Employment Services (CWES) participants who are now employed.

This program is not to be confused with the Kaiser coverage that may be available to MC clients under managed care as part of the Santa Clara Family Health Plan.

13.20.1 Eligibility Criteria

Two years of reduced cost health care coverage may be available to qualified individuals who are employed and meet the following conditions:

- Have been CWES participants (those who have only registered at Employment Services are not eligible).
- Have been terminated from CW due to unsubsidized employment (increased wages, etc.).
- Do not qualify for Transitional Medi-Cal (TMC) or other MC programs with no SOC, OR
- Are being terminated from TMC.
- Are within Kaiser's income and asset guidelines.
- Work for an employer who does not contribute to the cost of a medical care plan.
- Reside within Kaiser's service area.

Individuals with a SOC or restricted MC are potentially eligible. Certain dependents of qualified individuals may also be covered.

13.20.2 How To Apply

Potentially eligible individuals must contact Kaiser Permanente directly at (800) 255-5053. Kaiser will send an enrollment packet and determine eligibility. No medical review is required.

Kaiser will require the client's termination or denial notice of TMC as verification of eligibility to the program.