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## 3.1 Enrollment and Eligibility

# Section 3: Eligibility

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# Introduction

This section describes Blue Shield's HMO enrollment procedures, eligibility criteria and processes for communicating enrollment and eligibility information to IPA/medical groups. It also describes Blue Shield's HMO service delivery rules and the importance of the member's primary care physician (PCP) to follow these rules.

*Note: For enrollment and eligibility information on Blue Shield's Medicare Advantage plans, see Section 6.*

# Initial Enrollment

Eligible members who select the Blue Shield Access+ HMO® or the Blue Shield Added Advantage POS℠ (Point-of-Service) group plan must complete an HMO enrollment application during the initial enrollment period. Each member and each dependent are required to reside or work in Blue Shield's HMO service area to ensure access to care and must include their primary care physician choice on the enrollment application. If an invalid PCP or no PCP is selected, the member will be assigned a PCP.

Blue Shield also offers the HMO Trio Plans for Individuals and Families (IFP). As with our employer sponsored plans, each member of the family must live or work in Blue Shield's HMO service area to ensure access to care. Off-exchange applicants aged 19 or older must meet underwriting criteria in order to enroll in an individual or family plan. All primary care physicians are assigned at the time of enrollment, but the member has the option to change the Blue Shield-designated primary care physician.

If the Commercial Blue Shield Access+ HMO subscriber or dependent no longer lives or works in Blue Shield's HMO service area, they may be subject to a plan change. This can be considered a qualifying event depending on the availability of other group employer plans and eligibility rules set by the employer. Special arrangements may be available for dependents of employer group subscribers who are full-time students or do not live in the subscriber's home. Member Services will assist these dependents to enroll under the BlueCard Away From Home Care Program®.

# 3.1 Enrollment and Eligibility

## Member Eligibility and Coverage

Blue Shield's standard eligibility and coverage requirements for members and dependents are outlined below.

*Note: Specific employer groups may have different negotiated eligibility provisions in their health plan.*

Members are defined as either a subscriber or dependent and are:

- Employees who are enrolled in an Access+ HMO Group Plan or Blue Shield POS Group Plan after satisfying their employers' eligibility requirements. Spouses, domestic partners, and dependent children who are covered by the subscriber's contract are eligible at the same time. Generally, enrollment becomes effective on the date specified by the employer, which is usually the first day of the month following the group's open enrollment period. Coverage is effective at 12:01 A.M. Pacific Standard Time on the established date.

  Newly hired or transferred employees who become eligible at any time other than during the annual open enrollment must complete the Blue Shield enrollment form within 31 days of becoming eligible. If employees do not enroll themselves or their eligible dependents during an open enrollment period or within 31 days of becoming eligible, they must generally wait until the next open enrollment period to enroll (with some limited exceptions, as mandated by California law or as otherwise permitted in the employer's group health service contract).
- Individuals who are enrolled in the Blue Shield HMO Trio IFP and have been accepted for membership by Blue Shield's Medical Underwriting Department if required. The effective date for coverage under this plan is assigned by Underwriting.

Dependents are defined as:

1. A subscriber's legally married spouse who is:

   a) Not covered for benefits as a subscriber; and

   b) Not legally separated from the subscriber; or,

2. A subscriber's domestic partner who is not covered for benefits as a subscriber; or,

3. A child of, adopted by, or in legal guardianship of the subscriber, spouse, or domestic partner. This category includes any stepchild or child placed for adoption or any other child for whom the subscriber, spouse, or domestic partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction, who is not covered for benefits as a subscriber, is less than 26 years of age, has been enrolled and accepted by Blue Shield of California as a dependent, and has maintained membership in accordance with the contract.

*Note: Children of dependent children (i.e., grandchildren of the subscriber, spouse, or domestic partner) are not dependents unless the subscriber, spouse, or domestic partner has adopted or is the legal guardian of the grandchild.*

## Member Eligibility and Coverage *(cont'd.)*

Dependent *(cont'd.)*

4. If coverage for a dependent child would be terminated because of the attainment of age 26, and the dependent child is disabled, benefits for such dependent will be continued upon the following conditions:

    a) The child must be chiefly dependent upon the subscriber, spouse, or domestic partner for support and maintenance;

    b) The subscriber, spouse, or domestic partner submits to Blue Shield a Physician's written certification of disability within 60 days from the date of the employer's or Blue Shield's request; and

    c) Thereafter, certification of continuing disability and dependency from a physician is submitted to Blue Shield on the following schedule:

        (1) Within 24 months after the month when the dependent would otherwise have been terminated; and

        (2) Annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the dependent child becomes ineligible for coverage under this plan for any reason other than attained age.

Domestic Partners - Blue Shield's Access+ HMO or Blue Shield POS Group plans include spouse-equivalent dependent coverage for domestic partners and their children as required by law. Although not required by law, Blue Shield's HMO Trio Plan for Individuals and Families (IFP) also includes coverage for domestic partners and their children.

## Member Eligibility and Coverage *(cont'd.)*

### Premium Payment Policy

The member is responsible for payment of premiums to Blue Shield. Blue Shield does not accept direct or indirect payments of premiums from any person or entity other than the member, his or her family members or a legal guardian, or an acceptable third party payor, which are:

- Ryan White HIV/AIDS programs under Title XXVI of the Public Health Services Act;
- Indian tribes, tribal organizations, or urban Indian organizations;
- A lawful local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf; and
- Bona fide charitable organizations and organizations related to the member (*e.g.,* church or employer) when all of the following criteria are met: payment of premiums is guaranteed for the entire plan year; assistance is provided based on defined financial status criteria and health status is not considered; the organization is unaffiliated with a healthcare provider; and the organization has no financial interest in the payment of a health plan claim. (Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a financial interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a financial interest in the payment of health insurance claims.)

Upon discovery that premiums were paid directly or indirectly by a person or entity other than the member or an acceptable third party payor, Blue Shield has the right to reject the payment and inform the member that the payment was not accepted and that the premiums remain due. Payment of member premiums by a Blue Shield contracted provider represents a material breach of the provider's agreement. Please note that processing any payment does not waive Blue Shield's right to reject that payment and future payments under this policy.

## Member Identification (ID) Cards

Subscribers who are enrolled in a Blue Shield Access+ HMO, HMO Trio, or Added Advantage POS Plan are:

- Notified of their Blue Shield coverage
- Provided an *Evidence of Coverage* (EOC) booklet describing their benefits
- Mailed ID cards or are issued cards electronically, depending on the member's preference

The Blue Shield ID card is generally issued prior to the member's effective date. Additionally, an ID card is reissued each time:

- A member's name or the subscriber's ID number changes
- A group or individual's benefit plan changes or the group number changes
- A new primary care physician is selected or designated
- A dependent is added or deleted
- A primary care physician changes IPA/medical group affiliation
- A change in office visit copayment
- A change in ID card information

The ID card contains the following information:

- Subscriber's name and identification number
- Employer/Individual group number or IFP number
- Member's effective date of coverage in their current benefit selections
- Names of the subscriber's enrolled dependents
- Names, telephone numbers and IPA/medical group affiliation of the primary care physician selected by the subscriber and dependents and their effective dates, including an "A+" designation for IPA/medical groups who participate in Access+*Specialist.*
- Subscriber/Member copayment for office visits
- Subscriber's language preference if other than English
- Blue Shield of California's Members Services phone number

## Enrollment Changes

### Adding, Deleting, or Transferring Dependents

All employer group plan changes (except primary care physician change requests) affecting the enrollment of employees and their dependents must be submitted by the employee to the employer group before being processed by Blue Shield within 31 days from the date of the following changes:

- A new dependent is added due to marriage or domestic partnership
- A birth or adoption
- A death of a dependent
- A dependent's health benefits are covered by another health plan

IFP members must complete and send a "Member Change Request Form" to Blue Shield.

### Terminating Coverage

Refer to *Provider Requests to Transfer or Disenroll Commercial Members* (further in this section), for Blue Shield's policy for involuntary transfer or disenrollment of members.

In general, coverage for group or IFP subscribers and dependents terminates when any of the following occurs:

1. The employer group contract terminates.
2. Group member retires or leaves employment (subject to disability, leave of absence and Consolidated Omnibus Budget Reconciliation Act (COBRA) provisions), unless the employer group purchased retiree coverage.
3. Nonpayment of dues.
4. Dependent ceases to qualify as dependent. Dependent may be eligible for COBRA.
5. Subscriber fails to pay any applicable copayments and continues not to pay after written notice by the plan.
6. Member makes repeated and unreasonable demands for unnecessary medical services and continues to do so after written notice by the IPA/medical group or by plan.
7. Member violates any provision of the service contract, and such violations continue after written notice by the plan.
8. Blue Shield determines that the subscriber or dependent committed fraud or intentionally misrepresented any material facts during or after enrollment after written notice was sent.
9. Member moves out of the Blue Shield of California HMO service area. Members under group employer plans may be able to transition to an applicable out of state plan if available by the employer. Subject to eligibility rules and Blue Shield guidelines.
10. IFP member requests to terminate their coverage.

# Enrollment Changes *(cont'd.)*

## Coverage After Termination

### Group Benefits

A group member may be eligible for one of the following types of continued coverage under the terms of the group health plan when eligibility for group coverage would otherwise terminate:

- Federal COBRA
- Cal-COBRA (for employer groups with less than 20 employees)
- Cal-COBRA for individuals who have exhausted benefits totaling less than 36 months under federal COBRA
- Extension of benefits for a "Totally Disabled" member

The IPA/medical group should contact Blue Shield's Provider Customer Service at (800) 541-6652 for additional information about coverage under these extended benefit options.

Blue Shield will notify and capitate the IPA/medical group for any members with extended benefits. The IPA/medical group will continue to provide all medically necessary services.

> *Note: For members receiving coverage under the extension of benefit for a "Totally Disabled" member, services are limited to only those services necessary to treat the disabling condition.*

### Individual Coverage Options

Subscribers and their dependents who are no longer eligible for group coverage may apply for a Blue Shield HMO Trio Plan or a PPO Individual Family Plan (IFP) by completing an IFP application.

# 3.1 Enrollment and Eligibility

## Eligibility Verification

For routine eligibility verification for commercial members, the IPA/medical group may:

- Log onto Provider Connection at blueshieldca.com/provider for current and historical eligibility and benefit information that is updated daily.
- Check the member's ID card; if verifying for Blue Shield Access+ HMO eligibility, check for an "A+" designation next to the name of the IPA/medical group.
- Check the most current monthly eligibility report (see information below).

If eligibility cannot be verified, the provider should obtain written verification that the member agrees to accept financial responsibility if not eligible for Blue Shield coverage.

The provider may use his/her own office form or Blue Shield's Member Acknowledgment of Financial Responsibility Form for this purpose. A copy of this form can be found on Provider Connection at blueshieldca.com/provider under *Guidelines & resources, Forms,* then *Patient care forms*.

In the event the IPA/medical group makes reasonable efforts to confirm eligibility of a member and reasonably relies on the information obtained, the IPA/medical group may seek payment from Blue Shield for these services. For more on procedures to follow when seeking payment under this circumstance, see Section 4.

### Monthly Eligibility Reports

As a cost-effective measure, Blue Shield provides the Combined Eligibility/Capitation Report and the Eligibility Adds and Termination Report only in electronic format. Receiving eligibility information electronically enables IPA/medical groups to use and sort the information in many ways to meet their specific reporting needs.

Blue Shield distributes these eligibility reports via Blue Shield secure email or SFTP to all IPA/medical groups no later than the tenth of each calendar month. For details on the file formats, refer to Appendix 3-A and 3-B in the back of this manual.

Both reports include the member's name and identification number, the member's primary care physician name and identification number, as well as the activity code for all member status changes. The files also include the member's group number and Product IDs. The Product IDs are codes that identify the member's standard office visit copayments. Product IDs and Physician Office Copayment Guides are forwarded each month along with the Combined Eligibility/Capitation Reports.

# Member Primary Care Physician Selection, Assignment, and Change

## Member Primary Care Physician Selection

Commercial members must select a primary care physician (PCP) from *Find a Doctor* on blueshieldca.com during enrollment. If an invalid PCP or no PCP is selected, the member will be assigned a PCP. Each family member may select a different PCP, including pediatricians for children. Family members may have the same PCP, different PCPs within the same IPA/medical group, or PCPs from different IPA/medical groups.

Parents are also expected to select a primary care physician for a newborn or newly adopted dependent, preferably prior to birth or placement for adoption, but always within 31 days from the birth or placement for adoption. The PCP must belong to the same IPA/medical group as the mother's primary care physician when the newborn is the natural child of the mother. If the mother or newborn is not enrolled as a member, or if the child has been placed with the subscriber for adoption, the PCP selected must belong to the same IPA/medical group as the subscriber. If a PCP is not selected within 31 days following the birth or placement for adoption, Blue Shield will assign a primary care physician that belongs to the same IPA/medical group as the natural mother or subscriber. This assignment will remain in effect for the first calendar month during which the birth or placement for adoption occurred. To change the primary care physician after the month of birth or placement for adoption, see the section below on member primary care physician changes. If the child is ill during the first month of coverage, see the section below on changing a primary care physician during the course of treatment or hospitalization.

Members are advised to call the primary care physician or go to *Find a Doctor* on blueshieldca.com before submitting their enrollment applications to confirm that the PCP is still accepting new patients. If the selected PCP is not accepting new patients but the member was already a patient of the PCP before becoming a Blue Shield HMO member, the member may be assigned to the PCP pending the PCP's and IPA/medical group's approval.

## Member Primary Care Physician Assignment

If a commercial member does not select a primary care physician at enrollment or makes an invalid selection, Blue Shield will designate a PCP based on the member's residence and PCP availability and notify the member of the selection. The member has the option to change the Blue Shield-designated primary care physician.

## Member Primary Care Physician Selection, Assignment, and Change *(cont'd.)*

### Member Primary Care Physician Change

Commercial and IFP members may change a primary care physician or designated IPA/medical group by calling Blue Shield's Member Services Department at (800) 218-8601 or by logging in to their member page on blueshieldca.com. The hearing impaired may contact Member Services through Blue Shield's toll-free TTY number at (800) 241-1823. These changes are generally effective on the first day of the month following approval by Blue Shield. Members receive an updated Blue Shield ID card that reflects the primary care physician or designated IPA/medical group change.

Once the primary care physician or designated IPA/medical group change is effective, all care must be provided or referred by the new PCP or designated IPA/medical group, except for obstetrician/gynecologist (OB/GYN) services provided to a female member by an OB/GYN or family practice physician in the same IPA/medical group as the PCP, or to any member under the self-referral provisions of the Blue Shield Access+ *Specialist* benefit.

Voluntary IPA/medical group changes are not permitted during the third trimester of pregnancy or while confined to a hospital. The effective date of the new IPA/medical group will be the first of the month following discharge from the hospital, or when pregnant, following the completion of post-partum care.

Additionally, changing primary care physicians or designated IPA/medical groups during the course of treatment may interrupt the quality and continuity of care. For this reason, the effective date of the transfer when requested during the course of treatment or during an inpatient hospital stay will be the first of the month following the date it is medically appropriate to transfer the member's care to the new primary care physician or designated IPA/medical group, as determined by Blue Shield.

> *Note: Exceptions must be approved by the Blue Shield Medical Director. If the Blue Shield Medical Director approves such a change of IPA/medical group, financial responsibility will be determined by the Division of Financial Responsibility (DOFR) detailed in the IPA/medical group contract.*

# Provider Requests to Transfer or Disenroll Members

## For Commercial Members

Blue Shield policies for involuntary transfer or disenrollment of members are based on Health & Safety Code Section 1365 and California Code of Regulations Section 1300.65. Blue Shield retains sole and final authority to review and act upon the requests from providers to transfer or terminate a member. Members are not transferred against their will nor terminated until Blue Shield carefully reviews the matter, determines that transfer or termination is appropriate, and confirms that Blue Shield's internal procedures as outlined below have been followed. All transfer requests are carefully reviewed, and care is taken to preserve member rights against discrimination due to age, race, gender, or health status.

A Blue Shield HMO IPA/medical group may not end its relationship with a member because of his or her medical condition or the cost and type of benefits that are required for treatment. A member who alleges that an enrollment has been canceled or not renewed because of the member's health status or requirements for health care services may request a review by the DMHC.

## For Access+ HMO Members

### Reasons for Immediate Disenrollment

A Blue Shield HMO IPA/medical group may request that Blue Shield end its relationship with a member for cause, **IMMEDIATELY** after the member receives written notice for any of the following:

1. Abusive or disruptive behavior that:
    a) threatens the life or well-being of plan personnel, or providers of services;
    b) substantially impairs the ability of Blue Shield to arrange for services to the Member; or
    c) substantially impairs the ability of providers of services to furnish services to the Member or to other patients.
2. Providing false or misleading material information on the enrollment application or otherwise to Blue Shield;
3. Permitting use of a Member identification card by someone other than the Subscriber or Dependents to obtain Covered Services; or
4. Obtaining or attempting to obtain Covered Services under the Group Health Service Contract by means of false, materially misleading, or fraudulent information, acts or omissions.

Blue Shield must review any request for an involuntary transfer request. The Blue Shield review, for most situations, looks for evidence that the individual continued to behave inappropriately after being counseled/warned about his or her behavior and that an opportunity was given to correct the behavior. The provider must have made several attempts to provide counseling to the member. A minimum of three (3) documented written warnings must be provided for consideration of an involuntary transfer request. Counseling done by plan providers is considered informal counseling and an initial warning letter related to the member's behavior must also be sent by Blue Shield. Blue Shield requires documentation/medical records from the physician group prior to sending the member an official warning letter from the plan. If the inappropriate behavior was due to a medical condition (such as any mental health issue or a physical disability), the provider must demonstrate that the underlying medical condition was controlled and was not the cause of the inappropriate behavior.

## Provider Requests to Transfer or Disenroll Members *(cont'd.)*

### Procedures for Transfer or Disenrollment

#### IPA/Medical Group Responsibilities

Before requesting to involuntarily transfer a member for cause, the primary care physician must counsel the member verbally and in writing about the problem. Provider warning letters to the member must be sent by the provider via certified mail or courier service to track that the warning letter was received. (A copy of the letter must also be sent to Blue Shield Member Services Department.) If the behavior or problem continues, the provider may request Blue Shield to take steps to counsel the member and initiate the protocols required for the plan to involuntarily transfer the member to another provider or physician group.

Providers are required to submit all documentation related to disruptive members to Blue Shield for review. This documentation includes:

- Documentation of the disruptive behavior, including a thorough explanation of the individual's behavior and how it has impacted the provider's ability to arrange for or provide services to the individual or other members;
- Written warning letters or counseling letters from the provider and/or the physician group showing serious efforts have been made to resolve the problem with the individual;
- Relevant police reports or documentation of intervention by the Police Department (if applicable);
- Documentation establishing that the member's behavior is not related to the use, or lack of use, of medical services;
- Proof that the member was provided with appropriate written notice of the consequences of continued disruptive behavior;
- Member information, including diagnosis, mental status, functional status, a description of his or her social support systems, and any other relevant information; and
- Proof of effort to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act.

The physician's or physician group's request for involuntary transfer or disruptive behavior must be complete. All documentation should be submitted to Blue Shield Member Services.

Please provide Blue Shield with sufficient documentation so that Blue Shield will be able to make a decision based on the evidence. Please send the information to the following address:

Blue Shield of California
Attention: Member Disenrollment
P.O. Box 272550
Chico, CA 95927-2550

# Provider Requests to Transfer or Disenroll Members *(cont'd.)*

## Procedures for Transfer or Disenrollment *(cont'd.)*

Upon receipt of the transfer request and all required documentation, Blue Shield reviews the case and may:

- Decide the evidence is not sufficient to involuntarily transfer the member. The provider or physician group (where applicable) will be notified of the plan's determination.
- Send additional counseling letters to the member describing the behavior that has been identified as disruptive and how it has impacted the plan's ability to manage the individual's care. (Note: If the disruptive behavior ceases after the member receives notice and then later resumes, the disenrollment process must begin again.)
- Request Medical Care Solutions intervention to assist the member in managing their healthcare.
- Transfer the member to another network provider (when the member has been provided appropriate (30-day) written notice and there has been an irreconcilable breakdown in the patient /physician relationship).

*Note: If the transfer request is received verbally by Blue Shield from a primary care physician, the call is transferred to the appropriate Member Services Team Leader who will request the written documentation and forward any pertinent information to Provider Relations and Medicare Compliance, as necessary. A verbal request will still require that the provider send Blue Shield all written documentation related to the member's behavior.*

Blue Shield sends the provider a written notice of its decision. Please note that Blue Shield considers counseling done by the primary care physician or physician group for Blue Shield members as informal notice and only recognizes counseling letters sent from the health plan as formal notification to the member.

*Note: Providers must work with Blue Shield to provide sufficient documentation so that Blue Shield can send a formal warning notice to members.*

- If the provider does not provide adequate documentation to substantiate an involuntary transfer request, Member Services and/or Provider Relations contacts the provider and advises them that they must provide additional written documentation of the issues or events that led to the transfer request.
- If Blue Shield determines that a member transfer is warranted, the member is notified in writing (certified, return receipt) under the signature of the appropriate Blue Shield Member Services department. The transfer notification letter informs the member of the request made by the primary care physician and that the member can select another primary care physician in the same IPA/medical group or (if warranted) in another IPA/medical group. The letter clearly outlines the reasons why the request is being made and informs the member that if they do not select a new primary care physician within 30 days of the date the letter was mailed, a new primary care physician will be selected for them.

  The member will be transferred once the written notice is given and is effective the first of the following month. If applicable, the letter informs the member that Blue Shield may pursue involuntary disenrollment if the events leading to the transfer reoccur. An explanation of the member's rights to a hearing under the Blue Shield grievance procedure is also included in the letter.

## Provider Requests to Transfer or Disenroll Members *(cont'd.)*

### Procedures for Transfer or Disenrollment *(cont'd.)*

- When a member transfers to a new IPA/medical group, the previous provider must supply patient records, reports, and other documentation at no charge to Blue Shield, the new IPA/medical group, provider, or member.
- The existing primary care physician must continue to coordinate care through the date of transfer.

Blue Shield follows regulatory guidelines and retains sole and final authority to review and act upon the requests from providers to transfer a member. Members are not transferred against their will until Blue Shield carefully reviews the matter, determines that transfer is appropriate, and confirms that Blue Shield's internal procedures have been followed. All transfer requests are carefully reviewed, and care is taken to preserve member rights against discrimination due to age, race, gender, or health status.