



Policy and Procedure No: MS 7.5	Revision No: 5
Division: Care Management	
Department: Member Services	
Title: PHC-CA Plan Enrollment and Enrollment Eligibility	
Effective Date: 3/1/2008	
Supersedes Policy No: MS 7.0, MS 7.1, MS 7.2, MS 7.3, MS 7.4	
Reviewed/Revised by: Sandy Johansson	Review/Revision Date: 12/5/2025
Approving Committee: Member Provider Committee	Date: 12/15/2025
Executive Oversight Committee Date: 12/16/2025	

Purpose:

To describe the process PHC California (the Health Plan) uses to enroll a Medi-Cal eligible beneficiary into the Health Plan and the eligibility criteria to enroll.

Policy:

1. The Health Plan shall accept and process enrollment applications from Medi-Cal beneficiaries who meet the following criteria:
 - a. Twenty-one (21) years of age or older
 - b. Have an AIDS diagnosis, AIDS-defining diagnosis, or CD4 count <200 in his/her medical record
 - c. Reside in Los Angeles County (DHCS county no. 19)
 - d. Be assigned one of the following California Department of Health Care Services (DHCS)-issued aid codes:
 - i. Adult and Family: 01, 02, 0E, 2V, 30, 32, 33, 34, 35, 38, 39, 54, 59, 0A, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 5V, 76, 86, 8E, M3, M9, R1
 - ii. Adult and Family Dual: 0A, 0E, 2V, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4W, 54, 59, 5V, 7S, 7X, 8E, 8P, 8R, K1, M3, M7, M9, R1
 - iii. SPD: 10, 14, 16, 18, 1E, 1H, 20, 24, 26, 28, 36, 60, 64, 66, 68, 2E, 2H, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, L6
 - iv. SPD/Dual Eligible: 10, 14, 16, 1E, 1H, 1X, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6X, 6Y
 - v. Adult Expansion: L1, M1, 7U
 - vi. Breast and Cervical Cancer Treatment Program: 0M, 0N, 0P, 0R, 0T, 0U, 0W
 - vii. Long-Term Care/Medi-Cal Only: 13, 23, 53, 63
 - viii. Long-Term Care/Dual Eligible: 13, 23, 53, 63

2. The Health Plan shall enroll Medi-Cal-eligible individuals who are 21 through 49 years of age without satisfactory immigration status (SIS) who meet plan enrollment eligibility requirements listed above.
3. The Health Plan shall verify applicant eligibility prior to submitting the enrollment transaction file to the Department of Managed Health Care Service's (DHCS) enrollment broker (MAXIMUS).
4. The Health Plan shall submit enrollment data to DHCS's enrollment broker daily before the cut-off dates following the MAXIMUS enrollment processing calendar and concurrently advise the DHCS Contract Manager of submitted enrollments.
5. The Health Plan shall provide enrollee coverage beginning on the first day of the calendar month and indefinitely unless the enrollee chooses to voluntarily disenroll, health plan contract expires or terminated, the enrollee loses Medi-Cal eligibility, the enrollee's aid code changes to one not covered under the contract, or the enrollee is disenrolled pursuant to the Health Plan-Initiated disenrollment reasons listed in the Plan Disenrollment Policy.
6. The Health Plan shall utilize Department of Insurance-licensed employee enrollment representatives to enroll eligible Medi-Cal beneficiaries into the Health Plan. The enrollment representatives shall utilize a California Department of Health Care Services (DHCS)-approved enrollment application and DHCS-approved enrollment materials when enrolling eligible Medi-Cal beneficiaries.
7. Upon receipt of the enrollment response file, the Health Plan shall active the enrollee record in its enrollee management system and send newly enrolled beneficiaries their new enrollee materials no later than seven (7) calendar days after the effective date of the enrollee's enrollment.
8. Should DHCS reject an enrollment, the Health Plan shall advise the rejected applicant by telephone and in writing.
9. The Health Plan shall not discriminate against eligible beneficiaries for their race, color, national origin, creed, ancestry, religion, language, age, marital status, sex, sexual orientation, gender identity, health status physical or mental disability.
10. The Health Plan shall provide covered services to a child born to an enrollee for the month of birth and the following month and for a child born in the preceding month of the mother's membership, the health plan shall provide covered services for the first month of enrollment.

Procedure:

1. The Director of Member Services and Call Center Operations or his or her designee is responsible for accepting and processing new enrollment applications from the Health Plan's enrollment representatives. He or she takes the following steps when processing an enrollment application:
 - a. Enter the enrollment data into the Member Services Managed Care Applications Intake Log.

- b. Verify eligibility in the Medi-Cal system and Centers for Medicare and Medicaid Services (CMS) MARx system for those applicants who have Original Medicare as primary payer.
 - c. Verify AIDS diagnosis by contacting the applicant's primary care provider's office, or for applicants who use AHF Healthcare Centers, review the applicant's medical record for the diagnosis details.
 - d. Assuming the applicant is eligible to enroll into the Health Plan, enter enrollment data into the member management system.
 - e. As a quality check, pull the DHCS Enrollment Report sorted by effective date to confirm submission to DHCS was complete.
 - f. Sends an email to the DHCS Contract Manager advising of enrollments submitted for the month.
2. The Associate Director of Data and Information Architecture, Information Technology or designee packages and submits the enrollment file to DHCS's enrollment broker for processing.
 3. The Associate Director of Data and Information Architecture or designee maintains an automated system to download DHCS's monthly and daily enrollment files to the Health Plan's data warehouse.
 4. The Director of Member Services and Call Center Operations or his or her designee reviews the Enrollment Reconciliation Report on a monthly basis before the month end. For enrollments that are accepted, he or she activates the enrollments in the Health Plan's enrollee management system. For enrollments that are rejected by DHCS, he or she contacts the applicant by phone and follows up with a written notice explaining the rejection and why. Should the eligibility information in DHCS's Medi-Cal eligibility portal not support the rejection, he or she will request the assistance of the DHCS Contract Manager to work the enrollment through the Office of the Ombudsman.
 5. The Director of Member Services and Call Center Operations or his or her designee is responsible to assemble and mail new enrollee materials upon confirmation of enrollment. He or she ensures that new enrollee materials are sent pursuant to paragraph 7 in the Policy section of this Policy and Procedure.
 6. The Director of Member Services and Call Center Operations in collaboration with the Health Plan Administrator is responsible for training Member Services agents to answer enrollment enquiries from enrollees and enrollment representatives.
 7. Health Plan Administrator is responsible for including language describing the Health Plan's enrollment and disenrollment policies and procedures in its Membership Guide (Evidence of Coverage and Disclosure Form) following DHCS's model EOC document.

Definitions:

1. Department of Health Care Services (DHCS) or Department: means the single State department responsible for the administration of the Medi-Cal Program, California Children's

Services (CCS), Genetically Handicapped Persons Program (GHPP), and other health-related programs, as provided by statute and/or regulation.

2. Enrollment: means the process by which a Potential Member becomes a Member of Health Plan.
3. Member or Enrollee: means a Potential Member who has enrolled with the Health Plan.
4. Member Handbook or Evidence of Coverage (EOC): means the document that describes the health care benefits and Covered Services that are available to a Member.
5. Potential Member or Potential Enrollee: means a Medi-Cal beneficiary who resides in Health Plan’s Service Area and is subject to mandatory Enrollment, or who may voluntarily elect to enroll, but is not yet enrolled, in a Medi-Cal managed care health plan and is in one of the aid codes found within Exhibit L, Article 1.0.
6. Service Area: means the county or counties that Health Plan is approved to operate in under the terms of this Contract. A Service Area may be limited to designated zip codes (under the U.S. Postal Service) within a county

Monitoring:

This policy is updated, as necessary, and reviewed and approved at least annually by the Member Provider Committee.

Reference:

DHCS Contract 23-30211, Exhibit L, Requirements Specific to Contractor

Regulatory Agency Approvals:

Date	Version	Agency	Purpose	Response
10/17/2023	MS 7.3	Dept. of Health Care Services (DHCS)	2024 Operational Readiness (O/R) R.0102	Approved
11/6/2023	MS 7.3	DHCS	2024 O/R R.0103	Approved
	MS 7.4	DHCS	Update aid codes per Contract 23-30211	Pending

