ALAMEDA COUNTY HEALTH

HealthPAC PLAN:

Eligibility, Applications, Enrollment, and Services Interpretations and Procedures

Effective: January 1, 2026

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HEALTH PROGRAM OF ALAMEDA COUNTY (HealthPAC) PLAN

A. POLICY STATEMENT AND PROGRAM OBJECTIVES:

It is the policy of the County of Alameda to provide comprehensive health care services through a contracted network of health care providers to its medically indigent population. This program is referred to as the Health Program of Alameda County (HealthPAC). Health care services are provided through the HealthPAC Provider Network, which includes Alameda Health System (AHS), Alameda County Health Behavioral Health Department, and community-based organizations. HealthPAC is not health insurance.

The Program objectives are to (1) optimize patient health and well-being by focusing on prevention and proactive health management, (2) control health care costs through a variety of means including reductions in the inappropriate utilization of crisis and emergency services, (3) provide an equitable and uniform method of payment for health services, (4) provide consistency in application of eligibility standards, (5) develop a standardized and coordinated demographic and service database, and (6) more fully empower patients to take a more active role in their own care.

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B. PROGRAM MANAGEMENT:

The HealthPAC Plan, under the direction of the Board of Supervisors, is **administered by the Alameda County Health (ACH)ACH.**

C. SCOPE OF SERVICES:

The **HealthPAC** services are modeled on the Medi-Cal Scope of Services as defined in Section 14132 of the California Welfare and Institutions Code.

See Appendix A, the HealthPAC Division of Financial Responsibility (DOFR) for more information. HealthPAC has an approved formulary (which is hereby incorporated and made part of this Plan by this reference) that is available at https://health.alamedacountyca.gov/healthpac/

- *The HealthPAC formulary is a floor and not a ceiling. HealthPAC providers are required to provide at a minimum the medications outlined in the formulary.*
- *If the Alameda County resident is eligible for full-scope Medi-Cal or Covered California, or enrolled in private insurance, then that person is not eligible for HealthPAC.*

D. ELIGIBILITY:

1. TO BE ELIGIBLE FOR HEALTHPAC COVERAGE, AN INDIVIDUAL MUST:

a. Be a current County of Alameda resident, with proof of residency.
    i. Persons with a valid Visa are not eligible, **and**

b. Age 19 or over, **and**

c. Have a gross monthly household income level between 0% to200% of the Federal Poverty Level (FPL) (refer to Appendix B**,** HealthPAC Federal Poverty Level and Liability Schedule, Appendix C, Guidelines for Determining Family Size, and Appendix D, Using Federal Income Tax Forms to Document Income), **and**

*Interpretations***:**

- *In calculating rental property it is: total rental income minus total mortgage payment minus actual documented expenses, e.g., insurance, utilities, maintenance, etc. May also use previous year tax return to prove rental income, line 8 of Form 1040 along with Schedule E (see Appendix D for more detail). The sum should be divided by 12 to determine gross monthly income.*

- *If an applicant is receiving free board in lieu of rental payment, e.g., he/she manages an apartment unit, then the income for free board would not be considered in calculating income.*
- *Student loans, grants and scholarships are not counted as income.*
- *Care expenses are not deducted from income. This includes but is not limited to alimony, child/elderly support.*
- *When social security benefits are used to establish income, the gross monthly income is the social security income before the Medicare premium is deducted.*
- *For those persons who present a U.S. Individual Income Tax Return, IRS Form 1040 as proof of income (to prove self-employment income only), income should be determined by referring to line 8 on Form 1040 along with Schedule C (see Appendix D for more detail). The sum should be divided by 12 to determine gross monthly income.*

d. Not be enrolled in or eligible for full-scope Medi-Cal,

e. Not be enrolled in or eligible for Covered California[1] (whether the enrollment period is open or not) **and**

f. Not be enrolled in private insurance.

g. Enrollment is voluntary.

h. Enrollment discrimination is prohibited.

E. APPLICATION:

1. SCREENING FOR THE HEALTHPAC APPLICATION:

The HealthPAC Provider Network and enrollment sites determine HealthPAC eligibility using HealthPAC Connect (HPACC), the web-based eligibility and enrollment system of record for HealthPAC.

Interpretation: Applicants may apply for and be enrolled in HealthPAC (i.e., issued a HealthPAC card) without seeking services. Since the applicant includes full household information as a part of the HPACC process, these other household members are considered for and, if eligible, may be enrolled in HealthPAC.

a. All reasonable efforts should be made to initiate HealthPAC applications prior to the clinical appointment to ensure HealthPAC coverage.

[1] *Individuals who did not sign up for Covered California during open enrollment and do not have a change of circumstance must wait until the next open enrollment period and are not eligible for HealthPAC.*

i. Eligibility for ***unscheduled*** services, i.e., ER/UC should be determined at time of service unless previously enrolled.

ii. Assistors are prohibited from handling any applications for themselves, their relatives, friends, fellow employees, or acquaintances.

Interpretation: Any such application should be referred to a supervisor. If an assistor erroneously begins an application in HPACC involving a relative, friend, fellow employee, or acquaintance, the assistor shall immediately notify his/her Supervisor. The Supervisor will decide if the application needs to be transferred to another assistor or to the ACHACH offices for completion.

b. During the application process, the applicant is required to choose a medical home. Participants can change their medical home at any time by calling HealthPAC customer service.

c. As part of the application process the application assistor will inform applicants of how to report a complaint or problem.

d. Approved applications are randomly audited by ACH staff. If an approved application is missing verification documentation, it may be returned to the application assistor. The application assistor has 45 calendar days to complete and return the application to the auditor. If the approved application is not modified, the member may be disenrolled.

2. DISENROLLMENT NOTIFICATION:

a. Disenrolled participants may request a disenrollment letter from an assistor or by contacting customer service confirming that they are no longer in HealthPAC. The letter will clearly state the effective date and the reason(s) for the disenrollment.
b. HealthPAC provider sites can use HPACC to verify a participant's HealthPAC program status at the time of service or for billing purposes. HPACC will indicate if a participant has been disenrolled and display the disenrollment effective date.

F. ENROLLMENT:

1. ENROLLMENT PERIOD:

The enrollment period for HealthPAC will be for a one-year period.

The enrollment period starts on, and dates back to the first day of the month in which the application was started.

Interpretation:

- *HealthPAC enrollment is for one year. For example, if a person is enrolled on 10/15/23, then his/her enrollment starts on 10/1/23and is good through 9/30/24.*
- *After a year, there will be a redetermination for renewal. Applicants must bring in new income documentation and verify residency. If this is not done within the renewal month, the enrollment period will end and the person will be disenrolled from the program.*
- *Renewals can be undertaken up to 60 days prior to the renewal month. For example, if the enrollment date starts on 10/1/24; renewals can begin as early as 8/1/24.*
- *HealthPAC enrollment must be honored regardless of the enrollment entity, i.e. a provider must honor the enrollment even if a different agency completed the application. If the provider does not have the capacity to take on new patients, the provider must report themselves as "closed" via the HealthPAC customer service line.*
- *ACH will provide HealthPAC eligibility tapes via an 834 file to providers with valid enrollment periods.*

2. DOCUMENTATION REQUIREMENTS:

a. Enrollment in **HealthPAC** requires documentation to prove identity, income, and Alameda County residency (see Appendix E, HealthPAC Verification Documents, and Appendix F, HealthPAC Statement of Income and Residency).

Interpretation:

- *All reasonable efforts will be made to obtain required documentation. When documentary evidence is required but is unavailable and all other verification attempts that have been attempted are unsuccessful, then a sworn affidavit (HealthPAC Statement of Income and Residency) signed under penalty of perjury by the applicant is acceptable.*
- *Self-declaration for income is allowable if no other documentation is available.*

3. RETROACTIVE ENROLLMENT:

a. There is **no** retroactive eligibility for **HealthPAC**. In other words, the enrollment begins no sooner than the first of the month of the application as described above in F.1.

4. SERVING PARTICIPANTS:

a. HealthPAC eligibility determined **for any participant** by **any** provider within the HealthPAC **outpatient** provider network shall be honored by all providers within the HealthPAC **outpatient** provider network for the duration of the eligibility

determination period if there has been no change of circumstance impacting eligibility.

b. All new HealthPAC participants will receive an identification card indicating membership and a designated medical home chosen by the participant. A HPAC ID card can be generated and printed at the time of program approval via HPACC. Primary care services will be provided by the medical home provider. Specialty, emergency room, and inpatient services will be provided by Alameda Health System.

c. A medical home provides:
    i. Enrollment and renewal assistance in HealthPAC.
    ii. A primary health care contact who facilitates the participant's access to preventive, primary, specialty, behavioral health, or chronic illness treatment, as appropriate.
    iii. An intake assessment of each new participant's general health status.
    iv. Referrals to qualified professionals, community resources, or other agencies as needed.
    v. Care coordination for the beneficiary across the service delivery system, as agreed to between the medical home and the County. This may include facilitating communication among participant's health care providers, including appropriate outreach to mental health providers.
    vi. Care management, case management, and transitions among levels of care, if needed and as agreed to between the medical home and the County. This includes arranging the Participants' follow-up appointment and short-term refill of medications associated with an inpatient stay.
    vii. Use of clinical guidelines and other evidence-based medicine when applicable for treatment of the participant's health care issues and timing of clinical preventive services.
    viii. Focus on continuous improvement in quality of care.
    ix. Timely access to qualified health care interpretation as needed and as appropriate for participants with limited English proficiency, as determined by applicable federal guidelines.
    x. Health information, education, and support to beneficiaries and, where appropriate, their families, if and when needed, in a culturally competent manner.

d. Primary Care and related pharmacy, radiology and laboratory services are provided by the patient's medical home. Specialty, inpatient, and emergency services (and related pharmacy, radiology, and laboratory) are provided by the Alameda Health System. If Alameda Health System hospitals do not provide a covered specialty or inpatient service, AHS will contract out to another provider.

e. Specialty behavioral health services are provided through Alameda County Behavioral Health Department (BHD) or a contractor of BHD and include, but are

not limited to outpatient mental health visits, group therapy, crisis intervention and psychiatric medications. Once a patient is stabilized (either by County specialty mental health or AHS), and sent back to primary care, the care and related pharmacy services are the responsibility of the medical home.

5. DISENROLLMENT:

a. HealthPAC participants can voluntarily disenroll anytime during their enrollment period by contacting their medical home or HealthPAC Customer Service.

b. A participant can be disenrolled from **HealthPAC at any time** for the following reasons:
   i. He/she/they no longer meets the Federal Poverty Level requirement
   ii. He/she/they no longer meets the Alameda County residency requirement
   iii. He/she/they provided false information at the time of enrollment
   iv. He/she/they is deceased.
   v. He/she/they is enrolled in private insurance
   vi. He/she/they is enrolled in or becomes eligible for Medi-Cal
   vii. He/she/they is enrolled in or becomes eligible for Covered California
   viii. He/she/they requests disenrollment
   ix. His/hertheir application is audited and determined to be incomplete

Interpretation: To complete disenrollment, notification of disenrolled individuals should be sent from the community-based organizations or AHS to the HPACC help desk.

Disenrollment dates cannot be prior to a member's enrollment period even if their change in circumstance happened prior to their enrollment start date. For example, a member has an enrollment period of 1/1/22 – 12/31/22 but the member was enrolled in Medi-Cal effective 11/1/21, the latest disenrollment date would be 1/1/22.

c. Disenrollment discrimination is prohibited.

G. <u>FINANCIAL LIABILITY:</u>

1. HealthPAC eligible participants may be responsible for a co-payment at the time of service (refer to Appendix B, HealthPAC Federal Poverty Level and Liability Schedule). Providers will be responsible for collection of a co-payment and for determining the rules governing collection of these fees.

2. HealthPAC participants eligible for specialty mental health services may be responsible for an UMDAP (Uniform Method of Determining Ability to Pay) amount that may or may not exceed the HealthPAC co-payment amount *(refer to Appendix B, HealthPAC Federal Poverty Level and Liability Schedule)*. UMDAP is mandated by Sections 5709 and 5710 of

the California Welfare and Institutions Code. The UMDAP amount is based on a sliding fee schedule that determines an annual fee for a family, regardless of the type of mental health service or the number of visits, and is based on family size, assets and income. All HealthPAC participants receiving mental health services are liable for this annual amount.

3. HealthPAC participants who receive bills for services rendered outside of the HealthPAC provider network other than the co-payment or UMDAP liability are financially responsible for these bills. Per program rule, HealthPAC does not cover services rendered outside of the HealthPAC provider network (refer to Appendix A, HealthPAC DOFR).

4. HealthPAC participants that receive bills for covered services rendered in the HealthPAC provider network should contact their medical home or HealthPAC customer service. Covered services may be provided at HPAC provider sites or through a contractor referral arrangement with an outside provider when the covered services cannot be provided by the HPAC provider.

5. HealthPAC eligible persons who have a referral from the Public Health Department that requires a mandated Public Health Service shall have their HealthPAC co-payment waived. This includes assessment, evaluation, and treatment for: outpatient Tuberculosis (TB), sexually transmitted diseases (STDs), immunizations, vaccine preventable diseases, enteric infections and other acute communicable disease related medical services for cases and suspected cases and contacts.

H. AUDIT PROTOCOL:

HealthPAC application audits will be randomly conducted remotely via the ACH centralized eligibility and enrollment database (HPACC). Audits will be comprehensive and will include, but not be limited to the following:

1. Review of verifications of identifications.
2. Review of verifications of income.
3. Review of verifications of Alameda County residency.
4. Review of current Medi-Cal and/or Covered California eligibility or coverage or non-compliance with enrollment.
5. Review of consent signatures and dates.

Based on audit results, HealthPAC administration will develop a report with key findings that will be used to improve Assistor training and provide technical assistance.

I. QUALITY MEASUREMENT AND IMPROVEMENT:

Alameda County Health will objectively monitor and evaluate the quality, appropriateness, and outcome of care and services delivered to participants of HealthPAC (see Appendix G, HealthPAC Quality Measurement and Improvement Plan).