CenCal Health Member Eligibility
Frequently Asked Questions (FAQ)

CenCal Health currently serves over 200,000 residents in our service area of Santa Barbara and San Luis Obispo counties. The Department of Social Services and Social Security Administration, using income and property guidelines, determine Medi-Cal eligibility. Eligible Medi-Cal members are automatically inscribed into our program by the State of California.

What services does CenCal Health's Member Services Department provide?

Members Services assist members with the following:

- Understanding how the Health Plan works
- Selecting a Primary Care Provider (PCP)
- Finding a specialist
- Benefit education
- Filing a complaint or appeal
- Arranging interpreter services
- Scheduling appointments
- Replacing Health Plan Identification Cards

REMINDER: Always verify a member's eligibility status prior to treatment!

All providers are urged to verify member eligibility and PCP assignment (or Special Class status) prior to rendering services. This will serve to:

- Reinforce case management
- Avoid possible referral/authorization/claims problems
- Identify instances of member misrepresentation

Who are Medi-Cal (SBHI & SLOHI) Special Class Members?

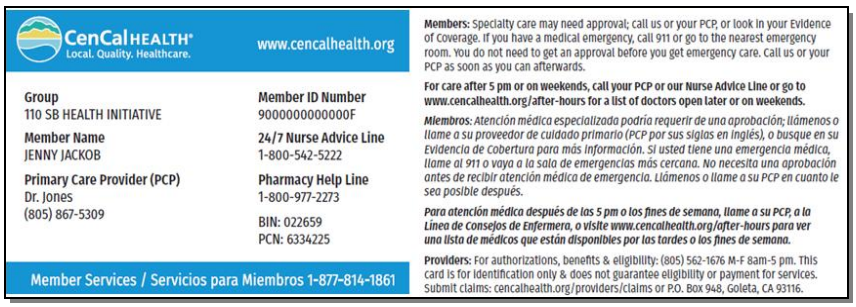
Members who are Special Class can be seen by any SBHI/SLOHI provider who is willing to see them. Special Class members should be considered fee-for-service. Special Class Members will be assigned to CenCal Health; therefore, they do not require Referral Authorization Forms (RAFs), they may require Authorization Requests when appropriate.

Categories for Special Class include:

- The first month of eligibility
- Members that reside in long-term care facilities (skilled nursing or institutions for the developmentally disabled)
- Members who have met their share-of-cost
- Members in Hospice
- Members that reside out of county
- Members that are eligible under the Genetically Handicapped Persons Program
- Members that are eligible under the Breast and Cervical Cancer Treatment Program

Are CenCal Health members issued ID cards?

Yes, CenCal Health members receive a CenCal Health Identification Card shown below. The group listed indicates the program under which the member is covered. Other information printed on the card includes member name, ID number, PCP name and PCP phone number. These cards are issued only once, and are reissued only when information on the card changes. These cards are intended to be a means of identification only. **They are not considered proof of eligibility.**



The State also issues a permanent, plastic ID card for all Medi-Cal members called the "Benefits Identification Card" or BIC. Currently there are two versions of the BIC that members may present (see examples below).

The BIC is a permanent card, which does not provide proof of eligibility. Providers must verify eligibility information using the information on this card through one of the various options made available

How do I verify member eligibility?

Providers can access CenCal Health eligibility information using two options.

Via CenCal Health Website: www.cencalhealth.org
You can verify eligibility for CenCal Health members as well as State Medi-Cal members through our Provider Portal online at Provider Only (Restricted) (cencalhealth.org).

First, the provider must have an active web account. To create a web account or to see who can grant you access within your organization, please contact webmaster@cencalhealth.org. Users can access our Provider Portal User Guide for instructions on how to manage the online Eligibility tool. If the member is not eligible through CenCal Health, you have the option to check with DHS for further eligibility information.

A representative of the Member Services Department can provide information for CenCal Health eligible members. Be prepared to give the provider identification number (PIN or NPI) **Toll Free Number (877) 814-1861**

Medi-Cal Eligibility Verification options available through the State

Options for eligibility verification currently made available by the State do not take into account the need for SBHI and SLOHI providers to verify a member's PCP. PCP affiliation is important, as Referral Authorization Forms (RAFs) from the PCP are needed for most specialty services.

Automated Eligibility Verification Service (AEVS)

AEVS (800) 456-2387 is a free telephone service provided by the State for Medi-Cal providers. AEVS requires the use of your Provider Identification Number (PIN).

What are Aid Codes?

An aid code is the two digit alphanumeric number, which is used to assist in identifying the types of services for which Medi-Cal recipients are eligible.

What if I see a Medi-Cal member that is not enrolled in SBHI or SLOHI?

CenCal Health is a State contracted Medi-Cal Managed Care plan which delivers care in San Luis Obispo and Santa Barbara counties. If a member resides in a different county, they may be eligible with another County Managed Care plan. Please check with the Managed Care plan in the county the member resides for eligibility and guidelines. If the member is eligible with State Medi-Cal, you can bill Affiliated Computer Systems (ACS) following State Medi-Cal guidelines.

Is a CenCal Health member eligible to see a doctor out of county?

If a member is outside of the health plan's service area (Santa Barbara and San Luis Obispo Counties) and needs medical services, they are instructed to call their PCP unless it is an emergency or urgent situation. If it is an emergency or urgent situation, they may go to the nearest urgent care facility, emergency room or call 911. For non-urgent issues, a member's PCP must authorize (with a RAF) any medical care. It is the Provider's responsibility to check eligibility and obtain a RAF from the assigned PCP. Providers must be Medi-Cal* certified in order to be reimbursed.

**Out of State providers need to be Medicaid certified*

What is Share of Cost?

Share of Cost (SOC) is a monthly dollar amount which a patient is required to pay before he/she becomes eligible with Medi-Cal and SBHI/SLOHI. The SOC amount is based on criteria supplied by the patient to his/her Eligibility Worker at the Department of Social Services.

CenCal Health is not involved with determining SOC or eligibility. SOC is only applicable to Medi-Cal and SBHI/SLOHI.

(Note: If the member does not have any medical expenses for a particular month, no SOC is paid)

Is a Share of Cost (SOC) a Co-Pay?

No, a Medi-Cal recipient's SOC is similar to a private insurance plan's out-of-pocket deductible. This SOC is monthly and is based on the amount of income a recipient receives in excess of "maintenance need" levels (determined by the State). Medi-Cal rules require that recipients pay income in excess of their "maintenance need" level toward their own medical bills before Medi-Cal begins to pay.

To whom does the member pay a SOC payment?

A patient can pay or make a payment plan for his/her SOC with any Medi-Cal provider. SOC can also

be met with providers who are not Medi-Cal certified. In this case, the member must get a receipt with the following information: provider name pre-printed company letterhead, procedure code, date of service, and total amount paid. The patient must take this to his/her Eligibility Worker to have applied towards SOC. Additionally, the patient can pay providers who are not medical providers (such as dentists), or pay for services which are not normally Medi-Cal benefits such as non-formulary medications and circumcisions.

What does "payment plan" mean?

If a patient cannot pay the total SOC amount or has a large SOC and needs to make payments, the patient can make a payment plan with the provider. The payment arrangements that are made will be entirely between the patient and the provider. CenCal Health does suggest that this agreement be made in writing.

SOC patients are considered 'cash pay' patients until SOC is met for a particular month. If the member does not fulfill an obligation, your office policy for "nonpayment" can apply. CenCal Health is not responsible and cannot be billed.

Important: When arrangements are made to accept payments for SOC amount owed, the entire SOC amount owed should be cleared immediately. Providers should never wait to clear the SOC until the entire amount is paid. This may keep the patient from obtaining other medical services if needed.

How do I apply or clear SOC?

Providers collect payments from the patient or accept the patient's payment plan to pay for services that are rendered up to this SOC amount. Providers should immediately submit a SOC clearance transaction to the State www.medi-cal.ca.gov/mcwebpub/login.aspx

Providers must have a Medi-Cal provider number, PIN number and have a Medi-Cal Point of Service (POS) Network/Internet Agreement form on file. Please call the Telephone Service Center (TSC) at 1-800-541-5555 for more information.

A provider's failure to immediately clear the patient's SOC may prevent the patient from receiving necessary services or medicine, despite having fulfilled the SOC obligation.

Why does a patient's SOC amount change?

Depending upon fluctuations in the patient's monthly income, SOC amounts may change from month to month. Additionally, if a patient's SOC is partially met by multiple providers, different 'remaining' SOC amounts will appear during eligibility verification, until the total SOC is satisfied for that month.

CenCal Health strongly suggests verifying eligibility at every visit to get updated SOC information.

Do SOC recipients have PCPs?

No, once a patient does meet the total SOC obligation, they will become an SBHI/SLOHI member and be classified as Special Class (not case managed). The member PCP will be indicated as "CenCal Health" when verifying eligibility via CenCal Health's Provider Portal.

What is an LTC SOC?

This type of SOC is associated with a Long Term Care (LTC) Facility. This SOC is paid to the nursing facility by the patient before the LTC can send a claim to Medi-Cal for the remaining difference. This SOC is always handled by the LTC on their monthly billing, other medical providers are not affected. If you are not an LTC provider, do not charge a SOC to the patient who resides in a LTC.

Do I need to submit a TAR for approval if the patient has a SOC?

If the total SOC amount will not cover the full billed charges and the SBHI/SLOHI allowable payment for the provider would be higher than the SOC amount, providers should follow the usual procedures for TAR approval. This authorization and a cleared SOC will allow you to bill CenCal Health the difference.

Example: Member has a SOC of $50.00. The billed charges for the TAR required procedure are $250.00. SBHI/SLOHI allowable is $150.00. You will need to submit a TAR for authorization, spend down the SOC and after TAR is approved, and member is eligible with SBHI/SLOHI, bill SBHI for the remaining balance owed. SBHI/SLOHI pays up to the allowable, minus the SOC payment.

Do I submit a claim for a SOC patient?

If the patient's SOC equals or exceeds your total charges, do not submit a claim to CenCal Health. The paid/obligated SOC is considered to be your full payment and CenCal Health will not pay you more than that amount.

When the SOC payment you receive is less than the SBHI/SLOHI/Medi-Cal allowable and the patient's SOC has been met, making them eligible, then there will be additional payment consideration. If you do submit a claim, you will need to enter the SOC information (see "Where to Put SOC").

Where do I put the SOC information on the claim?

Medical & Allied Health Providers
On the CMS 1500 claim forms enter the amount paid in Box 29

For provider's who bill on UB-04 Claim Forms
On the UB-04 claim forms enter the amount paid in Box 39-41 (value codes amount).

You can refer to pages 'share' in your EDS Provider Manual for more details