Section G: Eligibility Verification and Enrollment

G1: Eligibility Verification and Enrollment

CenCal Health currently serves approximately 232,000 residents in our service area of Santa Barbara and San Luis Obispo counties.

The Department of Social Services (DSS) and/or each counties Social Security Administration determine SBHI and SLOHI eligibility, not CenCal Health.

CenCal Health's Member Services Department can assist with:

- 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
- Transportation needs for those members that qualify
- Translation and Alternative Format Services
- Help creating a personal account on our member portal

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, and identify instances of member misrepresentation.

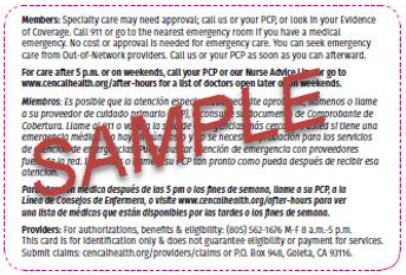
SBHI/SLOHI contracted provider who is willing, can see members who are Special Class. Special Class Members are considered fee-for-service and are assigned to CenCal Health; therefore, they do not require Referral Authorization Forms (RAFs), though they may require a Prior Authorization Request when 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 qualified under the Genetically Handicapped Persons Program

CenCal Health members receive an Identification Card, as shown below. The group lists 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. The back of the card will also have important numbers for emergency care, after-hours care and the 24/7 Nurse Advice Line. These cards are issued only once, and are reissued only when information on the card changes. These cards are intended only to be a means of identification. 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.

Verify Member Eligibility

Providers can access CenCal Health eligibility information using two options.

Option 1: Via CenCal Health Website: www.cencalhealth.org
You can verify eligibility for CenCal Health members as well as State Medi-Cal members through our website. First, the provider must have an active web account. To create a web account, contact providerservices@cencalhealth.org. Once you are logged into the restricted 'For Providers' section, click the Eligibility tab on the left-hand side, enter the CenCal Health Member ID and date of service. If the member is not eligible through CenCal Health, you have the option to check with DHCS for further eligibility information.

Option 2: Via CenCal Health's Member Services Department: Toll-Free Number (877) 814-1861, select option 3. A representative of the Member Services Department can provide information for CenCal Health eligible members. Be prepared to give your provider's identification number (NPI).

Medi-Cal Eligibility Verification options available through the State

Note: 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).

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.

Medi-Cal member that is not CenCal Health SBHI or SLOHI Plan
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.*

G2: Share of Cost (SOC)
Share of Cost (SOC) is a monthly dollar amount, which a patient is required to pay before they become eligible with Medi-Cal. The SOC amount is based on the income information supplied by the patient to their Eligibility Worker at the Department of Social Services.

CenCal Health is not involved with determining SOC or eligibility.
(Note: If the member does not have any medical expenses for a particular month, no SOC is paid)

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.

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 their Eligibility Worker to have the paid amount applied towards their 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.

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; this is sometimes call obligating the SOC. The payment arrangements will be entirely between the patient and the provider. CenCal Health does suggest that this agreement be in writing.

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.

SOC patients are considered 'cash pay' patients until their 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.

When does a SOC patient become Medi-Cal eligible?

When the patient meets their monthly SOC and the provider clears the SOC amount. This means a patient's total SOC amount is paid and the provider has applied or cleared SOC with the State.

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 using either of the methods below.

State Medi-Cal Website Clearance: mcweb.apps.prd.cammis.medi-cal.ca.gov/transaction/services

Must have a Medi-Cal provider number, PIN number and have a Medi-Cal Point of Service (POS) Network/Internet Agreement form on file. For information on Provider Enrollment, visit the Provider Enrollment page https://files.medi-cal.ca.gov/pubsdoco/prov_enroll.aspx

Please call the Telephone Service Center (TSC) at (800) 541-5555 for more information. A provider's failure to clear the patient's SOC immediately may prevent the patient from receiving necessary services or medicine, despite having fulfilled the SOC obligation.

(Remember, the State, not CenCal Health clears the SOC. Although CenCal Health has the ability to transmit this information to the State, records are not kept in our database. We strongly suggest that you print out the information and place in the member's file.)

Changes to a patient's SOC amount

Depending upon fluctuations in the patient's monthly income, SOC amounts may change from month to month. Additionally, if a patients' 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, the recipient will not have a PCP. Once a patient meets the total SOC obligation, they will become an SBHI/SLOHI member and will be classified as "Special Class" (not case managed). The member's PCP will appear as "CenCal Health" when verifying eligibility.

Long Term Care members with 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 an 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.

Submitting 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 the full payment and CenCal Health will not pay more than that amount.

Only 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 do I put the SOC information" below).

Medical & Allied Health Provider Claim details

On the CMS 1500, claim forms enter the "claim codes" in box 10D and amount paid in Box 29.

For providers who bill on UB-04 Claim Forms

On the UB-04, claim forms enter the amount paid in Box 39-41 (value codes amount).