Medi-Cal

Individuals and families apply for Medi-Cal through their county Human Services/Social Services Department and through Covered California. Applications may be done in person, online, through the mail or over the phone. Individuals who receive Supplemental Security Income (SSI) automatically receive Medi-Cal along with their SSI benefit.

Eligibility for Medi-Cal is month to month. Medi-Cal recipients must re-certify their eligibility periodically. It is not uncommon for individuals or families to lose Medi-Cal eligibility and then regain it at a later date. Eligibility for Medi-Cal can also be effective retroactively in some cases. Please note that a member's eligibility must be verified ***before delivery of services*** and that the Alliance identification card *alone* is **not** a guarantee of eligibility.

Eligibility for CCS is determined by the County CCS program in the county in which the member resides, CCS eligibility information is available in the State Children's Medical Services Network (CMS Net) Provider Electronic Data Interchange (PEDI) and is visible in the Alliance portal.

Timing of Eligibility through Fee-For-Service Medi-Cal and the Alliance

Not all Medi-Cal beneficiaries in Santa Cruz, Monterey, and Merced counties are Alliance members. Those that are not Alliance members are eligible under the Medi-Cal Fee-For-Service system (FFS Medi-Cal). Providers seeing these beneficiaries would bill and be reimbursed directly for covered services by Affiliated Computer Services, the state Medi-Cal fiscal intermediary. Any necessary prior authorization for elective services (referred to as an "Authorized Referral Request," formerly known as "Treatment Authorization Request" or "TAR") for Medi-Cal beneficiaries not covered by the Alliance should be submitted to the Medi-Cal field office, not to the Alliance.

FFS Medi-Cal beneficiaries with CCS eligible conditions are not Alliance members. Providers seeing these beneficiaries would bill and be reimbursed directly for covered services by Electronic Data Systems (EDS). Any necessary authorization for CCS services (referred to as a "Service Authorization Request") for FFS Medi-Cal beneficiaries with CCS eligible conditions should be submitted to the local county CCS Program

Newly eligible Medi-Cal beneficiaries are covered through FFS Medi-Cal for at least their initial month of eligibility and, depending on when during the month they became eligible, could be covered under FFS for the following month as well. If they requested and received eligibility for any prior months, known as retroactive eligibility, those months would also be covered through FFS Medi-Cal. Newly eligible Medi-Cal beneficiaries will not become Alliance members until the first of the month following their enrollment as long as their eligibility is processed in time to be transmitted to the Alliance by the state in a month end eligibility file. For example:

A Medi-Cal applicant is determined eligible on June 3: Once eligibility is determined, eligibility will be effective as of June 1. The beneficiary will be covered through FFS Medi-Cal for the month of June. Alliance enrollment will begin on July 1.

A Medi-Cal applicant is determined eligible on June 26: Once eligibility is determined, eligibility will be effective as of June 1. The beneficiary will be covered through FFS Medi-Cal for the months of June and July. Alliance enrollment will begin on August 1.

In addition, the Alliance may be responsible for services provided to an Alliance Medi-Cal member whose annual eligibility redetermination occurs within 60-days after the member's annual eligibility redetermination date. If the member completes the redetermination process within 60 days after their eligibility redetermination date, their eligibility will be made retroactive to that date and the member will be covered by the Alliance for the entire period. The member would not be considered "newly eligible." If the member allows his or her benefits to lapse for more than 60 days from their annual renewal date, he/she would be considered newly eligible upon re-enrollment, with any period of retroactive eligibility covered by FFS Medi-Cal.

Providers should always verify eligibility ***prior to rendering services***, to ensure eligibility and find out if coverage is through FFS Medi-Cal or the Alliance.

How to Verify Eligibility with the Alliance

Member eligibility verification is available online through the Provider Portal. If you have not used this feature in the past, you should complete the Provider Portal Account Request Form to register to use the Provider Portal. A link to the state Medi-Cal website is also accessible on our website in case you need to verify FFS Medi-Cal status.

The online and automated eligibility systems will provide you with the following information:

- Eligibility status for the date(s) of service requested.
- Name of the member's PCP or notification that the member is an administrative member.
- Other health coverage the member may have (if applicable and if the Alliance is aware of coverage).
- The member's eligibility for CCS (if applicable).
- A confirmation number.

Other ways to verify eligibility are:

- Call (800) 700-3874 ext.5501 for the 24-hour interactive voice-response eligibility verification line.
- Call the Alliance Member Services department at (800) 700-3874 (Mon–Fri, 8 a.m. - 5:30 p.m.). Eligibility can be verified for a *maximum of three members* at a time; please note that no confirmation number will be given.

When you telephone, please provide *all* of the following:

- The member's full name.
- The member's Alliance Member ID number or Social Security Number. If you do not have either of these, you must provide the member's date of birth.
- Date(s) of service for which you want to check eligibility.

Please note that eligibility information is available for the current month and the preceding 11 months; we cannot check eligibility for dates of service past one year, nor can we verify eligibility for future dates of service. Remember that not all Medi-Cal beneficiaries will be Alliance members. If you cannot verify eligibility for a Medi-Cal member through the Alliance, swipe the Benefits Identification Card (BIC) or check the DHCS website; results should tell you if your patient is eligible for Medi-Cal but not covered under the Alliance. **The Alliance is not able to verify eligibility for Medi-Cal beneficiaries who are not Alliance members.**

If you are a PCP, you may also check your Alliance Member List through your Provider Portal account.

Administrative vs. Linked Member

A "linked" member of the Alliance is an individual who has selected or been assigned to a PCP. An "administrative member" is a member who is not assigned to a specific physician or clinic and, therefore, may see any willing Medi-Cal provider within the Alliance's Service Area. Administrative members will have "Administrative Member" listed on their Alliance ID cards in the PCP section, rather than the name of a doctor or clinic. Newly eligible Alliance members will have "Administrative Member – Newly Eligible" on their ID cards in the PCP section. Categories of administrative members include:

Share of Cost — A member who has Medi-Cal with a share of cost.

Long Term Care — A member who is residing in a skilled or intermediate-care nursing facility for more than 30 days after the month of admission.

Out of Area — A member who resides out of the Alliance's service area but whose Medi-Cal case remains in Santa Cruz, Monterey or Merced counties. These may include out-of-area foster-care or adoption-assistance placements and long term care placements. They would also include members who have moved out of area and are in the process of having their Medi-Cal case transferred to their new county.

Newly Eligible — A member in the first month of eligibility as an Alliance member who may see any willing Medi-Cal provider within the Alliance's service area until they have chosen or been assigned to a PCP.

Other Health Coverage (OHC) — A member who has other health insurance that is primary to their Medi-Cal; this includes members with both Medi-Cal and Medicare, as well as members with both Medi-Cal and commercial insurance. Alliance members with other health coverage must access care through their primary insurance. Except for dual eligibles (members with Medicare and Medi-Cal), an Alliance member with OHC does not become an administrative member until after the Alliance has verified their other health coverage.

The change of a member's status from linked to administrative is not automatic — the Alliance must be informed of the member's circumstances by the provider or the member in order to make the change in status. If you feel a member's status should be changed to administrative for medical reasons you may submit a Request for Administrative Member Status form. You may also contact our Health Services Department at (800) 700-3874 ext. 5512.

If you have information that an Alliance member has other health coverage (OHC) not reflected in the Alliance's system, please provide the information on the OHC using the Provider OHC Referral Form on the Finance section of the Form Library page of the Alliance provider website. You may also submit the Explanation of Benefits from the primary payer along with your claim when you bill the Alliance as secondary.

For other non-medical reasons for a change in member status, please contact the Member Services Department at (800) 700-3874.

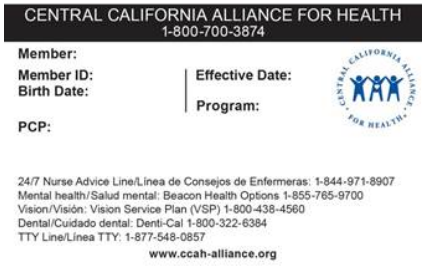
Claims for services rendered to administrative members must be sent to the Alliance. If the member has other health coverage, in addition to Medi-Cal, the claim should be sent first to the primary payer. All covered services that the Alliance is responsible for that are provided to administrative members are reimbursed by the Alliance on a fee-for-service basis.

For more information about administrative members, please see Policy 200-5000 - Administrative Member Status for Medi-Cal Members.

Member ID Card

The state of California issues a plastic Medi-Cal ID card known as the Benefits Identification Card, or BIC. The BIC shows the member's name, date of birth, 14-digit identification number and the card issue date. Use this information to verify eligibility with the state or with the Alliance (the Alliance uses the first nine digits of the Medi-Cal ID number as the Alliance Member ID number). The county Social Services Department may issue a temporary, emergency "paper card" when the member cannot wait for the state to issue the BIC.

The Alliance also issues an ID card to members, an example of which is shown below.



The Alliance ID card is a black and white card that identifies Medi-Cal recipients as Alliance members; however, this ID card is *not a guarantee of eligibility or payment for services*. It is the responsibility of the provider to verify eligibility before providing services. Both eligibility and PCP linkage are subject to change. The provider is responsible for verifying eligibility for each date of service in which services are rendered. The Alliance member ID number has nine digits, starting with the number "9" and ending with a letter. Use this number to verify eligibility with the Alliance.

Alliance Medi-Cal members who are required to pay a share of cost (SOC) do not receive an Alliance ID card until they have met their SOC for the first time. Once a member meets his/her SOC for the first time, he/she will receive an Alliance ID card.

Out-of-Area Medi-Cal Beneficiaries

Medi-Cal beneficiaries who become eligible in counties other than Santa Cruz, Monterey or Merced are not the responsibility of the Alliance. However, any Medi-Cal provider may render services to these members and bill Affiliated Computer Services or the appropriate Medi-Cal Managed Health Care Plan.

When an Alliance member moves, the member must notify their County Medi-Cal benefits representative or, for those receiving Supplemental Security Income (SSI), notification is required to the Social Security Administration. Depending on when the move is reported, the member may be dropped from your case-management list by the first of the following month and will remain an administrative member until the member's case is transferred to his/her new county.

If the Alliance member is CCS eligible, the Alliance will work with the County CCS program to transfer the CCS case to the new county of residence and coordinate appropriate care.

The majority of Alliance members who leave the service area will eventually become the financial responsibility of the new county of residence and cease to be Alliance members. The timeframe in which to effect this change depends on several factors and can take from 1-3 months. During this time, the member is covered by the Alliance only for emergency services while outside of the Alliance service area.

Circumstances in which a member moves or relocates out of our services area(s) that may not result in a change of the responsible county include: placement of foster care, adoption assistance for children out of our service area(s) or other out-of-area placement of children or residents who reside in long-term care facilities when there is a local conservator or guardian involved.

Alliance Care In-Home Supportive Services Program – Monterey County

Eligibility is determined by the Monterey County In-Home Supportive Service Program (IHSS) Public Authority and the Public Authority handles enrollment and premium collection. To be eligible for enrollment, a person must meet all of the following requirements:

- Work at least the minimum number of months and hours per month as established by the In-Home Supportive Services Public Authority of Monterey County, also referred to as the Public Authority.
- Live or work in Monterey County.
- Not have previously been terminated by the Alliance for fraud, deception or failing to provide complete information.
- Have submitted the required enrollment information to the Public Authority; and
- Applied at the time the Public Authority has openings to add subscribers to the Alliance Care IHSS Health Plan.

The Public Authority informs individuals when they are eligible to enroll in the Alliance Care IHSS Health Plan. After notification of eligibility, individuals may enroll themselves by submitting an enrollment application to the Public Authority at 1000 S. Main Street, Suite 211C, Salinas, CA 93901 within 30 days of notification of eligibility.

Please contact the Public Authority at (831) 755-4466 for more information about eligibility, enrollment, premiums and the start of coverage.

Provider Linkage

All Alliance Care IHSS members are linked to a PCP from their first day of eligibility. They select their PCP during the enrollment process. Members may change their PCP by contacting Member Services at (800) 700-3874. The change will be effective the first of the following month.

Alliance Care IHSS Member ID Card

The member ID card for our IHSS program has a strip of red across the top and the Alliance logo in the top right hand corner.