



**L.A. Care**  
HEALTH PLAN

## SHARE OF COST

# PROVIDER RESOURCE GUIDE

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## 1.0 INTRODUCTION

Effective August 1, 2014 in Los Angeles County, a subset of Share of Cost (SOC) Medi-Cal members transitioned from fee for services to managed care Medi-Cal. These SOC members reside in an LTC facility or receive IHSS, MSSP, or CBAS.

SOC members are Medi-Cal subscribers who pay a monthly dollar amount toward their medical expenses before they qualify for covered Medi-Cal benefits, similar to a private insurance plan's out-of-pocket deductible. Unlike the typical members who are eligible for coverage on the first day of the month, SOC members can be eligible for services any day of the month depending on when they meet their SOC. For example, a SOC member who meets their SOC on May 16<sup>th</sup> is eligible for covered Medi-Cal managed care services from May 16<sup>th</sup> through the end of the month.

Providers play a critical role and are solely responsible for clearing members' share of cost by following the protocols established by The California Department of Healthcare Services (DHCS) to report all medical expenditures that are the responsibility of the member. The exception is members residing in an LTC facility with a SOC. For these members, the SOC is paid to the facility by the member before the facility can send a claim to Medi-Cal for the remaining difference. This SOC is always handled by the LTC facility on their monthly billing, so other providers are not involved. Failure or delays in collecting SOC may impair or block members from receiving medically needed services or medicine.

### **Purpose**

The purpose of this Resource Guide is to provide additional information to compliment LA Care's Share of Cost Provider webinars. All of the materials referenced in this guide are provided by LA Care and DHCS. For the most updated information, please visit the Medi-Cal website at: <http://www.medi-cal.ca.gov/default.asp>, or contact your Account Specialist at L.A. Care Plan.

## **Share of Cost FAQ**

Updated on November 7, 2014

### **What is Share of Cost?**

Share of Cost (SOC) is a monthly dollar amount which a beneficiary is required to pay, or obligate to pay, for health care costs before he/she becomes eligible with Medi-Cal, and therefore before Medi-Cal will pay for services exceeding that amount for the given month.

Depending upon fluctuations in the beneficiary's monthly income, SOC amounts may change from month to month. Additionally, if a beneficiary'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.

Additionally, SOC can be adjusted in a single month. On occasion, due to decreased income, a member who previously had a SOC may become eligible with *no* SOC. In rare instances, a member's SOC might even have retroactive adjustments in which the SOC paid to a provider, or obligated to be paid by the member in a particular month, is reduced.

### **Is a Share of Cost a Co-Pay?**

No, a Medi-Cal beneficiary's SOC is similar to a private insurance plan's out-of-pocket deductible. This SOC is a monthly 'deductible' 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.

### **What is the difference between "cost-sharing" and "share of cost"?**

Cost-sharing/co-pay requirements differ from share of cost (SOC) requirements. SOC requires beneficiaries to fully cover their health care expenses up to a certain amount before Medi-Cal benefits kicks in. Cost-sharing requires the beneficiary to pay a set amount for the health care service received/percentage of the health care service received.

### **Where can plans find information about Medi-Cal beneficiaries with Share of Cost?**

The DHCS Medi-Cal Provider Manual provides an overview of Share of Cost (SOC). Plans should use these guidelines for instructing their providers on how to identify, collect and clear SOC obligations prior to submitting claims to the plans. The following provides a link to the SOC overview:

[http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share\\_z01.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share_z01.doc)

Refer to the appropriate Medi-Cal Part 2 Provider Manual for SOC billing instructions.

[http://files.medi-cal.ca.gov/pubsdoco/Manuals\\_menu.asp?pg=&PgDwn=Yes&hURL=&qu=share+of+cost&Action=Go#top\\_search](http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp?pg=&PgDwn=Yes&hURL=&qu=share+of+cost&Action=Go#top_search)

### **To whom does the member pay SOC payments?**

A beneficiary can pay or obligate to pay his/her SOC with any Medi-Cal provider (professional or institutional including long term care). SOC can also be met with providers who are not Medi-Cal certified providers. In this case, the member must get a receipt with the following information: (1) provider name pre-printed company letterhead, (2) procedure code, (3) date of service, and (4) total amount paid or obligated. The beneficiary must take this information to his/her Eligibility Worker to have it applied towards SOC. Additionally, the beneficiary 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 “obligate” the SOC mean?**

If a beneficiary cannot pay the total SOC amount, or has a large SOC and needs to make payments, the beneficiary can obligate to pay by making arrangements or payment plans with the provider. The obligation to pay and the specific arrangements that are made will be the responsibility of the beneficiary and the provider. When arrangements are made to accept payments for the SOC amount owed, the entire SOC amount owed should be cleared immediately.

### **When does a SOC beneficiary become Medi-Cal eligible?**

When the beneficiary meets SOC and the provider has collected the amount paid or obligated to meet SOC.

### **Who is responsible for ensuring SOC payments are cleared?**

The provider is responsible for clearing the SOC and deducting the SOC amount from any claims submitted to the Plan. Instructions for performing SOC clearance transactions are provided in the Medi-Cal SOC provider manual: [http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share\\_z01.doc](http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/share_z01.doc)

If a beneficiary has a SOC and receives IHSS services (identified by secondary aid codes 2k, 2L, 2M, 2N), the SOC is usually met by the wages paid to the IHSS worker; this is completed through the CMIPS system and occurs on the 1<sup>st</sup>, or by the 16<sup>th</sup>, of the month depending on the amount of the SOC and/or covered IHSS hours.

### **What does “meeting share of cost” mean?**

Meeting share of cost means a beneficiary’s total SOC amount has been paid or obligated.

### **What does “spending down SOC” mean?**

Spending down SOC means the provider has applied or cleared SOC with the State.

### **What are the SOC aid codes?**

Beneficiaries with share of cost obligations include, but are not limited to the following aid codes: 1Y, 17, 27, 37, 6R, 6W, 6Y, 67.

LTC facility aid codes: 13, 23, 53, 63, may have a share of cost. If a member has an LTC SOC, the eligibility verification will indicate this. Only LTC providers should charge a SOC to a member who resides in an LTC.

For members receiving IHSS with a SOC, the SOC is usually met by the wages paid to the IHSS worker; this is done through the CMIPS system and occurs on the 1st or by the 16th of the month depending on the amount of the SOC and/or covered IHSS hours

Beneficiary’s receiving IHSS services have secondary aid codes: 2k, 2L, 2M, 2N.

### **How do plans know if a beneficiary has met his/her SOC obligation? And how often are plans notified?**

The 834 file includes daily updates to the following data elements to track SOC payments:

#### **HCP STATUS (Loop 2300/HD04)**

- The HCP STAT code is 55 for a beneficiary with an unmet SOC (Potential plan member – unmet SOC) -- Plan should not pay claims for Medi-Cal services.
- Once the SOC is met, the HCP STAT code will change to 51(Enrollment activated – supplemental capitation to be paid at end of month).
- HCP STAT code S1 (active enrollment – Supplemental capitation paid) indicates that the SOC is cleared and plan capitation has been paid.

**SOC AMT (Loop 2300/AMT01)** – Identifies the member’s SOC amount.

**SOC Cert Date (Loop 2300/REF01)** – Identifies the day of the month beneficiary SOC is cleared. For example, if SOC is cleared on the 15th of the month, ‘15’ will appear in this field.

### **What happens to a Plan’s capitation payment when SOC is not cleared at the beginning of the month?**

The monthly capitation payment for the member is released at the end of the month after SOC is cleared.

**Shall providers call the plan to verify SOC obligation?**

This information will be displayed when providers check for member eligibility through the SOC Transaction “Spend Down” section of the Medi-Cal website, using a POS device, or calling the phone-based AEVS.

**Where is SOC information entered on the CMS-1500 claim form?**

SOC amounts are entered in the Claim Codes (Box 10D) and Amount Paid (Box 29) fields of the CMS-1500 claim form.

**Where is SOC information entered on the UB-04 claim form?**

SOC is entered in the Value Codes and Amounts field (Boxes 39-41). Value code “23” in the “code” column of the field designates that the corresponding “amount” column contains the Share of Cost.

## 2.0 Appendix A: DHCS Medi-Cal SOC resources

### Medi-Cal Provider Manual - Part 1

For the most current information, please refer to the *Share of Cost (SOC)* section in Part 1 of the Medi-Cal Program and Eligibility Manual for an explanation of SOC and how to determine the following:

- If a recipient must pay a SOC
- The SOC amount a recipient must pay

To access the Provider Manual – Part 1, go to: [http://files.medi-cal.ca.gov/pubsdoco/manuals\\_menu.asp](http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp)

### Claim Forms

Information below includes how to complete claims for services rendered to recipients who paid a Share of Cost (SOC).

#### *CMS-1500*

For instructions go to: [http://files.medi-cal.ca.gov/pubsdoco/Manuals\\_menu.asp?pg=&PgDwn=Yes&hURL=&qu=SOC+CMS-1500&Action=Go#top\\_search](http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp?pg=&PgDwn=Yes&hURL=&qu=SOC+CMS-1500&Action=Go#top_search)

#### *UB-04*

For instructions, go to: [http://files.medi-cal.ca.gov/pubsdoco/Manuals\\_menu.asp?pg=&PgDwn=Yes&hURL=&qu=SOC+25-1&Action=Go#top\\_search](http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp?pg=&PgDwn=Yes&hURL=&qu=SOC+25-1&Action=Go#top_search)

**Note:** When billing for room and board (revenue code 0658), the Hospice provider includes the LTC SOC amount for Medi-Cal-covered services on the UB-04 claim form. Refer to the *Hospice Care: General Billing Instructions* section in Part 2 of the Medi-Cal manual for additional information at:

[http://files.medi-cal.ca.gov/pubsdoco/manuals\\_menu.asp](http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp)

#### *25-1 (LTC Facility)*

For instructions, go to: [http://files.medi-cal.ca.gov/pubsdoco/Manuals\\_menu.asp?pg=&PgDwn=Yes&hURL=&qu=%2225-1+for+Long+Term+Care%22&Action=Go#top\\_search](http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp?pg=&PgDwn=Yes&hURL=&qu=%2225-1+for+Long+Term+Care%22&Action=Go#top_search)

**Note:** An LTC facility includes the LTC SOC amount for Medi-Cal-covered services on the Payment Request for Long Term Care (25-1). Refer to the Share of Cost (SOC): 25-1 for Long Term Care section in the Medi-Cal Provider Part 2 manual for additional information at:

[http://files.medi-cal.ca.gov/pubsdoco/manuals\\_menu.asp](http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp)

## Claim Payment Flowchart

This step-by-step guide for Medi-Cal payment of services is not designed to be all-inclusive. Refer to the provider manual index for more information about the specific steps referenced in this document:

[http://files.medi-cal.ca.gov/pubsdoco/Manuals\\_menu.asp?pg=&PgDwn=Yes&hURL=&qu=claim+payment+flowchart&Action=Go#top\\_search](http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp?pg=&PgDwn=Yes&hURL=&qu=claim+payment+flowchart&Action=Go#top_search)

## Eligibility Verification (Point of Service) Device

The Medi-Cal-supplied Point of Service (POS) device is used to verify recipient eligibility, clear Share of Cost liability, reserve medical services, perform Family PACT (Planning, Access, Care and Treatment) client eligibility transactions and submit pharmacy or CMS-1500 claims.

[http://files.medi-cal.ca.gov/pubsdoco/manuals\\_menu.asp?pg=&PgDwn=Yes&hURL=&qu=%22Point+of+Service%22&Action=Go#top\\_search](http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp?pg=&PgDwn=Yes&hURL=&qu=%22Point+of+Service%22&Action=Go#top_search)

## The Aid Codes Master Chart

The Aid Codes Master Chart was developed for use in conjunction with the Medi-Cal Eligibility Verification System (EVS). Providers must submit an inquiry to the EVS to verify a recipient's eligibility for services. The eligibility response system returns a message indicating if the recipient is eligible, and for what services. The message includes an aid code, if the recipient is eligible. If a recipient has an unmet Share of Cost (SOC), an aid code is not returned, since the recipient is not considered eligible until the Share of Cost is met. **Note:** A recipient may have more than one aid code, and may be eligible for multiple programs and services.

The aid codes in this chart are meant to assist providers in identifying the types of services for which Medi-Cal and Public Health Program recipients are eligible. The chart includes only aid codes used to bill for services through the Medi-Cal claims processing systems and for other non Medi-Cal programs that require verification of eligibility through EVS.

**Note:** Unless stated otherwise, aid codes cover United States citizens, United States Nationals and immigrants in a satisfactory immigration status. Satisfactory immigration status includes lawful permanent residents, Permanently Residing in the U.S. Under Color of Law (PRUCOL), aliens and certain amnesty aliens. For access to the most updated chart, go to: [http://files.medi-cal.ca.gov/pubsdoco/Manuals\\_menu.asp?pg=&PgDwn=Yes&hURL=&qu=%22The+Aid+Codes+Master+Chart%22&Action=Go#top\\_search](http://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.asp?pg=&PgDwn=Yes&hURL=&qu=%22The+Aid+Codes+Master+Chart%22&Action=Go#top_search)

### **3.0 Conclusion**

We hope that you have found the information and resources in this guide useful. If you have additional questions about any aspect of your relationship as a provider for L.A. Care, we encourage you to call Provider Relations at (213) 694-1250, extension 4719. We look forward to our continued partnership with you to provide quality and affordable healthcare for our members.