

September 22, 2016

Andy Slavitt
Acting Administrator
Center for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Submitted electronically via email.

RE: Request for Information: Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans

Dear Mr. Slavitt:

Blue Shield of California (“Blue Shield”) appreciates the opportunity to respond to your Request for Information on Inappropriate Steering of Individuals Eligible for or Receiving Medicare and Medicaid Benefits to Individual Market Plans. Blue Shield is a nonprofit health plan that offers health benefits coverage to individuals and groups throughout the State of California. Our mission is to ensure that all Californians have access to high quality care at an affordable price.

In 2011, Blue Shield was the first, and remains the only, health plan to voluntarily place a cap on its earnings. Since then, we have limited our net income to 2 percent of our annual revenue. As a nonprofit, Blue Shield’s mission is to increase the number of insured Californians, improve health care quality, and provide higher-value care at an affordable price. This year we were the most popular plan on California’s Exchange, Covered California.

Insurers participating in Covered California, particularly carriers like Blue Shield with broader networks, are seeing increased gaming of the guaranteed issue mandate that is the core reform of the ACA. Guaranteed-issue requires issuers to accept all enrollees regardless of their health status or preexisting conditions. Blue Shield supported health reform and continues to believe that health care should be accessible and affordable to all Americans. However, these rules require protections to ensure that bad actors cannot manipulate the market for financial gain and thereby drive up the cost of coverage.

Before the ACA, carriers used underwriting to screen-out enrollees with high-cost conditions. In contrast, programs like Medicare and Medicaid accepted enrollment regardless of health status. While these public programs provide lower reimbursement for providers, they provided an important safety net for consumers. Now that health status cannot be a criteria for enrollment, providers may see a significant financial advantage in steering people out of public programs and into commercial coverage with higher reimbursements.

There is no doubt that providers steer enrollment to commercial coverage for the benefit of their bottom line, not for the benefit of enrollees. Consider the following examples that Blue Shield has experienced in the last year:

- A county Medicaid managed care plan enrolled 40 of its sickest enrollees in Blue Shield coverage. The actual advertisement for the program said, “**Providers may receive higher reimbursement from the private insurance than from Medi-Cal.**” The Chief Financial Officer of the Medicaid plan paid the initial premium with his corporate credit card. The Medicaid plan continued to receive payments from the state for these enrollees even when Blue Shield was paying for coverage.
- Dialysis claims for Blue Shield’s individual market coverage have increased by more than 350 percent since 2014. Internal estimates show that premiums paid by the American Kidney Fund are associated with \$24 million in claims for enrollees, most of whom would otherwise be eligible for Medicare or Medicaid coverage. **Assuming a one percent operating margin for Blue Shield, it takes 3,800 members enrolled for 12 months to make up for a single dialysis patient enrolled by the American Kidney Fund.**
- Interviews with enrollees moved out of public coverage show they often are unaware of their eligibility for, or current enrollment in, Medicare or Medicaid, even though “enrollment counselors” at dialysis centers steer them to the American Kidney Fund for premium assistance.
- The American Kidney Fund will not continue premium payments if an enrollee receives a kidney transplant, leaving these enrollees without coverage when they are the most fragile.
- The American Kidney Fund increasingly uses pre-paid debit cards to hide their premium payments from insurers. If the program is altruistic, it is hard to understand why such efforts are needed to avoid transparency.

Blue Shield has a long record of supporting health reform and expanded access to affordable coverage, and we currently have the largest Exchange enrollment in the state. This type of risk shifting unfairly adds costs to our members and jeopardizes our efforts to keep premiums low. We believe action is critical to protect the core ACA market reforms as well as to promote basic program integrity. We strongly believe that clear rules banning direct or indirect premium payments by financially interested third-party payers are required to protect the core market reforms of the ACA.

Below we provide responses to the questions posed in your request for information. We would welcome the opportunity to discuss our experience further at your convenience.

In what types of circumstances are healthcare providers or provider-affiliated organizations in a position to steer people to individual market plans? How, and to what extent, are health care providers actively engaged in such steering?

Blue Shield has seen an increasing pattern of providers steering enrollees to individual market plans and paying their premiums as a way to avoid costs or increase their own reimbursement. We believe this represents a significant abuse of the core ACA market reforms and threatens the affordability of health insurance coverage. This type of steering impacts rates for both on and off-Exchange plans, since Blue Shield is required to combine those risk pools for rate setting.

Below we outline in detail the three largest examples of abuse, but more are uncovered on a regular basis. We strongly believe that clear rules banning direct or indirect premium payments by financially interested third-party payers are required.

1) Cost-Shifting by State Programs:

CenCal is a County Organized Health System that administers Medi-Cal for residents of Santa Barbara and San Luis Obispo counties under a contract with the state. CenCal is a Managed Care Organization (MCO) that receives capitated payments from the state. In early 2015, Blue Shield became aware that CenCal had been enrolling medically fragile members into Blue Shield's off-Exchange individual and family plans ("IFPs") via premium payments made on a credit card issued to David Ambrose, CenCal's CFO. Only one of the CenCal members had prior Blue Shield coverage, and that person's prior employer-based coverage had already terminated.

As of March 31, 2016, Blue Shield had identified a total of forty members enrolled in off-Exchange IFPs under CenCal's unauthorized HIPP program. Thirty-nine of the CenCal members had been diagnosed with end-stage renal disease; some subsequently were authorized by Blue Shield to receive kidney transplants. The remaining member had a malignant neoplasm of the brain. Some members had multiple comorbidities, including hepatitis and HIV, requiring intensive treatments. By June 1, 2016, Blue Shield had paid more than \$11.5 million in claims for these members.

CenCal did not select these members at random; they were all members with very high-cost medical conditions. CenCal openly described the program in its FY2015-2016 budget as follows: "This program pays existing private or group health insurance premiums for members with existing high-cost medical conditions. **Purchasing health coverage for these members helps shift the cost of their medical care to the other insurance carrier, allowing CenCal Health to limit its financial exposure to only the monthly insurance premiums.**"

Blue Shield conducted interviews with CenCal, associated providers, brokers, and members to investigate this issue. Through its investigation, Blue Shield learned that CenCal advertised its program to providers as a way to obtain higher reimbursement for covered services provided to CenCal members with high-cost medical conditions. CenCal coordinated closely with a kidney dialysis center and broker to identify and funnel CenCal members with ESRD into the program. The broker told Blue Shield that he received CenCal's authorization to use a credit card issued to CenCal's CFO to initiate Blue Shield coverage for members identified by the dialysis center and CenCal. Many CenCal members did not recall applying for coverage with Blue Shield, let alone working with a broker to obtain coverage.

While Blue Shield raised these concerns with state regulators for nearly a year, they would not require CenCal to assume primary coverage and stop paying premiums to Blue Shield. Instead, press scrutiny from a lawsuit brought by Blue Shield ultimately convinced CenCal to voluntarily withdraw their program.

2) The American Kidney Fund and Gaming of Reimbursement Rates in Commercial Coverage:

Internal investigations by Blue Shield have shown a significant increase in dialysis claims for their individual market population linked to third-party premium payments by the American Kidney Fund. Since the ACA took effect Blue Shield has paid more than \$24 million in claims from enrollees with premiums paid by the American Kidney Fund. Our investigations suggest that the premium program, while advertised as altruistic in nature, was designed for the purpose of steering patients into commercial individual market plans, and to defer and deter those patients from enrolling in Medicaid and Medicare, presumably while claiming a tax write-off for charitable contributions. The direct result of this is a financial benefit for the dialysis providers that are the major funders of the program, by way of a tax-free charitable contribution that results in claims payments that far exceed the cost of member premiums.¹ **Assuming a one percent operating margin for Blue Shield, it takes 3,800 members enrolled for 12 months to make up for a single dialysis patient enrolled by the American Kidney Fund.**

Interviews with members enrolled by the American Kidney Fund show a similar fact pattern:

- 1) Members who are approached for financial assistance usually are receiving services from a dialysis center owned by the two-largest contributors to the American Kidney Fund, DaVita and Fresenius.
- 2) “Enrollment Counselors” or “social workers” at these facilities approach patients about “financial assistance” with their health care premiums. These “enrollment counselors” offer no information about Medicare eligibility to members. In several cases members were not aware that they were Medicare eligible until told by our interviewer. Others indicated they believed Medicare/MediCal plans do not cover dialysis.
- 3) The American Kidney Fund would pay premiums for these Medicare-eligible enrollees with a check. **However, recently the interviews indicated that premiums are now paid by pre-paid debit card supplied by the American Kidney Fund. Those payments cannot be tracked by Blue Shield or other carriers, making it difficult to assess the extent of these arrangements.**
- 4) When asked about bills for cost-sharing or other out of pockets cost, members are advised to ask the dialysis provider to bill them. In most cases the members never receive bills or they are waived.
- 5) If members receive a kidney transplant—and are no longer in need of dialysis services—the American Kidney Fund will no longer pay their premiums. One interviewee who became eligible for a kidney transplant at a major California hospital system was told by the social worker at the hospital that many of her clients have been on the American Kidney Fund premium support program and were later surprised to find out they lost the premium support once they had the transplant. This social worker now routinely advises members receiving American Kidney Fund payments that they will lose their premium payments after a transplant—when these enrollees will be in critical need of health coverage to ensure a successful recovery.

¹ American Kidney Fund, Our Corporate Sponsors. <http://www.kidneyfund.org/about-us/corporate-sponsors/>.

3) Residential Treatment Facilities:

We have also seen several cases of widespread fraud using third-party payments by residential treatment facilities providing substance abuse treatment. Many of the individuals enrolled through these programs would be eligible for Medicaid, but they are enrolled in off-Exchange coverage to avoid any eligibility screening. These facilities advertise to out-of-state or homeless people, and then enroll the individuals through the SEP for a “permanent move” even though they do not qualify. The premiums are frequently paid by the residential treatment facility on behalf of the enrollees.

One facility in particular is owned by a convicted felon who is linked to multiple cease and desist orders for unlicensed activity. This provider billed \$60 million in claims, most of which were denied after investigation. These facilities often pay premiums and offer financial incentives including rent reductions and waiver of patient responsibilities as long as patients agree to reside at the facility. Investigations consistently show excessive lab fees and falsified billing from these facilities.

In another example, 219 on-Exchange Covered California enrollments were facilitated by an unlicensed individual, a convicted felon, affiliated with a billing company that works for multiple substance abuse treatment providers. 115 enrollments were completed using this person’s cell phone as a home telephone. He paid the initial and subsequent premiums for multiple members. In many cases, the initial premium was the only payment made. Billed claims associated with enrolled members totaled \$12.7 million.

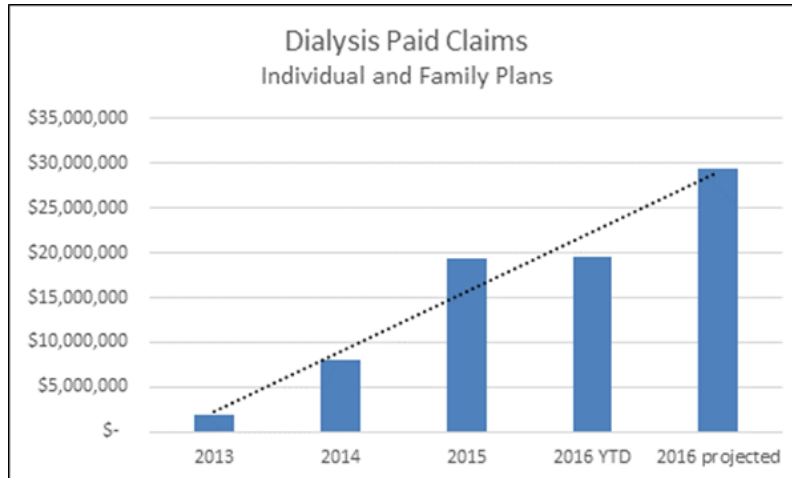
Recently these residential treatment facilities have started claiming to be “non-profits” to shield themselves from the allegation of financial gain. For example, two residential treatment facilities that our investigations have confirmed enroll members through fraudulent SEPs and engage in excessive billing, have claimed to be non-profit public benefit corporations. One went further, claiming that they were paying premiums on behalf of a non-profit foundation—which research showed was controlled by the same owner. Any regulation in this area must therefore not rely on an organization’s status as a “non-profit” because that status can be readily manipulated.

What impact is there to the single risk pool and to rates when people enter the single risk pool who might not otherwise have been in the pool because they would normally be covered under another government program? Are issuers accounting for this uncertainty when they are setting rates?

The increased incidence of third-party payments used to game the ACA market reforms has a significant impact on rates. Blue Shield has tracked at least \$64 million in paid claims since the ACA took effect in 2014 that are related to fraudulent or abusive third-party payments. While the majority of this enrollment took place off-Exchange, it has a direct impact on our on-Exchange premiums because enrollees share the same risk pool. We estimate that every \$10 million in claims drives up rates by one-half a percent.

We are particularly concerned about the targeted movement of enrollees from public programs, specifically Medicare and Medicaid. The members targeted for these premium support programs

have very high claims. For example, a member with ESRD can easily generate \$250,000 a year in claims. As stated above, assuming a one percent operating margin for Blue Shield, it takes 3,800 members enrolled for 12 months to make up for a single dialysis patient enrolled by the American Kidney Fund. Given the accelerating trend of this steering (as shown below), our premiums must include an expectation that dialysis and other claims will continue to grow at an accelerating pace.



Are there examples of steering practices that specifically target people eligible for or receiving Medicare and/or Medicaid benefits to enroll in individual market plans? In what ways are people eligible for or receiving Medicare and/or Medicaid benefits particularly vulnerable to steering? To what extent, if any, are providers steering people eligible for or receiving Medicare and/or Medicaid to individual market plans because they are prohibited from billing the Medicare and Medicaid programs, through exclusion by the HHS Office of Inspector General, termination from State Medicaid plans or the revocation of Medicare billing privileges?

Providers are specifically targeting high cost enrollees in Medicare or Medicaid for their premium payment programs. CenCal, the Medi-Cal plan enrolling its members in Blue Shield coverage, made this explicit in their provider bulletin (attached). The bulletin says that in order to qualify for their premium payment program the enrollee, “Must have full-scope Medi-Cal benefits with or without a share of cost.” Moreover, the benefit to the providers for steering members to the program is explicit: **“Providers may receive higher reimbursement from the private insurance than from Medi-Cal.”**

Similarly, interviews with members who received payments from the American Kidney Fund showed that enrollees were almost always Medicare eligible, but frequently were not told. In several instances our investigator was the first person to notify the enrollee of their Medicare eligibility. This is true even though “financial advisers” at the dialysis centers signed the enrollee up for the third-party payment program.

This steering has a clear financial motive for dialysis providers. While Medicare reimburses around \$80,000 annually for an ESRD enrollee, commercial carriers like Blue Shield may pay \$250,000 for the same condition. There is a significant opportunity for payment arbitrage for these providers by steering members out of Medicare or Medicaid and into commercial coverage.

Is the payment of premiums and cost-sharing commonly used to steer individuals to individual market plans, or are other methods leading to Medicare and Medicaid eligible individuals being enrolled in individual market plans? Specifically, how often are issuers receiving payments directly from health care providers and/or provider affiliated organizations? Are issuers capable of determining when third party payments are made directly to a beneficiary and then transferred to the issuer? What actions could CMS consider to add transparency to third party payments?

Blue Shield has direct evidence that providers are paying premiums for high-cost enrollees. For example, the CFO for CenCal paid the initial premium for their 39 Blue Shield enrollees with his corporate credit card. The American Kidney Fund poses a harder question. While the American Kidney Fund had paid premiums with an identifiable check, interviews show they are switching to using pre-paid debit cards. These debit card payments cannot be tracked by health plans. This certainly suggests an intent by the Kidney Fund to hide the payments given their increased scrutiny. Blue Shield has investigated another case in which a substance abuse provider purchased untraceable money orders for patient premiums.

Given the increased reliance on under-the-table methods to hide the real source of payments, we do not believe that increased transparency will address the current threat to the risk pool posed by these payments. We believe the only proper policy response is a clear prohibition on direct or indirect payment of premiums by financially interested payers.

How are enrollees impacted by the practice of a health care provider or provider affiliated organizations enrolling an individual into an individual market plan and paying premiums for that individual market plan, when the individual was previously or concurrently receiving Medicare and/or Medicaid benefits? We are concerned about instances where individuals eligible for Medicare and/or Medicaid benefits may have been disadvantaged by unscrupulous practices aimed at increasing provider payments, including impacts to the enrollee's continuity of care. We would be interested in knowing more about these practices and the extent to which they may be more widespread or varied than we have identified.

Our experience with third-party payments suggests that enrollees are often unknowingly caught in the middle when organizations step in to move them out of Medicaid or Medicare and into public coverage. In many instances enrollees did not know they had been moved out of public coverage until we contacted them. In the case of CenCal, the managed care Medicaid plan that enrolled its highest cost members into Blue Shield coverage, the members stayed enrolled in Medicaid coverage but with public coverage as the secondary payer. The member was therefore concurrently receiving Medicaid benefits and commercial coverage—although Blue Shield was paying virtually all of the claims. Other members indicated they believed Medicare/Medicaid

plans did not cover dialysis—even when “enrollment counselors” at dialysis centers had provided help enrolling in premium support programs.

Notably, interviews confirmed that the American Kidney Fund will stop paying premiums if an enrollee receives a kidney transplant and is no longer receiving dialysis treatment. Therefore enrollees could lose their health care coverage when they would be most vulnerable. Additionally, in the case of CenCal, Blue Shield paid for kidney transplants for multiple enrollees at a nationally-recognized hospital outside CenCal’s network. If CenCal chose to stop paying commercial premiums for these enrollees, they would have been left in a similarly fragile situation.

How are enrollees impacted by the practice of a health care provider enrolling an individual into an individual market plan and paying premiums for individual market plans, when the individual was eligible for Medicare and/or Medicaid, but not enrolled? We are particularly interested in information about how to measure negative impacts on beneficiaries and enrollees, and what data sources and measurement methodologies are available to assess the impact of this behavior described in this request for information on beneficiaries and enrollees. We are seeking information on any financial impacts that are in addition to Medicare late enrollment penalties. For example, differentials in copayments and deductibles paid by enrollees in individual market plans, Medicare or Medicaid, and the impact of individual market plan network limitations on the financial obligations of enrollees, such as increased copayments and deductibles where the enrollee’s chosen provider is out-of-network to the individual market plan.

We believe that consumers can often be caught in the middle of these practices to steer enrollees. Our interviews with members suggest that they often don’t know they have a choice of public coverage, and in some cases they do not know that they had been moved out of a public program. For Medicaid in particular, this can have real financial impacts on consumers. And for Medicare, late enrollees would face higher premiums costs. For that reason, as well as fundamental program integrity, consumer groups joined Blue Shield in advocating that these enrollees be returned to Medi-Cal.

What remedies could effectively deter health care providers or provider-affiliated organizations from steering people eligible for or enrolled in Medicare and/or Medicaid to individual market plans and paying premiums for the provider’s financial gain? CMS is considering modifying regulations regarding civil monetary penalties and authority related to individual market plans.

It is critical that regulators take action to protect the individual market risk pool from inappropriate steering with a clear bright-line prohibition. Similar to the federal rules used to protect the Medicare program, the rule should provide a prohibition on third-party payments made directly or indirectly by a financially interested party. Additionally, HHS should provide explicit authority for plans to reject third-party premium payments, aside from those enumerated in law, in order to preserve the stability of the risk pool. While we believe HHS has been very clear in their guidance that plans should be able to reject these payments, regulators in California and other states have indicated that the current guidance is insufficient.

Specifically, we recommend:

- ✓ Explicit authority that issuers can reject premium payments other than payments from the subscriber, his or her family, legal guardian or an acceptable third party payor.
- ✓ Define acceptable third party payor as:
 - Those enumerated in 45 CFR 156.1250; and
 - Religious institutions and other not-for-profit organizations –directly or through the subscriber--when each of the following criteria are met:
 - the assistance is provided on the basis of the insured’s financial need;
 - the assistance is provided for the full plan year;
 - the institution/organization is not a healthcare provider; and
 - the institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

It is important to note that only allowing plans to reject third-party payments may no longer provide a sufficient remedy. This is because, as noted above, entities like the American Kidney Fund are increasingly switching to pre-paid debit cards to avoid detection. Individual market carriers may therefore no longer be able to identify inappropriate payments even if a rule permitted insurers to reject such payments. This evidence emphasizes the critical need for a bright-line rule.

We seek comment on policies prohibiting providers from making offers of premium assistance and routine cost-sharing waivers for individual market plans when a beneficiary is currently enrolled or could become enrolled in Medicare Part A and other adjustments to federal policy on premium assistance programs in the individual market to prevent negative impact to beneficiaries and the single risk pool.

As stated above, we believe clear bright-line rules are necessary to prevent inappropriate steering for financial gain by certain provider-affiliated groups. An appropriate policy response would be to ensure that enrollees who are enrolled or could become enrolled in Medicare Part A would not be eligible for premium assistance programs. This would allow Medicare-eligible enrollees to purchase Medicare coverage on their own, but would prevent inappropriate provider steering. Given the robust benefits and network access in Medicare, we believe there would be a strong consumer benefit in ensuring that eligible enrollees receive coverage through Medicare unless they make a personal choice to stay with their private coverage.

We seek comments on changes to Medicare and Medicaid provider enrollment requirements and conditions of participation that would potentially restrict the ability of health care providers to manipulate patient enrollment in various health plans for their own benefit. We are also interested in information on the extent steering is associated with other inappropriate behavior, such as billing for services not provided, or quality of care concerns. We seek comment on the advisability of such restrictions, as well as considerations of how such restrictions would affect health care providers and beneficiaries.

As stated above, we believe a clear rule is necessary to prevent provider steering of Medicare or Medicaid eligible enrollees into private coverage for the purpose of increasing reimbursement. The conditions of participation of a provider receiving federal funds should include a requirement that they not directly or indirectly (through payments to a so-called “charitable” organization) steer enrollees away from public coverage to seek higher reimbursements.

We would note that inappropriate third-party payments go beyond steering in Medicare or Medicaid. As described above, residential treatment facilities in particular increasingly are engaging in fraudulent billing and excessive enrollment. It is important to ensure any policy response includes the ability for carriers to address these types of abuse.

We seek comment on policies to require Medicare and Medicaid-enrolled providers to report premium assistance and cost-sharing waivers for individual market enrollees to CMS or issuers.

Given our concerns with inappropriate steering, we believe a bright-line rule prohibiting provider steering is required. However, transparency on third-party payments—along with clear authority to reject these payments—would be a useful backstop. HHS should consider requiring that any entity that directly or indirectly receives funds from a Medicare or Medicaid provider should directly disclose any premium payments to the plan receiving the enrollment. The carrier can then determine if the payment is appropriate under their policies.

We seek comments on whether individual market plans considered limiting their payment to health care providers to Medicare-based amounts for particular services and items of care and on potential approaches that would allow individual market plans to limit their payment to health care providers to Medicare-based amounts for particular services and items of care.

It would be difficult in practice to implement this policy as a solution to provider steering. Provider reimbursement rates are set by contract, which often are the result of complex negotiations with agreements lasting several years. Given the market power of the leading dialysis providers, we do not believe this limitation would be realistic in practice.

We seek comment on policies that would allow individual market plans to make retroactive payment adjustments to providers, when health care providers are found to have steered Medicare or Medicaid beneficiaries and enrollees to enroll in an individual market plan for the provider’s financial gain.



Again, we think this would be a challenging policy to implement in practice. First, carriers may not know when enrollees are receiving payments by third-parties. Secondly, this could involve potential retrospective litigation over millions of dollars of claims, which would be lengthy and costly. Our experience is that pay-and-chase methods of resolving improper payments do not work effectively in practice.

Conclusion:

Thank you for the opportunity to comment on these proposed rules. We would welcome the opportunity to discuss any of these issues with you at your convenience.

Sincerely,

A handwritten signature in cursive script that reads "Andy Chasin".

Andy Chasin
Policy Director
Blue Shield of California

Provider Bulletin

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HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

Did You Know?

CenCal Health may pay private insurance premiums for certain qualified Medi-Cal beneficiaries when it is cost effective.

Why the HIPP Program?

Providers and members can both benefit from the HIPP program:

- Providers may receive higher reimbursement from the private insurance than from Medi-Cal.
- Members can keep their existing coverage, which may cover expenses excluded from current Medi-Cal benefits.
- Members may have greater access to health care providers.
- Providers can increase HIPP program enrollment by informing their Medi-Cal members about the program.

Who Can Qualify for the HIPP Program?

Potential HIPP program members:

- Must have full-scope Medi-Cal benefits with or without a share of cost.
- Must have current private insurance paid by employer or beneficiary.
- Must not have Medicare benefits.
- Must have a high-cost medical condition covered by a private insurance.

Contact the CenCal Health HIPP Program Coordinator at 805.562.1071 or 805.562.1066 to get started!

IN THIS ISSUE

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HOLIDAY CLOSURE

CenCal Health will be closed on Monday, Sept. 1st in observance of Labor Day

RENDERING PROVIDER NOTIFICATION



CenCal Health requires notification of any changes to rendering providers within your group or practice. In order to avoid claims pending AT or denying 9E (Internal Review of Rendering Provider due to rendering provider not in system or rendering provider number invalid), CenCal Health would like to remind our providers to contact your Provider Services Representative prior to a new rendering provider's effective date with your group.

For any questions regarding rendering providers, please contact your Provider Services Representative at 805.562.1676.



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