Policy:	AA.1220
Title:	**Member Billing**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	*/s/ Michael Hunn 06/20/2024*
Effective Date:	08/01/2010
Revised Date:	04/01/2024
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ PACE ☐ Administrative

I. PURPOSE

This policy details the circumstances under which a Member may or may not be billed for health care services.

II. POLICY

A. Except as specified in Section II.C. of this Policy, in no event, including but not limited to non-payment by CalOptima Health or a Health Network, CalOptima Health's or a Health Network's insolvency, or breach of a Contract for Health Care Services, shall a Health Network, Provider, Subcontractor, or Affiliate bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against the State, the County of Orange, a Member, or the Member's representative for CalOptima Health Covered Services rendered to a Member.

B. A Provider who accepts a Member as a patient shall accept payment from CalOptima Health or a Health Network for CalOptima Health Covered Services as payment in full.

C. A Member may be billed under the following circumstances:

1. Services that are not Covered Services and are offered at a charge. CalOptima Health shall obtain approval from the Department of Health Care Services (DHCS) if CalOptima Health provides services that are not Covered Services at a charge to Members. CalOptima Health shall notify Members of the scope of the additional services and applicable charges:

   a. During the enrollment process;

   b. Any time the scope of services is changed; and

   c. Prior to rendering such service.

2. Non-Covered Services. A Provider may bill a Member for Non-Covered Services if:

   a. The Member agrees to the fees in writing prior to the actual delivery of Non-Covered Services,

b. A copy of such agreement is given to the Member and placed in the Member's Medical Record; and/or

c. Services are rendered by a Provider who is not registered with Medi-Cal.

D. A Provider shall verify a CalOptima Health Medi-Cal Member's eligibility prior to rendering Covered Services in accordance with CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification, or through the Automated Eligibility Verification System.

E. A Provider shall obtain appropriate prior authorization for Covered Services, as appropriate, in accordance with CalOptima Health Policy GG.1500: Authorization Instructions for CalOptima Health Direct and CalOptima Health Community Network Providers, or the Health Network's prior authorization procedures.

F. This policy shall survive the termination of a Contract for Health Care Services for those Covered Services rendered prior to the termination of the Contract, regardless of the cause-giving rise to termination.

G. CalOptima Health shall notify Members of the circumstances under which a Member may be required to pay for health care services in the CalOptima Health Member Handbook, in accordance with CalOptima Health Policy DD.2005: Member Informing Materials Requirements.

H. CalOptima Health shall notify Health Networks and Providers of prohibition of Member billing during the contracting process.

I. Sanctions

1. In the event of a violation of this policy, CalOptima Health shall take appropriate action against a Health Network or Provider, including but not limited to, require repayment of any amounts collected and appropriate Sanctions, in accordance with CalOptima Health Policy HH.2002: Sanctions.

2. If a Health Network or Provider refuses to cease billing or demanding payment from a Member, CalOptima Health may report the Health Network or Provider's actions to DHCS or another regulatory agency, as necessary.

III. PROCEDURE

A. A Provider shall not bill, seek reimbursement, or attempt to collect payment from a Member or the Member's representative when the Provider is in receipt of proof of the Member's Medi-Cal eligibility. This may include, but is not limited to:

1. Covered Services;

2. Covered Services provided during a period of Retroactive Eligibility when the Provider has proof of the beneficiary's retroactive Medi-Cal eligibility;

3. Covered Services once a Medi-Cal beneficiary meets his or her Share of Cost and becomes a Member;

4. Copayment, coinsurance, deductible, or other cost sharing required under a Member's Other Health Coverage (OHC);

5. Pending or disputed claims;

6. Fees for missed, broken, canceled, or same day appointments;

7. Fees for completing paperwork or forms related to the delivery of medical care, including but not limited to:

    a. Immunization cards;

    b. WIC referral forms;

    c. Sports physical forms, or history of physical forms that are required by a school;

    d. Medical forms for Department of Motor Vehicles (DMV) requirements;

    e. Disability forms;

    f. Forms related to Medi-Cal eligibility; and

    g. Lead Testing questionnaire.

8. Other fees incurred during the course of providing Covered Services to a CalOptima Health Medi-Cal Member.

B. If a Member is required to pay a copayment, coinsurance, deductible, or other cost sharing under his or her OHC, the Provider shall bill the cost sharing amount as follows: CalOptima Health for a CalOptima Health Direct Member, or the Member's Health Network for a Health Network Member.

C. American Indian CalOptima Health Members who receive service directly from an Indian Health Care Provider (IHCP) or through a referral to an IHCP shall not be subjected to deductibles, copayments, cost sharing, or other similar charges.

D. A Member may be billed under the circumstances outlined in section II.C. of this policy.

E. Payment for services during a period of Retroactive Eligibility. If a Provider collected payment for Covered Services rendered to a Member during a period of Retroactive Eligibility, the Provider shall reimburse the Member and bill CalOptima Health.

F. If CalOptima Health becomes aware that a Provider is demanding payment from a Member for Covered Service, CalOptima Health shall manage such instances in accordance with CalOptima Health Policies DD.2013: Customer Service Grievance Process and AA.1230: Member Reimbursement for Covered Services.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Health Contract with the Department of Health Care Services (DHCS)
B. CalOptima Health Contract for Health Care Services
C. CalOptima Health Policy AA.1230: Member Reimbursement for Covered Services
D. CalOptima Health Policy DD.2003: Member Identification and Eligibility Verification

E. CalOptima Health Policy DD.2005: Member Informing Materials Requirements
F. CalOptima Health Policy DD.2013: Customer Service Grievance Process
G. CalOptima Health Policy HH.2002: Sanctions
H. Department of Health Care Services (DHCS) All Plan Letter (APL) 24-002: Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (Supersedes APL 09-009)Title 22, California Code of Regulations (CCR), §§ 51002, 53220, 53222, and 53210(d)
I. Title 42, Code of Federal Regulation (CFR), §447.15

VI. REGULATORY AGENCY APPROVAL

Date	Regulatory Agency	Response
07/14/2010	Department of Health Care Services (DHCS)	Approved as Submitted
06/13/2024	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTION

Date	Meeting
09/03/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program
Effective	08/01/2010	AA.1220	Member Billing	Medi-Cal
Revised	09/01/2016	AA.1220	Member Billing	Medi-Cal
Revised	10/01/2017	AA.1220	Member Billing	Medi-Cal
Revised	09/03/2020	AA.1220	Member Billing	Medi-Cal
Revised	11/01/2022	AA.1220	Member Billing	Medi-Cal
Revised	10/01/2023	AA.1220	Member Billing	Medi-Cal
Revised	04/01/2024	AA.1220	Member Billing	Medi-Cal

IX. GLOSSARY

Term	Definition
Affiliate	For the purposes of this policy, means an organization or person that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control with CalOptima Health and that provides service to, or receives services from, CalOptima Health.
CalOptima Health Community Network (CHCN)	A managed care network operated by CalOptima Health that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
CalOptima Health Direct (COHD)	A direct health care program operated by CalOptima Health that includes both COHD- Administrative (COHD-A) and CalOptima Health Community Network (CHCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Health Direct.
Covered Services	Those health care services, set forth in W&I sections 14000 et seq. and 14131 et seq., 22 CCR section 51301 et seq., 17 CCR section 6800 et seq., the Medi-Cal Provider Manual, the California Medicaid State Plan, the California Section 1115 Medicaid Demonstration Project, the contract with DHCS for Medi-Cal, and DHCS APLs that are made the responsibility of CalOptima Health pursuant to the California Section 1915(b) Medicaid Waiver authorizing the Medi-Cal managed care program or other federally approved managed care authorities maintained by DHCS. Covered Services do not include: 1. Home and Community-Based Services (HCBS) program as specified in the DHCS contract for Medi-Cal Exhibit A, Attachment III, Subsections 4.3.15 (Services for Persons with Developmental Disabilities), 4.3.20 (Home and Community-Based Services Programs) regarding waiver programs, 4.3.21 (In-Home Supportive Services), and Department of Developmental Services (DDS) Administered Medicaid Home and Community-Based Services Waiver. HCBS programs do not include services that are available as an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) service, as described in 22 CCR sections 51184, 51340 and 51340.1. EPSDT services are covered under the DHCS contract for Medi-Cal, as specified in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services), Subsection F4 regarding services for Members less than twenty-one (21) years of age. CalOptima Health is financially responsible for the payment of all EPSDT services; 2. California Children's Services (CCS) as specified in Exhibit A, Attachment III, Subsection 4.3.14 (California Children's Services), except for Contractors providing Whole Child Model (WCM) services; 3. Specialty Mental Health Services as specified in Exhibit A, Attachment III, Subsection 4.3.12 (Mental Health Services); 4. Alcohol and SUD treatment services, and outpatient heroin and other opioid detoxification, except for medications for addiction treatment as specified in Exhibit A, Attachment III, Subsection 4.3.13 (Alcohol and Substance Use Disorder Treatment Services); 5. Fabrication of optical lenses except as specified in Exhibit A, Attachment III, Subsection 5.3.7 (Services for All Members);

Term	Definition
	6. Direct Observed Therapy for Treatment of Tuberculosis (TB) as specified in Exhibit A, Attachment III, Subsection 4.3.18 (Direct Observed Therapy for Treatment of Tuberculosis); 7. Dental services as specified in W&I sections 14131.10, 14132(h), 14132.22, 14132.23, and 14132.88, and EPSDT dental services as described in 22 CCR section 51340.1(b). However, CalOptima Health is responsible for all Covered Services as specified in Exhibit A, Attachment III, Subsection 4.3.17 (Dental) regarding dental services; 8. Prayer or spiritual healing as specified in 22 CCR section 51312; 9. Educationally Necessary Behavioral Health Services that are covered by a Local Education Agency (LEA) and provided pursuant to a Member's Individualized Education Plan (IEP) as set forth in Education Code section 56340 et seq., Individualized Family Service Plan (IFSP) as set forth in California Government Code (GC) section 95020, or Individualized Health and Support Plan (IHSP). However, CalOptima Health is responsible for all Medically Necessary Behavioral Health Services as specified in Exhibit A, Attachment III Subsection 4.3.16 (School-Based Services); 10. Laboratory services provided under the State serum alpha-feto-protein-testing program administered by the Genetic Disease Branch of California Department of Public Health (CDPH); 11. Pediatric Day Health Care, except for Contractors providing Whole Child Model (WCM) services; 12. State Supported Services; 13. Targeted Case Management (TCM) services as set forth in 42 USC section 1396n(g), W&I sections 14132.48 and 14021.3, 22 CCR sections 51185 and 51351, and as described in Exhibit A, Attachment III, Subsection 4.3.11 (Targeted Case Management Services). However, if Members less than twenty-one (21) years of age are not eligible for or accepted by a Regional Center (RC) or a local government health program for TCM services, CalOptima Health must ensure access to comparable services under the EPSDT benefit in accordance with DHCS APL 23-005; 14. Childhood lead poisoning case management provided by county health departments; 15. Non-medical services provided by Regional Centers (RC) to individuals with Developmental Disabilities, including but not limited to respite, out-of-home placement, and supportive living; 16. End of life services as stated in Health and Safety Code (H&S) section 443 et seq., and DHCS APL 16-006; and 17. Prescribed and covered outpatient drugs, medical supplies, and enteral nutritional products when appropriately billed by a pharmacy on a pharmacy claim, in accordance with DHCS APL 22-012.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima Health to provide Covered Services to Members assigned to that Health Network.
Medical Record	The record of a Member's medical information including but not limited to, medical history, care or treatments received, test results, diagnoses, and prescribed medications.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima Health program.

Term	Definition
Non-Covered Medical Services	Medical services rendered by a non-Medi-Cal Provider; or Medical services in the following categories of services for which: 1. An authorization request must be submitted and approved before CalOptima Health will pay; or 2. An authorization request is not submitted, or an authorization request is submitted but is denied by CalOptima Health because the service is not considered medically necessary.
Other Health Coverage (OHC)	The responsibility of an individual or entity, other than CalOptima Health or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.
Provider	For the purpose of this policy, a person or institution that furnishes Covered Services to Members.
Retroactive Eligibility	Eligibility for Medi-Cal and the CalOptima Health program established retrospectively by the County of Orange Social Services Agency.
Sanction	An action taken by CalOptima Health, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Health programs.
Share of Cost	The amount of health care expenses that a recipient must pay for each month before he or she becomes eligible for Medi-Cal benefits. A recipient's Share of Cost is determined by the county Social Services Agency.