HCA
Health Consumer Alliance
1764 San Diego Avenue, Suite 200 San Diego, CA 92110
Phone 619-471-2606 Statewide Toll Free 888-804-3536 HealthConsumer.org

November 29, 2022

Susan Philip, Deputy Director
Health Care Delivery Systems
Department of Health Care Services
1501 Capitol Avenue, MS 0000
P.O. Box 997413
Sacramento, CA 95899-7413
Sent via email

RE: Improper billing of FFS beneficiaries by MCP providers

Dear Susan,

On behalf of the Health Consumer Alliance (HCA), thank you for your letter of October 13, 2022, sent in response to the letter I sent on HCA's behalf on August 30, 2022.

As you know, the HCA is a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, which includes: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Community Legal Aid SoCal, Greater Bakersfield Legal Assistance, Legal Aid Society of San Diego, Inland Counties Legal Services, Legal Aid Society of San Mateo, Legal Services of Northern California, Neighborhood Legal Services of Los Angeles County, the Western Center on Law and Poverty, and the National Health Law Program. HCA appreciates the opportunity to continue discussing this important issue with you.

As we explained in our August letter, over the last several years, HCA programs have seen a growing number of cases where a FFS Medi-Cal beneficiary sees a Medi-Cal managed care provider who then claims not to accept FFS Medi-Cal and illegally bills the beneficiary. We appreciate DHCS's efforts to engage in provider education and training on this issue. Unfortunately, despite DHCS's efforts, we are continuing to hear from beneficiaries who are experiencing this billing issue, as discussed in more detail below.

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Again, while we appreciate DHCS's actions to date, HCA encourages DHCS to do more pursuant to its power and duty to enforce the protections under WIC §§ 14019.4 and 14019.3 against **any** Medi-Cal provider. As described in more detail below, we encourage DHCS to take the following steps: (1) Maintain signed provider agreements with all Medi-Cal providers; (2) Ensure that beneficiaries can both disenroll and enroll into managed care expeditiously to avoid improper billing or remedy it as appropriate; (3) Require MCPs to take enforcement action against contracted providers who engage in unlawful billing; (4) Issue more explicit direction to all Medi-Cal providers reminding of their obligation to refrain from illegal billing; and (5) Align billing policies for existing Medi-Cal beneficiaries with Conlan..

(1) Maintain signed provider agreements with all Medi-Cal providers

We understand that, where providers only provide services to Medi-Cal beneficiaries pursuant to their relationship with an MCP, they must nevertheless sign DHCS's Medi-Cal Provider agreement. *See* APL 22-013. This agreement should be sufficient to establish a relationship between DHCS and an MCP provider, such that DHCS can enforce billing protections against MCP-only providers as necessary to protect beneficiaries. WIC § 14043.2. However, it appears that currently, MCPs require providers to sign the Provider agreement, but never return the completed agreements back to DHCS. *See* APL 22-013. DHCS should ensure that it maintains a copy of the completed agreement for all contracted Medi-Cal providers itself, even for those who do not accept FFS Medi-Cal, to ensure that DHCS can account for, and enforce against, all Medi-Cal providers. In addition, DHCS should consider amending the existing agreement to make explicit that providers may not bill Medi-Cal beneficiaries, and set forth enforcement actions DHCS can take against providers that illegally bill beneficiaries.

(2) Ensure that beneficiaries can both disenroll and enroll into managed care expeditiously to avoid improper billing or remedy it as appropriate.

In addition, it is clear that many of the improper billing scenarios we have encountered originate from issues with beneficiaries' ability to enroll and disenroll from managed care appropriately and promptly. For example, many of the improper billing scenarios could be avoided if the Medi-Cal Managed Care Plan enrollment was not delayed. Thus, we respectfully urge DHCS investigate options for automatic MCP enrollment, especially in COHS Counties, to avoid gaps in treatment and to avoid such improper billing issues in the future. With the sunset of the CMC plans and the anticipation of the beneficiaries voluntarily disenrolling from the MMPs, we anticipate seeing an increase in disenrollment/enrollment delays and improper

billing among duals (see example below). By the same token, in some of our case examples, it is not clear why the beneficiary was disenrolled from managed care at all, and it appears that the disenrollment was improper. Thus, DHCS should work to ensure that beneficiaries are not improperly disenrolled from their plans, given the gaps in care and billing issues that such disenrollment can cause.

At the same time, we understand that DHCS will never be able to ensure that the enrollment and disenrollment processes are perfectly timed to avoid any situation where a person is temporarily placed in FFS Medi-Cal and thus may experience billing by a non-FFS providers. DHCS should make clear to Health Care Options that it may retroactively enroll beneficiaries into an MCP in situations where the beneficiary was previously enrolled in a particular MCP and received care from a provider who contracts with that MCP but not FFS Medi-Cal.

We understand from DHCS's October 13 letter that it will sometimes provide for these kind of retroactive enrollments when someone is disenrolled from their MCP due to an inter-country transfer. *See* WIC § 10003(e)(2). We appreciate DHCS's commitment to ensuring the enforcement of this provision and reinforcing, in ICT situations, the Medi-Cal Managed Care Ombudsman's obligation to expedite disenrollment from the prior county's MCP "upon request by the beneficiary or either county." We urge DHCS to clarify that expedited enrollment or reenrollment into the new county's MCP may also be performed by the Ombudsman's office.

In addition, DHCS should allow retroactive enrollments in all cases where such enrollment is necessary to address unlawful billing by a provider, rather than limiting such enrollment to ICT situations. DHCS must also allow retroactive enrollment where necessary to address billing issues and ensure continuity of care for beneficiaries. *See* 42 U.S.C. § 1396u-2(a)(4)(D); 42 C.F.R. §§ 438.54, 438.56; *see also* WIC § 14184.200(a)(3) (incorporating 42 CFR 438.56). Retroactive enrollment should be allowed for good cause, which should include situations where disenrollment was made in error, or any other situation where retroactive enrollment is necessary to address improper billing of a beneficiary.

(3) Require MCPs to take enforcement action against contracted providers who engage in unlawful billing.

In conjunction with the recommendations above, DHCS must provide more guidance to MCPs about their obligations to prevent and enforce against illegal billing by their providers.

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Specifically, DHCS should make clear to the MCPs, either through its contract with the MCPs, through an APL, or in other guidance, that they are responsible for enforcing beneficiary billing protections with their contracted providers, even when those providers are illegally billing a beneficiary who is not enrolled in their plan. In addition, DHCS should continue to monitor MCPs actions to prevent illegal billing by their providers and appropriately address illegal billing when it occurs. DHCS should work closely with the MCPs to ensure that in situations where MCP providers are illegally billing FFS beneficiaries, the MCP is taking action to stop that billing and take enforcement actions as appropriate.

(4) Issue more explicit direction to all Medi-Cal providers reminding of their obligation to refrain from illegal billing.

In addition, we encourage DHCS to issue another Provider Flash or Provider Bulletin on this issue. We appreciate that DHCS recently issued guidance to providers about illegal billing earlier this year. We are curious to know whether all MCPs shared this reminder to their providers by DHCS's November 1, 2022 deadline. If not, can DHCS please share which MCPs failed to do so?

In any event, we urge DHCS to build on that guidance to explicitly inform providers that it is their obligation to verify people's enrollment in Medi-Cal, and in whatever MCPs the provider accepts, before providing care. Such communication should make clear that if a provider chooses to accept a Medi-Cal beneficiary as a patient, the provider is absolutely prohibited from billing the beneficiary (other than nominal copays allowed under Medi-Cal). A provider's failure to adequately verify enrollment does not permit the provider to bill a beneficiary. DHCS should also remind providers that DHCS and its contracted MCPs have the power to enforce statutory balance billing protections against providers that illegally bill beneficiaries.

(5) Align billing policies for existing Medi-Cal beneficiaries with *Conlan*.

Finally, we respectfully request DHCS's billing policies align with *Conlan* policies, even in situations where the beneficiary is not newly enrolling in Medi-Cal. *Conlan* refunds are available for out-of-pocket expenses paid to any "Medi-Cal provider". DHCS's Conlan website and APL 07-002 does not make the distinction between FFS Providers and MCP Providers. In fact, the FAQs confirm that partial refund may be available for non-Medi-Cal providers claims. Yet our experience has been in practice, that DHCS will not allow *Conlan* claims for people who are seeking payment for bills incurred after they had been enrolled in Medi-Cal. Moreover, for

beneficiaries who cannot afford to pay incurred claims out-of-pocket, they are billed, sent to collections, and their credit report forever scarred with the unpaid debt. Thus, we request DHCS not make the distinction between FFS provider and MCP provider for Conlan purposes or for improper billing enforcement purposes.

Additional case examples since our last letter:

- **Example involving dual eligible beneficiary:** Community Legal Aid SoCal (CLA SoCal) recently assisted a FFS beneficiary who was improperly billed. The beneficiary is a dual with QMB status. In October 2021, this beneficiary disenrolled from her CMC plan and switched over to original Medicare. Unfortunately, as a result, for one month she was placed into FFS Medi-Cal, instead of the COHS County Medi-Cal managed care plan, CalOptima. She switched from FFS Medi-Cal to CalOptima MCP the following month of November 2021. Orange County is a COHS county, and both their CMC plan and Medi-Cal MCP are both operated by the same company, CalOptima. This beneficiary had not realized that during the month of October 2021, she was on FFS Medi-Cal. She went to see her MCP Dermatologist in October 2021. However, her doctor accepted CalOptima MCP but not FFS Medi-Cal and on learning that the beneficiary was in FFS during the October visit, illegally billed the beneficiary and sent the beneficiary to collections. In fact, the beneficiary also had QMB status, which adds an additional federal layer of protection against balance billing. CLA SoCal escalated the matter to DHCS's Brenda Gomez and the beneficiary was retroactively enrolled in the Medi-Cal MCP for October 2021. CLA SoCal has submitted a letter regarding the billing issue to the collections agency asking them to pull the bill from collections immediately and cease billing efforts. Thankfully the collection agency has sent the bill back to the provider. However, we have not received confirmation of $0 liability from the provider. Thus, it remains unclear if the provider will continue to bill this Medi-Cal beneficiary.
- **Example involving ICT:** Legal Services of Northern California (LSNC) recently assisted a beneficiary who was enrolled in Anthem (Blue Cross) and moved to a new county. When he reported the move in July 2022, the county initiated an inter-county transfer and took him out of Anthem retroactively, putting him into FFS for both May and June. In May, before the beneficiary moved, he saw two Anthem providers while the MEDS system reflected enrollment with Anthem. Both providers are contracted with Anthem, but are not enrolled in FFS. By the time the providers billed, the beneficiary's status was showing as FFS, and the beneficiary has been illegally billed for the providers' services, with the bills totaling over $2,000. Before contacting LSNC, the beneficiary had reached out to the County and the Medi-Cal Managed Care Ombudsman to try to be re-enrolled

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in Anthem for May and June so that his providers could bill. Neither the County nor the Ombudsman was able to assist him. He is currently still being billed by both providers.

Once again, we urge DHCS to take whatever steps are necessary to ensure that it is preventing Medi-Cal providers (both FFS and managed care) from improperly billing Medi-Cal beneficiaries. This should include DHCS's taking enforcement action against such providers who are inappropriately billing when necessary.

We appreciate the opportunity to provide you input on this important issue, and request a time to meet with you to discuss these issues further. Please contact Abbi Coursolle, at coursolle@healthlaw.org, to schedule a time to meet.

Sincerely,

Abbi Coursolle, National Health Law Program
On behalf of the Health Consumer Alliance

CC: René Mollow, Deputy Director, Health Care Benefits and Eligibility

Yingjia Huang, Assistant Deputy Director, Health Care Benefits and Eligibility

Bambi Cisneros, Assistant Deputy Director, Health Care Delivery Systems