Assembly Bill No. 2051

CHAPTER 356

An act to amend Section 24005 of, and to add Section 14043.17 to, the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor September 16, 2014. Filed with Secretary of State September 16, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2051, Gonzalez. Medi-Cal: providers: affiliate primary care clinics.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law also establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program to provide comprehensive clinical family planning services to individuals who meet specified income requirements. Existing law provides for a schedule of benefits under the Medi-Cal program, including services provided under the Family PACT Program.

Existing law authorizes the department to adopt regulations for certification of each applicant and each provider in the Medi-Cal program. Existing law requires certain applicants or providers, as defined, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location. Existing law generally requires the department to give written notice regarding the status of an application to an applicant or provider within a prescribed period of time, as specified.

This bill would require the department, within 30 calendar days of receiving confirmation of certification for enrollment as a Medi-Cal provider for an applicant that is an affiliate primary care clinic, to provide specified written notice to the applicant informing the applicant that its Medi-Cal enrollment is approved. The bill would require the department to enroll the affiliate primary care clinic retroactive to the date of certification. The bill would also impose similar requirements upon the department with respect to an application for enrollment into the Family PACT Program from an affiliate primary care clinic. The bill would make the effective date of enrollment into the Family PACT Program the later of the date the department receives confirmation of enrollment as a Medi-Cal provider, or the date the applicant meets all Family PACT provider enrollment requirements.

The people of the State of California do enact as follows:

SECTION 1. Section 14043.17 is added to the Welfare and Institutions Code, to read:

14043.17. (a) Notwithstanding any other law, within 30 calendar days of receiving confirmation of certification for enrollment as a Medi-Cal provider for an affiliate primary care clinic that is licensed pursuant to Section 1218.1 of the Health and Safety Code, the department shall provide written notice to the applicant informing the applicant that its Medi-Cal enrollment is approved.

(b) The department shall enroll the affiliate primary care clinic retroactive to the date of certification.

(c) This section shall not be construed to limit the department's authority pursuant to Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits.

SEC. 2. Section 24005 of the Welfare and Institutions Code is amended to read:

24005. (a) This section shall apply to the Family Planning, Access, Care, and Treatment Program identified in subdivision (aa) of Section 14132 and this program.

(b) Only licensed medical personnel with family planning skills, knowledge, and competency may provide the full range of family planning medical services covered in this program.

(c) Medi-Cal enrolled providers, as determined by the department, shall be eligible to provide family planning services under the program when these services are within their scope of practice and licensure. Those clinical providers electing to participate in the program and approved by the department shall provide the full scope of family planning education, counseling, and medical services specified for the program, either directly or by referral, consistent with standards of care issued by the department.

(d) The department shall require providers to enter into clinical agreements with the department to ensure compliance with standards and requirements to maintain the fiscal integrity of the program. Provider applicants, providers, and persons with an ownership or control interest, as defined in federal medicaid regulations, shall be required to submit to the department their social security numbers to the full extent allowed under federal law. All state and federal statutes and regulations pertaining to the audit or examination of Medi-Cal providers shall apply to this program.

(e) Clinical provider agreements shall be signed by the provider under penalty of perjury. The department may screen applicants at the initial application and at any reapplication pursuant to requirements developed by the department to determine provider suitability for the program.

(f) The department may complete a background check on clinical provider applicants for the purpose of verifying the accuracy of information provided to the department for purposes of enrolling in the program and in order to prevent fraud and abuse. The background check may include, but not be limited to, unannounced onsite inspection prior to enrollment, review of

business records, and data searches. If discrepancies are found to exist during the preenrollment period, the department may conduct additional inspections prior to enrollment. Failure to remediate significant discrepancies as prescribed by the director may result in denial of the application for enrollment. Providers that do not provide services consistent with the standards of care or that do not comply with the department's rules related to the fiscal integrity of the program may be disenrolled as a provider from the program at the sole discretion of the department.

(g) The department shall not enroll any applicant who, within the previous 10 years:

(1) Has been convicted of any felony or misdemeanor that involves fraud or abuse in any government program, that relates to neglect or abuse of a patient in connection with the delivery of a health care item or service, or that is in connection with the interference with, or obstruction of, any investigation into health care related fraud or abuse.

(2) Has been found liable for fraud or abuse in any civil proceeding, or that has entered into a settlement in lieu of conviction for fraud or abuse in any government program.

(h) In addition, the department may deny enrollment to any applicant that, at the time of application, is under investigation by the department or any local, state, or federal government law enforcement agency for fraud or abuse. The department shall not deny enrollment to an otherwise qualified applicant whose felony or misdemeanor charges did not result in a conviction solely on the basis of the prior charges. If it is discovered that a provider is under investigation by the department or any local, state, or federal government law enforcement agency for fraud or abuse, that provider shall be subject to immediate disenrollment from the program.

(i) (1) The program shall disenroll as a program provider any individual who, or any entity that, has a license, certificate, or other approval to provide health care, which is revoked or suspended by a federal, California, or other state's licensing, certification, or other approval authority, has otherwise lost that license, certificate, or approval, or has surrendered that license, certificate, or approval while a disciplinary hearing on the license, certificate, or approval was pending. The disenrollment shall be effective on the date the license, certificate, or approval is revoked, lost, or surrendered.

(2) A provider shall be subject to disenrollment if the provider submits claims for payment for the services, goods, supplies, or merchandise provided, directly or indirectly, to a program beneficiary, by an individual or entity that has been previously suspended, excluded, or otherwise made ineligible to receive, directly or indirectly, reimbursement from the program or from the Medi-Cal program and the individual has previously been listed on either the Suspended and Ineligible Provider List, which is published by the department, to identify suspended and otherwise ineligible providers or any list published by the federal Office of the Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and medicaid programs, to identify suspended, excluded, or otherwise ineligible providers.

(3) The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the program when warrants or documents mailed to a provider's mailing address, its pay to address, or its service address, if any, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the program for one year. Prior to taking this action, the department shall use due diligence in attempting to contact the provider at its last known telephone number and to ascertain if the return by the United States Postal Service is by mistake and shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in regulation.

(4) For purposes of this subdivision:

(A) "Mailing address" means the address that the provider has identified to the department in its application for enrollment as the address at which it wishes to receive general program correspondence.

(B) "Pay to address" means the address that the provider has identified to the department in its application for enrollment as the address at which it wishes to receive warrants.

(C) "Service address" means the address that the provider has identified to the department in its application for enrollment as the address at which the provider will provide services to program beneficiaries.

(j) Subject to Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, the department may enter into contracts to secure consultant services or information technology including, but not limited to, software, data, or analytical techniques or methodologies for the purpose of fraud or abuse detection and prevention. Contracts under this section shall be exempt from the Public Contract Code.

(k) Enrolled providers shall attend specific orientation approved by the department in comprehensive family planning services. Enrolled providers who insert IUDs or contraceptive implants shall have received prior clinical training specific to these procedures.

(*l*) Upon receipt of reliable evidence that would be admissible under the administrative adjudication provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, of fraud or willful misrepresentation by a provider under the program or commencement of a suspension under Section 14123, the department may do any of the following:

(1) Collect any State-Only Family Planning program or Family Planning, Access, Care, and Treatment Program overpayment identified through an audit or examination, or any portion thereof from any provider. Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal the collection of overpayments under this section pursuant to procedures established in Article 5.3 (commencing with Section 14170) of Chapter 7 of Part 3 of Division 9. Overpayments collected under this section

shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings, if the findings are against the provider. Overpayments shall be returned to a provider with interest if findings are in favor of the provider.

(2) Withhold payment for any goods or services, or any portion thereof, from any State-Only Family Planning program or Family Planning Access Care and Treatment Program provider. The department shall notify the provider within five days of any withholding of payment under this section. The notice shall do all of the following:

(A) State that payments are being withheld in accordance with this paragraph and that the withholding is for a temporary period and will not continue after it is determined that the evidence of fraud or willful misrepresentation is insufficient or when legal proceedings relating to the alleged fraud or willful misrepresentation are completed.

(B) Cite the circumstances under which the withholding of the payments will be terminated.

(C) Specify, when appropriate, the type or types of claimed payments being withheld.

(D) Inform the provider of the right to submit written evidence that is evidence that would be admissible under the administrative adjudication provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, for consideration by the department.

(3) Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal a withholding of payment under this section pursuant to Section 14043.65. Payments withheld under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings.

(m) As used in this section:

(1) "Abuse" means either of the following:

(A) Practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the medicaid program, the Medicare program, the Medi-Cal program, including the Family Planning, Access, Care, and Treatment Program, identified in subdivision (aa) of Section 14132, another state's medicaid program, or the State-Only Family Planning program, or other health care programs operated, or financed in whole or in part, by the federal government or any state or local agency in this state or any other state.

(B) Practices that are inconsistent with sound medical practices and result in reimbursement, by any of the programs referred to in subparagraph (A) or other health care programs operated, or financed in whole or in part, by the federal government or any state or local agency in this state or any other state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.

(2) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some

unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

(3) "Provider" means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of any partnership, group, association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, to a beneficiary and that has been enrolled in the program.

(4) "Convicted" means any of the following:

(A) A judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether there is a post-trial motion or an appeal pending or the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.

(B) A federal, state, or local court has made a finding of guilt against an individual or entity.

(C) A federal, state, or local court has accepted a plea of guilty or nolo contendere by an individual or entity.

(D) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.

(5) "Professionally recognized standards of health care" means statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue, recognize as applying to those peers practicing or providing care within a state. When the United States Department of Health and Human Services has declared a treatment modality not to be safe and effective, practitioners that employ that treatment modality shall be deemed not to meet professionally recognized standards of health care. This definition shall not be construed to mean that all other treatments meet professionally recognized standards of care.

(6) "Unnecessary or substandard items or services" means those that are either of the following:

(A) Substantially in excess of the provider's usual charges or costs for the items or services.

(B) Furnished, or caused to be furnished, to patients, whether or not covered by Medicare, medicaid, or any of the state health care programs to which the definitions of applicant and provider apply, and which are substantially in excess of the patient's needs, or of a quality that fails to meet professionally recognized standards of health care. The department's determination that the items or services furnished were excessive or of unacceptable quality shall be made on the basis of information, including sanction reports, from the following sources:

(i) The professional review organization for the area served by the individual or entity.

(ii) State or local licensing or certification authorities.

(iii) Fiscal agents or contractors, or private insurance companies.

(iv) State or local professional societies.

(v) Any other sources deemed appropriate by the department.

(7) "Enrolled or enrollment in the program" means authorized under any and all processes by the department or its agents or contractors to receive, directly or indirectly, reimbursement for the provision of services, goods, supplies, or merchandise to a program beneficiary.

(n) In lieu of, or in addition to, the imposition of any other sanctions available, including the imposition of a civil penalty under Sections 14123.2 or 14171.6, the program may impose on providers any or all of the penalties pursuant to Section 14123.25, in accordance with the provisions of that section. In addition, program providers shall be subject to the penalties contained in Section 14107.

(o) (1) Notwithstanding any other provision of law, every primary supplier of pharmaceuticals, medical equipment, or supplies shall maintain accounting records to demonstrate the manufacture, assembly, purchase, or acquisition and subsequent sale, of any pharmaceuticals, medical equipment, or supplies, to providers. Accounting records shall include, but not be limited to, inventory records, general ledgers, financial statements, purchase and sales journals, and invoices, prescription records, bills of lading, and delivery records.

(2) For purposes of this subdivision, the term "primary supplier" means any manufacturer, principal labeler, assembler, wholesaler, or retailer.

(3) Accounting records maintained pursuant to paragraph (1) shall be subject to audit or examination by the department or its agents. The audit or examination may include, but is not limited to, verification of what was claimed by the provider. These accounting records shall be maintained for three years from the date of sale or the date of service.

(p) Each provider of health care services rendered to any program beneficiary shall keep and maintain records of each service rendered, the beneficiary to whom rendered, the date, and such additional information as the department may by regulation require. Records required to be kept and maintained pursuant to this subdivision shall be retained by the provider for a period of three years from the date the service was rendered.

(q) A program provider applicant or a program provider shall furnish information or copies of records and documentation requested by the department. Failure to comply with the department's request shall be grounds for denial of the application or automatic disenrollment of the provider.

(r) A program provider may assign signature authority for transmission of claims to a billing agent subject to Sections 14040, 14040.1, and 14040.5.

(s) Moneys payable or rights existing under this division shall be subject to any claim, lien, or offset of the State of California, and any claim of the United States of America made pursuant to federal statute, but shall not otherwise be subject to enforcement of a money judgment or other legal process, and no transfer or assignment, at law or in equity, of any right of a provider of health care to any payment shall be enforceable against the state, a fiscal intermediary, or carrier.

(t) (1) Notwithstanding any other law, within 30 calendar days of receiving a complete application for enrollment into the Family PACT Program from an affiliate primary care clinic licensed under Section 1218.1 of the Health and Safety Code, the department shall do one of the following:

(A) Approve the provider's Family PACT Program application, provided the applicant meets the Family PACT Program provider enrollment requirements set forth in this section.

(B) If the provider is an enrolled Medi-Cal provider in good standing, notify the applicant in writing of any discrepancies in the Family PACT Program enrollment application. The applicant shall have 30 days from the date of written notice to correct any identified discrepancies. Upon receipt of all requested corrections, the department shall approve the application within 30 calendar days.

(C) If the provider is not an enrolled Medi-Cal provider in good standing, the department shall not proceed with the actions described in this subdivision until the department receives confirmation of good standing and enrollment as a Medi-Cal provider.

(2) The effective date of enrollment into the Family PACT Program shall be the later of the date the department receives confirmation of enrollment as a Medi-Cal provider, or the date the applicant meets all Family PACT Program provider enrollment requirements set forth in this section.

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