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AMENDED IN ASSEMBLY APRIL 29, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 2051

**Introduced by Assembly Members Gonzalez and Bocanegra
(Coauthor: Assembly Member V. Manuel Pérez)**

February 20, 2014

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

LEGISLATIVE COUNSEL'S DIGEST

AB 2051, as amended, 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, except as specified, within 30 calendar days of receiving an application for enrollment as a Medi-Cal provider from 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, if an affiliate primary care clinic's Medi-Cal enrollment is not approved, to collaborate with the State Department of Public Health to ensure that the applicant receives written notification informing the applicant of any deficiencies and providing the applicant with an opportunity to cure the deficiencies within 30 days of the date of the written notice, as specified. The bill would impose similar requirements upon the department with respect to an application for enrollment into the Family PACT Program. ~~The bill would require the department to concurrently review and approve an applicant's Family PACT Program application and Medi-Cal enrollment, as specified, if an affiliate primary care clinic files its Family PACT Program application either before or on the same day that it files its affiliate primary care clinic licensure application with the State Department of Public Health. The bill would also make the effective date of enrollment into both programs retroactive to the date Medi-Cal certification was approved by the State Department of Public Health. The bill would also 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.~~

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: no.

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

- 1 SECTION 1. Section 14043.17 is added to the Welfare and
- 2 Institutions Code, to read:
- 3 14043.17. (a) Notwithstanding any other law, and except as
- 4 provided in subdivision (b), within 30 calendar days of receiving

1 an application for enrollment as a Medi-Cal provider from an
2 affiliate primary care clinic that is licensed pursuant to Section
3 1218.1 of the Health and Safety Code and that has been certified
4 for enrollment by the State Department of Public Health, the
5 department shall provide written notice to the applicant informing
6 the applicant that its Medi-Cal enrollment is approved.

7 (b) If an affiliate primary care clinic's Medi-Cal enrollment is
8 not approved, the department shall collaborate with the State
9 Department of Public Health to ensure that the applicant receives
10 written notification informing the applicant of any deficiencies
11 and providing the applicant with an opportunity to cure the
12 deficiencies within 30 days of the date of the written notice. The
13 department shall have 30 days from the receipt of information
14 from the applicant under this subdivision to approve or deny the
15 Medi-Cal enrollment.

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

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

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

24 24005. (a) This section shall apply to the Family Planning,
25 Access, Care, and Treatment Program identified in subdivision
26 (aa) of Section 14132 and this program.

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

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

39 (d) The department shall require providers to enter into clinical
40 agreements with the department to ensure compliance with

1 standards and requirements to maintain the fiscal integrity of the
2 program. Provider applicants, providers, and persons with an
3 ownership or control interest, as defined in federal medicaid
4 regulations, shall be required to submit to the department their
5 social security numbers to the full extent allowed under federal
6 law. All state and federal statutes and regulations pertaining to the
7 audit or examination of Medi-Cal providers shall apply to this
8 program.

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

14 (f) The department may complete a background check on clinical
15 provider applicants for the purpose of verifying the accuracy of
16 information provided to the department for purposes of enrolling
17 in the program and in order to prevent fraud and abuse. The
18 background check may include, but not be limited to, unannounced
19 onsite inspection prior to enrollment, review of business records,
20 and data searches. If discrepancies are found to exist during the
21 preenrollment period, the department may conduct additional
22 inspections prior to enrollment. Failure to remediate significant
23 discrepancies as prescribed by the director may result in denial of
24 the application for enrollment. Providers that do not provide
25 services consistent with the standards of care or that do not comply
26 with the department's rules related to the fiscal integrity of the
27 program may be disenrolled as a provider from the program at the
28 sole discretion of the department.

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

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

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

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

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

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

35 (3) The department shall deactivate, immediately and without
36 prior notice, the provider numbers used by a provider to obtain
37 reimbursement from the program when warrants or documents
38 mailed to a provider's mailing address, its pay to address, or its
39 service address, if any, are returned by the United States Postal
40 Service as not deliverable or when a provider has not submitted a

1 claim for reimbursement from the program for one year. Prior to
2 taking this action, the department shall use due diligence in
3 attempting to contact the provider at its last known telephone
4 number and to ascertain if the return by the United States Postal
5 Service is by mistake and shall use due diligence in attempting to
6 contact the provider by telephone or in writing to ascertain whether
7 the provider wishes to continue to participate in the Medi-Cal
8 program. If deactivation pursuant to this section occurs, the
9 provider shall meet the requirements for reapplication as specified
10 in regulation.

11 (4) For purposes of this subdivision:

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

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

19 (C) “Service address” means the address that the provider has
20 identified to the department in its application for enrollment as the
21 address at which the provider will provide services to program
22 beneficiaries.

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

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

34 (l) Upon receipt of reliable evidence that would be admissible
35 under the administrative adjudication provisions of Chapter 5
36 (commencing with Section 11500) of Part 1 of Division 3 of Title
37 2 of the Government Code, of fraud or willful misrepresentation
38 by a provider under the program or commencement of a suspension
39 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 (1) “Abuse” means either of the following:

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

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

18 (2) “Fraud” means an intentional deception or misrepresentation
19 made by a person with the knowledge that the deception could
20 result in some unauthorized benefit to himself or herself or some
21 other person. It includes any act that constitutes fraud under
22 applicable federal or state law.

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

30 (4) “Convicted” means any of the following:

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

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

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

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

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

15 (6) “Unnecessary or substandard items or services” means those
16 that are either of the following:

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

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

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

30 (ii) State or local licensing or certification authorities.

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

32 (iv) State or local professional societies.

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

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

39 (n) In lieu of, or in addition to, the imposition of any other
40 sanctions available, including the imposition of a civil penalty

1 under Sections 14123.2 or 14171.6, the program may impose on
2 providers any or all of the penalties pursuant to Section 14123.25,
3 in accordance with the provisions of that section. In addition,
4 program providers shall be subject to the penalties contained in
5 Section 14107.

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

15 (2) For purposes of this subdivision, the term “primary supplier”
16 means any manufacturer, principal labeler, assembler, wholesaler,
17 or retailer.

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

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

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

36 (r) A program provider may assign signature authority for
37 transmission of claims to a billing agent subject to Sections 14040,
38 14040.1, and 14040.5.

39 (s) Moneys payable or rights existing under this division shall
40 be subject to any claim, lien, or offset of the State of California,

1 and any claim of the United States of America made pursuant to
2 federal statute, but shall not otherwise be subject to enforcement
3 of a money judgment or other legal process, and no transfer or
4 assignment, at law or in equity, of any right of a provider of health
5 care to any payment shall be enforceable against the state, a fiscal
6 intermediary, or carrier.

7 (t) (1) Notwithstanding any other law, ~~and only with respect~~
8 ~~to a Medi-Cal provider that is also an affiliate primary care clinic~~
9 ~~licensed under Section 1218.1 of the Health and Safety Code, the~~
10 ~~department shall, within 30 calendar days of receiving a complete~~
11 ~~application for enrollment into the Family PACT Program from~~
12 ~~an affiliate primary care clinic licensed under Section 1218.1 of~~
13 ~~the Health and Safety Code, the department shall do one of the~~
14 following:

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

18 (B) ~~Notify~~ *If the provider is an enrolled Medi-Cal provider in*
19 *good standing, notify* the applicant in writing of any deficiencies
20 in the Family PACT Program enrollment application. The applicant
21 shall have 30 days from the date of written notice to correct any
22 ~~eted~~ *identified* deficiencies. Upon receipt of all requested
23 corrections, the department shall approve the application within
24 30 calendar days.

25 ~~(2) If an affiliate primary care clinic files its Family PACT~~
26 ~~Program application either before or on the same day that it files~~
27 ~~its affiliate primary care clinic licensure application with the State~~
28 ~~Department of Public Health, the department shall concurrently~~
29 ~~review and approve the applicant's Family PACT Program~~
30 ~~application and Medi-Cal enrollment in accordance with this~~
31 ~~subdivision and Section 14043.17. The effective date of enrollment~~
32 ~~into both programs shall be retroactive to the date Medi-Cal~~
33 ~~certification was approved by the State Department of Public~~
34 ~~Health.~~

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

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

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