Assembly Bill No. 1142

Passed the Assembly September 10, 2009

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Chief Clerk of the Assembly

Passed the Senate September 8, 2009

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Secretary of the Senate

This bill was received by the Governor this _____ day of _____, 2009, at _____ o'clock ___M.

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Private Secretary of the Governor

CHAPTER _____

An act to amend Sections 14018.2 and 14019.4 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 1142, Price. Medi-Cal: proof of eligibility.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income persons receive health care services. Existing law provides that it is the responsibility of the Medi-Cal beneficiary to provide information and evidence of Medi-Cal eligibility to that person's health care provider if that information is requested by the provider prior to rendering services to that beneficiary.

Existing law provides that it is the responsibility of the provider prior to rendering Medi-Cal reimbursable services to persons presenting themselves as Medi-Cal beneficiaries to make a good faith effort to verify the person's identity, if the person is not known to the provider, otherwise payment for those services may later be disallowed by the department.

This bill would provide, if a hospital obtains proof of Medi-Cal eligibility for a patient subsequent to the date of service, that it is the responsibility of a hospital to provide all information regarding that person's Medi-Cal eligibility to certain providers that bill separately for all services associated with the person's treatment in the hospital rendered during the same time period for which the hospital is submitting a claim, as specified.

Existing law prohibits any provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility from seeking reimbursement or attempting to obtain payment for the cost of the covered health care services from the eligible applicant or recipient, or any person other than the department or a 3rd-party payor who provides a contractual or legal entitlement to health care services.

This bill would require a Medi-Cal provider, if the provider receives proof of a patient's Medi-Cal eligibility and has previously referred an unpaid bill for services rendered to the patient to a debt

collector, to promptly notify the debt collector of the patient's Medi-Cal coverage, instruct the debt collector to cease collection efforts on the unpaid bill for covered services, and notify the patient accordingly.

This bill would provide that a provider of health care services who obtains a label from, or copy of, the Medi-Cal card or other proof of eligibility and who subsequently pursues reimbursement or payment for the cost of covered services from the beneficiary or fails to cease collection efforts against the beneficiary for covered services, as prescribed, may be subject to a penalty, payable to the department, not to exceed 3 times the amount payable by the Medi-Cal program. The bill would also require that prescribed mitigating circumstances be considered when assessing the penalty. The bill would require that a provider have the right to appeal the assessed penalty, as specified.

Existing law prohibits a person furnishing information on a specific transaction or experience to any consumer credit reporting agency if the person knows or should know the information is incomplete or inaccurate.

This bill would provide that if a Medi-Cal provider or debt collector receives proof of Medi-Cal coverage for services rendered and then reports the services rendered to a consumer credit reporting agency or fails to provide corrections of, or instructions to delete, as appropriate, information regarding Medi-Cal covered services to a consumer reporting agency, the provider or debt collector shall be deemed to be in violation of the above-described provisions.

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

SECTION 1. Section 14018.2 of the Welfare and Institutions Code is amended to read:

14018.2. (a) Reimbursement shall not be denied to any qualified health care provider for care rendered to an eligible Medi-Cal beneficiary for the sole reason that a proof of eligibility label does not accompany the bill.

Proof of eligibility labels may, however, continue to be used as such and shall be made available to an eligible Medi-Cal beneficiary through the local office which has determined the person's eligibility or through the department. The provider may

submit machine-reproduced copies of the beneficiary Medi-Cal card for billing purposes as long as the copy is made from the original unaltered Medi-Cal card under circumstances controlled by the provider, for example, on the premises of the provider with copying equipment controlled by the provider.

(b) It shall remain the responsibility of a Medi-Cal beneficiary to provide information and evidence of Medi-Cal eligibility, restrictions on the eligibility, and non-Medi-Cal health coverage, to that person's health care providers, if this information is requested by those providers prior to rendering services to that beneficiary.

(c) It shall be the responsibility of the provider prior to rendering Medi-Cal reimbursable services to persons presenting themselves as Medi-Cal beneficiaries to make a good faith effort to verify the person's identity, if the person is not known to the provider, by matching the name and signature on his or her Medi-Cal card against the signature on a valid California driver's license, or California identification card issued by the Department of Motor Vehicles, or another type of picture identification card or other credible document of identification. When the provider verifies the beneficiary's identity with a signed Medi-Cal card and one of the documents described above, the state will deem this to be a good faith effort. If the provider does not make a good faith effort of reasonable identification prior to rendering Medi-Cal reimbursable services and renders services to a presenting person who is ineligible for those Medi-Cal services, payment for those services may later be disallowed.

This provision shall not apply to:

(1) Persons 17 years of age and under.

(2) Persons in long-term care.

(3) Persons receiving emergency services.

(d) Notwithstanding subdivision (b) of this section, county welfare departments may provide Medi-Cal eligibility information to other governmental agencies and their designated agents as necessary for proper administration of the Medi-Cal program.

(e) If a hospital obtains proof of Medi-Cal eligibility for a patient subsequent to the date of service, it shall be the responsibility of the hospital to provide all information regarding that person's Medi-Cal eligibility to all hospital-based providers, ambulance transportation services providers, providers that provide ambulance

transportation services through the "911" emergency response system, and other hospital-based providers of professional services that bill separately for all services associated with the person's treatment in the hospital rendered during the same time period for which the hospital is submitting a claim. The hospital may inform the provider that the person's Medi-Cal eligibility is pending, before a final determination is made on the patient's Medi-Cal application, to satisfy the requirements of this subdivision. If the provider or the provider's agent obtains this information from the hospital, the requirement has been satisfied.

(f) For purposes of this section, the following definitions apply:

(1) "Hospital-based provider" means an anesthesiologist, radiologist, pathologist, emergency room physician, or other physician or a group of physicians providing medical services at the hospital.

(2) "Hospital-based professional services" means services performed for a patient while at a hospital, related to the patient's hospital stay, and known to the hospital, including, but not limited to, diagnostic, laboratory, therapeutic, and radiologic services.

SEC. 2. Section 14019.4 of the Welfare and Institutions Code is amended to read:

14019.4. (a) A provider of health care services who obtains a label or copy from the Medi-Cal card or other proof of eligibility pursuant to this chapter shall not seek reimbursement nor attempt to obtain payment for the cost of those covered health care services from the eligible applicant or recipient, or a person other than the department or a third-party payor who provides a contractual or legal entitlement to health care services.

(b) Whenever a service or set of services rendered to a Medi-Cal beneficiary results in the submission of a claim in excess of five hundred dollars ($500), and the beneficiary has given the provider proof of eligibility to receive the service or services, the provider shall issue the beneficiary a receipt to document that appropriate proof of eligibility has been provided. The form and content of those receipts shall be determined by the provider but shall be sufficient to comply with the intent of this subdivision. Nursing facilities and all categories of intermediate care facilities for the developmentally disabled are exempt from the requirements of this subdivision.

(c) In addition to being subject to applicable sanctions set forth in law or regulation, a provider of health care services who obtains a label from, or copy of, the Medi-Cal card or other proof of eligibility pursuant to this chapter, and who subsequently pursues reimbursement or payment for the cost of covered services from the beneficiary or fails to cease collection efforts against the beneficiary for covered services as required by subdivision (d), may be subject to a penalty, payable to the department, not to exceed three times the amount payable by the Medi-Cal program. In implementing this subdivision, mitigating circumstances, which include, but are not limited to, clerical error and good faith mistake, shall be considered when assessing the penalty. Providers subject to penalties under this subdivision shall have the right to appeal the assessed penalty, consistent with department procedures.

(d) When a Medi-Cal provider receives proof of a patient's Medi-Cal eligibility and that provider has previously referred an unpaid bill for services rendered to the patient to a debt collector, the Medi-Cal provider shall promptly notify the debt collector of the patient's Medi-Cal coverage, instruct the debt collector to cease collection efforts on the unpaid bill for the covered services, and notify the patient accordingly.

(e) If a patient provides proof of Medi-Cal eligibility to a debt collector, and the debt collector fails to notify the provider of this proof, the provider shall not be responsible for ensuring that collection efforts against the patient cease pursuant to subdivision (d) until either the patient or the debt collector provides the provider with proof of the patient's Medi-Cal eligibility.

(f) A Medi-Cal provider or debt collector shall be deemed to be in violation of subdivision (a) of Section 1785.25 of the Civil Code if more than 30 days after receiving proof of Medi-Cal coverage the provider or debt collector does either of the following:

(1) Furnishes information regarding the rendering of the Medi-Cal covered services to a consumer credit reporting agency.

(2) Fails to provide corrections of, or instructions to delete, as appropriate, information regarding Medi-Cal covered services previously furnished by that Medi-Cal provider or debt collector to a consumer reporting agency.

(g) This section shall not apply to the Medi-Cal share of cost owed by a Medi-Cal beneficiary, unless the beneficiary's share of cost has been met for the month in which services were rendered.

(h) For purposes of this section, “debt collector” includes any person who regularly engages in debt collection, as defined by Section 1788.2 of the Civil Code, but does not include the original Medi-Cal provider.

Approved _____, 2009

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Governor