AMENDED IN ASSEMBLY MARCH 29, 2012

CALIFORNIA LEGISLATURE—2011–12 REGULAR SESSION

ASSEMBLY BILL No. 1629

Introduced by Assembly Member Halderman

February 9, 2012

An act to amend Section ~~14043.1~~ *14043.26* of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 1629, as amended, Halderman. ~~Medi-Cal.~~ *Medi-Cal: provisional provider status: medically underserved areas.*

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services and under which low-income persons receive health care benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid provisions. ~~Existing law defines an "applicant" as an individual or other entity, as specified, that applies to enroll as a Medi-Cal program provider, and defines a "provider" as an individual or other entity, as specified, that is enrolled in the Medi-Cal program and provides goods or services to a Medi-Cal beneficiary.~~ *Existing law requires applicants and providers, as defined, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location and requires the application form for enrollment, the provider agreement, and all attachments or changes to be signed under penalty of perjury. Existing law requires the department to grant provisional provider status to applicants and providers, as specified, and requires the department to grant preferred provisional provider status to an applicant or provider who meets specified criteria.*

~~This bill would make technical, nonsubstantive changes to those provisions.~~

This bill would require the department to grant provisional provider status to an applicant or provider who meets specified criteria as a provider practicing in a medically underserved area. This bill would provide, to the extent permitted by federal law, that an applicant or provider granted provisional provider status as a provider serving a medically underserved area whose application is ultimately denied, or whose provisional provider status is terminated, shall not be required to reimburse the department for Medi-Cal funds received during the provisional provider period.

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

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

SECTION 1. Section 14043.26 of the Welfare and Institutions Code is amended to read:

14043.26. (a) (1) On and after January 1, 2004, an applicant that currently is not enrolled in the Medi-Cal program, or a provider applying for continued enrollment, upon written notification from the department that enrollment for continued participation of all providers in a specific provider of service category or subgroup of that category to which the provider belongs will occur, or, except as provided in subdivisions (b) and (e), a provider not currently enrolled at a location where the provider intends to provide services, goods, supplies, or merchandise to a Medi-Cal beneficiary, shall submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location.

(2) Clinics licensed by the department pursuant to Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(3) Health facilities licensed by the department pursuant to Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(4) Adult day health care providers licensed pursuant to Chapter 3.3 (commencing with Section 1570) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(5) Home health agencies licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(6) Hospices licensed pursuant to Chapter 8.5 (commencing with Section 1745) of Division 2 of the Health and Safety Code and certified by the department to participate in the Medi-Cal program shall not be subject to this section.

(b) A physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California, or a dentist licensed by the Dental Board of California, practicing as an individual physician practice or as an individual dentist practice, as defined in Section 14043.1, who is enrolled and in good standing in the Medi-Cal program, and who is changing locations of that individual physician practice or individual dentist practice within the same county, shall be eligible to continue enrollment at the new location by filing a change of location form to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. Filing this form shall be in lieu of submitting a complete application package pursuant to subdivision (a).

(c) (1) Except as provided in paragraph (2), within 30 days after receiving an application package submitted pursuant to subdivision (a), the department shall provide written notice that the application package has been received and, if applicable, that there is a moratorium on the enrollment of providers in the specific provider of service category or subgroup of the category to which the applicant or provider belongs. This moratorium shall bar further processing of the application package.

(2) Within 15 days after receiving an application package from a physician, or a group of physicians, licensed by the Medical Board of California or the Osteopathic Medical Board of California, or a change of location form pursuant to subdivision (b), the department shall provide written notice that the application package or the change of location form has been received.

(d) (1) *(A)* If the application package submitted pursuant to subdivision (a) is from an applicant or provider who meets the criteria listed in ~~paragraph (2)~~ *subparagraph (B)*, the applicant or provider shall be considered a preferred provider and shall be granted preferred provisional provider status pursuant to this section and for a period of no longer than 18 months, effective from the date on the notice from the department. The ability to request consideration as a preferred provider and the criteria necessary for the consideration shall be publicized to all applicants and providers. An applicant or provider who desires consideration as a preferred provider pursuant to this ~~subdivision~~ *paragraph* shall request consideration from the department by making a notation to that effect on the application package, by cover letter, or by other means identified by the department in a provider bulletin. Request for consideration as a preferred provider shall be made with each application package submitted in order for the department to grant the consideration. An applicant or provider who requests consideration as a preferred provider shall be notified within 60 days whether the applicant or provider meets or does not meet the criteria listed in ~~paragraph (2)~~ *subparagraph (B)*. If an applicant or provider is notified that the applicant or provider does not meet the criteria for a preferred provider, the application package submitted shall be processed in accordance with the remainder of this section.

~~(2)~~

(B) To be considered a preferred provider, the applicant or provider shall meet all of the following criteria:

~~(A)~~

(i) Hold a current license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California, which license shall not have been revoked, whether stayed or not, suspended, placed on probation, or subject to other limitation.

~~(B)~~

(ii) Be a current faculty member of a teaching hospital or a children's hospital, as defined in Section 10727, accredited by the Joint Commission or the American Osteopathic Association, or be credentialed by a health care service plan that is licensed under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health

and Safety Code) or county organized health system, or be a current member in good standing of a group that is credentialed by a health care service plan that is licensed under the Knox-Keene Act.

~~(C)~~

(iii) Have full, current, unrevoked, and unsuspended privileges at a Joint Commission or American Osteopathic Association accredited general acute care hospital.

~~(D)~~

(iv) Not have any adverse entries in the federal Healthcare Integrity and Protection Data Bank.

~~(3)~~

(C) The department may recognize other providers as qualifying as preferred providers if criteria similar to those set forth in ~~paragraph (2)~~ *subparagraph (B)* are identified for the other providers. The department shall consult with interested parties and appropriate stakeholders to identify similar criteria for other providers so that they may be considered as preferred providers.

(2) (A) If the application package submitted pursuant to subdivision (a) is from an applicant or provider who meets the criteria in subparagraph (B), the applicant or provider shall be considered a provider practicing in a medically underserved area and shall be granted provisional provider status pursuant to this paragraph and for a period of no longer than 18 months, effective from the date on the notice from the department. The ability to request consideration as a provider practicing in a medically underserved area and the criteria necessary for the consideration shall be publicized to all applicants and providers. An applicant or provider who desires consideration as a provider practicing in a medically underserved area pursuant to this paragraph shall request consideration from the department by making a notation to that effect on the application package, by cover letter, or by other means identified by the department in a provider bulletin. Request for consideration as a provider practicing in a medically underserved area shall be made with each application package submitted in order for the department to grant the consideration. The department shall notify an applicant or provider who requests consideration as a provider practicing in a medically underserved area as to whether the applicant or provider meets or does not meet the criteria listed in subparagraph (B) within 30 days, or on the 31st day the applicant or provider shall be granted provisional

provider status, until a final determination on the application is made by the department in accordance with this section.

(B) To be considered a provider practicing in a medically underserved area, the applicant or provider shall meet all of the following criteria:

(i) Hold a current license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California, which license shall not have been revoked, whether stayed or not, suspended, placed on probation, or subject to other limitation.

(ii) Not have any adverse entries in the federal Healthcare Integrity and Protection Data Bank or the National Practitioner Data Bank.

(iii) Practice in a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA), or with a Medically Underserved Population (MUP), as defined by the United States Department of Health and Human Services.

(C) Notwithstanding any other state law and to the extent permitted by federal law, an applicant or provider granted provisional provider status pursuant to this paragraph whose application is ultimately denied, or whose provisional provider status is terminated, shall not be required to reimburse the department for Medi-Cal funds received during the provisional provider period unless the provider is under investigation for, or has been convicted of, fraud.

(e) (1) If a Medi-Cal applicant meets the criteria listed in paragraph (2), the applicant shall be enrolled in the Medi-Cal program after submission and review of a short form application to be developed by the department. The form shall comply with all minimum federal requirements related to Medicaid provider enrollment. The department shall notify the applicant that the department has received the application within 15 days of receipt of the application. The department shall issue the applicant a provider number or notify the applicant that the applicant does not meet the criteria listed in paragraph (2) within 90 days of receipt of the application.

(2) Notwithstanding any other provision of law, an applicant or provider who meets all of the following criteria shall be eligible for enrollment in the Medi-Cal program pursuant to this

subdivision, after submission and review of a short form application:

(A) The applicant's or provider's practice is based in one or more of the following: a general acute care hospital, a rural general acute care hospital, or an acute psychiatric hospital, as defined in subdivisions (a) and (b) of Section 1250 of the Health and Safety Code.

(B) The applicant or provider holds a current, unrevoked, or unsuspended license as a physician and surgeon issued by the Medical Board of California or the Osteopathic Medical Board of California. An applicant or provider shall not be in compliance with this subparagraph if a license revocation has been stayed, the licensee has been placed on probation, or the license is subject to any other limitation.

(C) The applicant or provider does not have an adverse entry in the federal Healthcare Integrity and Protection Data Bank.

(3) An applicant shall be granted provisional provider status under this subdivision for a period of 12 months.

(f) Except as provided in subdivision (g), within 180 days after receiving an application package submitted pursuant to subdivision (a), or from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider *or a provider serving a medically underserved area* under subdivision (d), the department shall give written notice to the applicant or provider that any of the following applies, or shall on the 181st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 181st day:

(1) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(2) The application package is incomplete. The notice shall identify additional information or documentation that is needed to complete the application package.

(3) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7, and is conducting background checks, preenrollment inspections, or unannounced visits.

(4) The application package is denied for any of the following reasons:

(A) Pursuant to Section 14043.2 or 14043.36.

(B) For lack of a license necessary to perform the health care services or to provide the goods, supplies, or merchandise directly or indirectly to a Medi-Cal beneficiary, within the applicable provider of service category or subgroup of that category.

(C) The period of time during which an applicant or provider has been barred from reapplying has not passed.

(D) For other stated reasons authorized by law.

(g) Notwithstanding subdivision (f), within 90 days after receiving an application package submitted pursuant to subdivision (a) from a physician or physician group licensed by the Medical Board of California or the Osteopathic Medical Board of California, or from the date of the notice to that physician or physician group that does not qualify as a preferred provider *or a provider serving a medically underserved area* under subdivision (d), or within 90 days after receiving a change of location form submitted pursuant to subdivision (b), the department shall give written notice to the applicant or provider that either paragraph (1), (2), (3), or (4) of subdivision (f) applies, or shall on the 91st day grant the applicant or provider provisional provider status pursuant to this section for a period no longer than 12 months, effective from the 91st day.

(h) (1) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is resubmitted with all requested information and documentation, and received by the department within 60 days of the date on the notice, the department shall, within 60 days of the resubmission, send a notice that any of the following applies:

(A) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) The application package is denied for any other reasons provided for in paragraph (4) of subdivision (f).

(C) The department is exercising its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits.

(2) (A) If the application package that was noticed as incomplete under paragraph (2) of subdivision (f) is not resubmitted with all requested information and documentation and received by the department within 60 days of the date on the notice, the application package shall be denied by operation of law. The

applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to resubmit is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the notice of an incomplete application package included a request for information or documentation related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years.

(i) (1) If the department exercises its authority under Section 14043.37, 14043.4, or 14043.7 to conduct background checks, preenrollment inspections, or unannounced visits, the applicant or provider shall receive notice, from the department, after the conclusion of the background check, preenrollment inspection, or unannounced visit of either of the following:

(A) The applicant or provider is granted provisional provider status for a period of 12 months, effective from the date on the notice.

(B) Discrepancies or failure to meet program requirements, as prescribed by the department, have been found to exist during the preenrollment period.

(2) (A) The notice shall identify the discrepancies or failures, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Failure to remediate discrepancies and failures as prescribed by the department, or notification that remediation is not available, shall result in denial of the application by operation of law. The applicant or provider may reapply by submitting a new application package that shall be reviewed de novo.

(B) If the failure to remediate is by a provider applying for continued enrollment, the failure shall make the provider also subject to deactivation of the provider's number and all of the business addresses used by the provider to provide services, goods, supplies, or merchandise to Medi-Cal beneficiaries.

(C) Notwithstanding subparagraph (A), if the discrepancies or failure to meet program requirements, as prescribed by the director, included in the notice were related to grounds for denial under Section 14043.2 or 14043.36, the applicant or provider shall not reapply for three years.

(j) If provisional provider status or preferred provisional provider status is granted pursuant to this section, a provider number shall be used by the provider for each business address for which an application package has been approved. This provider number shall be used exclusively for the locations for which it was approved, unless the practice of the provider's profession or delivery of services, goods, supplies, or merchandise is such that services, goods, supplies, or merchandise are rendered or delivered at locations other than the provider's business address and this practice or delivery of services, goods, supplies, or merchandise has been disclosed in the application package approved by the department when the provisional provider status or preferred provisional provider status was granted.

(k) Except for providers subject to subdivision (c) of Section 14043.47, a provider currently enrolled in the Medi-Cal program at one or more locations who has submitted an application package for enrollment at a new location or a change in location pursuant to subdivision (a), or filed a change of location form pursuant to subdivision (b), may submit claims for services, goods, supplies, or merchandise rendered at the new location until the application package or change of location form is approved or denied under this section, and shall not be subject, during that period, to deactivation, or be subject to any delay or nonpayment of claims as a result of billing for services rendered at the new location as herein authorized. However, the provider shall be considered during that period to have been granted provisional provider status or preferred provisional provider status and be subject to termination of that status pursuant to Section 14043.27. A provider that is subject to subdivision (c) of Section 14043.47 may come within the scope of this subdivision upon submitting documentation in the application package that identifies the physician providing supervision for every three locations. If a provider submits claims for services rendered at a new location before the application for that location is received by the department, the department may deny the claim.

(*l*) An applicant or a provider whose application for enrollment, continued enrollment, or a new location or change in location has been denied pursuant to this section, may appeal the denial in accordance with Section 14043.65.

(m) (1) Upon receipt of a complete and accurate claim for an individual nurse provider, the department shall adjudicate the claim within an average of 30 days.

(2) During the budget proceedings of the 2006–07 fiscal year, and each fiscal year thereafter, the department shall provide data to the Legislature specifying the timeframe under which it has processed and approved the provider applications submitted by individual nurse providers.

(3) For purposes of this subdivision, "individual nurse providers" are providers authorized under certain home- and community-based waivers and under the state plan to provide nursing services to Medi-Cal recipients in the recipients' own homes rather than in institutional settings.

(n) The amendments to subdivision (b), which implement a change of location form, and the addition of paragraph (2) to subdivision (c), the amendments to subdivision (e), and the addition of subdivision (g), which prescribe different processing timeframes for physicians and physician groups, as contained in Chapter 693 of the Statutes of 2007, shall become operative on July 1, 2008.

~~SECTION 1. Section 14043.1 of the Welfare and Institutions Code is amended to read:~~

~~14043.1. As used in this article:~~

~~(a) "Abuse" means either of the following:~~

~~(1) Practices that are inconsistent with sound fiscal or business practices and result in unnecessary cost to the federal Medicaid and Medicare programs, the Medi-Cal program, another state's Medicaid program, or other health care programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state.~~

~~(2) Practices that are inconsistent with sound medical practices and result in reimbursement by the federal Medicaid and Medicare programs, the Medi-Cal program or other health care programs operated, or financed in whole or in part, by the federal government or a state or local agency in this state or another state, for services that are unnecessary or for substandard items or services that fail to meet professionally recognized standards for health care.~~

~~(b) "Applicant" means an individual, partnership, group, association, corporation, institution, or entity, and an officer, director, owner, managing employee, or agent of a partnership, group, association, corporation, institution, or entity, that applies to the department for enrollment as a provider in the Medi-Cal program.~~

~~(c) "Application or application package" means a completed and signed application form, signed under penalty of perjury or notarized pursuant to Section 14043.25, a disclosure statement, a provider agreement, and all attachments or changes in the form, statement, or agreement.~~

~~(d) "Appropriate volume of business" means a volume that is consistent with the information provided in the application and any supplemental information provided by the applicant or provider, and is of a quality and type that would reasonably be expected based upon the size and type of business operated by the applicant or provider.~~

~~(e) "Business address" means the location where an applicant or provider provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary. A post office box or commercial box is not a business address. The business address for the location of a vehicle or vessel owned and operated by an applicant or provider enrolled in the Medi-Cal program and used to provide services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary shall either be the business address location listed on the provider's application as the location where similar services, goods, supplies, or merchandise would be provided or the applicant's or provider's pay to address.~~

~~(f) "Convicted" means any of the following:~~

~~(1) 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 posttrial motion, an appeal pending, or the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.~~

~~(2) A federal, state, or local court has made a finding of guilt against an individual or entity.~~

~~(3) A federal, state, or local court has accepted a plea of guilty or nolo contendere by an individual or entity.~~

~~(4) 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.~~

~~(g) "Debt due and owing" means 60 days have passed since a notice or demand for repayment of an overpayment or another amount resulting from an audit or examination, for a penalty assessment, or for another amount due to the department was sent to the provider, regardless of whether the provider is an institutional provider or a noninstitutional provider and regardless of whether an appeal is pending.~~

~~(h) "Enrolled or enrollment in the Medi-Cal program" means authorized under any 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 Medi-Cal beneficiary.~~

~~(i) "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.~~

~~(j) "Location" means a street, city, or rural route address or a site or place within a street, city, or rural route address, and the city, county, state, and nine-digit ZIP Code.~~

~~(k) "Not currently enrolled at the location for which the application is submitted" means either of the following:~~

~~(1) The provider is changing location and moving to a different location than that for which the provider was issued a provider number.~~

~~(2) The provider is adding a business address.~~

~~(*l*) (1) "Individual dentist practice" means a dentist licensed by the Dental Board of California enrolled or enrolling in Medi-Cal as an individual provider who is a sole proprietor of his or her practice or is a corporation owned solely by the individual dentist and the only dentist practitioner is the owner. An individual dentist practice may include nondentist allied dental health professionals employed and supervised by the dentist.~~

~~(2) "Individual physician practice" means a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California enrolled or enrolling in Medi-Cal as an individual provider who is sole proprietor of his~~

~~or her practice or is a corporation owned solely by the individual physician and the only physician practitioner is the owner. An individual physician practice may include nonphysician medical practitioners employed and supervised by the physician.~~

~~(m) "Preenrollment period" or "preenrollment" includes the period of time during which an application package for enrollment, continued enrollment, or for the addition of or change in a location is pending.~~

~~(n) "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 subdivision shall not be construed to mean that all other treatments meet professionally recognized standards of care.~~

~~(o) "Provider" means an individual, partnership, group, association, corporation, institution, or entity, and an officer, director, owner, managing employee, or agent of a partnership, group association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal program.~~

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

~~(1) Substantially in excess of the provider's usual charges or costs for the items or services.~~

~~(2) 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:~~

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

~~(B) State or local licensing or certification authorities.~~

~~(C) Fiscal agents or contractors or private insurance companies.~~

~~(D) State or local professional societies.~~

~~(E) Any other sources deemed appropriate by the department.~~

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