AMENDED IN SENATE MAY 18, 2000

AMENDED IN ASSEMBLY JANUARY 3, 2000

CALIFORNIA LEGISLATURE—1999–2000 REGULAR SESSION

ASSEMBLY BILL No. 1098

Introduced by Assembly Member Romero
(Coauthors: Assembly Members Aroner, Firebaugh, Honda, and Keeley)

February 25, 1999

An act to amend ~~Section 14171.6 of~~ *Sections 1265, 1287, 1301, and 1320 of, and to add Sections 1281.1, 1282.1, 1282.2, 1311, and 1320.5 to, the Business and Professions Code, and to amend Sections 14040, 14040.5, 14043.1, 14043.2, 14043.36 14043.37, 14043.65, 14043.7, 14043.75, 14100.75, 14107, 14107.11, 14115.5, 14124.1, 14124.2, 14170, 14170.8, 14171.6, and 24005 of, and to add Sections 14040.1, 14043.34, 14043.61, 14043.62, and 14123.25 to,* the Welfare and Institutions Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1098, as amended, Romero. ~~Medi-Cal~~ *Health*.

Existing law contains provisions governing the licensure and registration of clinical laboratories, which are administered by the State Department of Health Services.

This bill would make various modifications to these requirements, including the provision of additional grounds for denial, suspension, or revocation of licensure or registration, as well as provisions relating to the retention of records.

The bill would also provide that a violation of provisions that constitute grounds for denial, registration suspension, or revocation of clinical laboratory licensure or registration that results in bodily harm to a human being or involves the taking of blood from a minor child or dependent adult shall be a crime, punishable as specified.

The bill would also make it unlawful, and subject to criminal penalties, for any person to: (1) provide any form of payment or gratuity for human blood or any other human specimen provided for the purpose of clinical laboratory testing or practice, (2) solicit, or to provide any form of payment or gratuity to, another person for the procurement of that person's blood or any other specimen from his or her body, unless the solicitor is serving as the agent of either a clinical laboratory performing tests or examinations for purposes of research or teaching or a licensed biologics producer, or (3) perform venipuncture, skin puncture, or arterial puncture, unless authorized by law.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which medical benefits are provided to public assistance recipients and certain other low-income persons.

Existing law defines a provider for the purposes of the Medi-Cal program.

This bill would revise the definition of a provider for that purpose.

Existing law provides for the State-Only Family Planning Program, under which family planning services are provided to eligible individuals.

Existing law also establishes the Family Planning Access, Care, and Treatment Waiver Program, as part of the Medi-Cal program.

The bill would enact various provisions relating to billing for Medi-Cal and family planning services, including provisions relating to provider billing agents.

Existing law provides that any person, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing Medi-Cal program services or merchandise, knowingly submits false information for the purpose of obtaining greater compensation than that to which

he or she is legally entitled, or knowingly submits false information for the purpose of obtaining authorization of obtaining Medi-Cal program services or merchandise is guilty of a crime.

This bill would, instead, make it a crime for any person, including a Medi-Cal provider, an applicant for provider status, or a billing agent, who engages in specified activities, punishable as prescribed.

The bill would also permit, subject to specified requirements, the forfeiture of property of persons engaging in these activities.

Because the bill creates additional crimes, the bill would constitute a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

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

~~SECTION 1. Section 14171.6 of the Welfare and~~

SECTION 1. Section 1265 of the Business and Professions Code is amended to read:

1265. (a) (1) A clinical laboratory performing clinical laboratory tests or examinations classified as of moderate or of high complexity under CLIA shall obtain a clinical laboratory license pursuant to this chapter. The department shall issue a clinical laboratory license to any person who has applied for the license on forms provided by the department and who is found to be in compliance with this chapter and the regulations pertaining thereto. No clinical laboratory license shall be issued by the department unless the clinical laboratory and its personnel meet the CLIA requirements for laboratories performing tests or examinations classified as of moderate or high complexity, or both.

(2) A clinical laboratory performing clinical laboratory tests or examinations subject to a certificate of waiver or a certificate of provider-performed microscopy under CLIA, shall register with the department. The department shall issue a clinical laboratory registration to any person who has applied for the registration on forms provided by the department and is found to be in compliance with this chapter, the regulations pertaining thereto, and the CLIA requirements for either a certificate of waiver or a certificate of provider-performed microscopy.

(b) An application for a clinical laboratory license or registration shall include the name or names of the owner or the owners, the name or names of the laboratory director or directors, the name and location of the laboratory, a list of the clinical laboratory tests or examinations performed by the laboratory by name and total number of test procedures and examinations performed annually (excluding tests the laboratory may run for quality control, quality assurance, or proficiency testing purposes). The application shall also include a list of the tests and the test kits, methodologies, and laboratory equipment used, and the qualifications (educational background, training, and experience) of the personnel directing and supervising the laboratory and performing the laboratory examinations and test procedures, and any other relevant information as may be required by the department. If the laboratory is performing tests subject to a provider-performed microscopy certificate, the name of the provider or providers performing those tests shall be included on the application. Application shall be made by the owners of the laboratory and the laboratory directors prior to its opening. A license or registration to conduct a clinical laboratory if the owners are not the laboratory directors shall be issued jointly to the owners and the laboratory directors and the license or registration shall include any information as may be required by the department. The owners and laboratory directors shall be severally and jointly responsible to the department for the

maintenance and conduct thereof or for any violations of this chapter and regulations pertaining thereto.

(c) The department shall not issue a license or registration until it is satisfied that the clinical laboratory will be operated within the spirit and intent of this chapter, that the owners and laboratory directors are each of good moral character, and that the granting of the license will not be in conflict with the interests of public health.

(d) A separate license or registration shall be obtained for each laboratory location, with the following exceptions:

(1) Laboratories that are not at a fixed location, that is, laboratories that move from one testing site to another, such as mobile units providing laboratory testing, health screening fairs, or other temporary testing locations, may apply for and obtain one license or registration for the designated primary site or home base, using the address of that primary site.

(2) Not-for-profit, or federal, state, or local government laboratories that engage in limited (not more than a combination of 15 moderately complex or waived tests, as defined under CLIA, per license) public health testing may apply for and obtain a single license or registration.

(3) Laboratories within a hospital that are located at contiguous buildings on the same campus and under common direction, may file a single application or multiple applications for a license or registration of laboratory locations within the same campus or street address.

(4) Locations within a single street and city address that are under common ownership may apply for and obtain a single license or registration or multiple licenses or registrations, at the discretion of the owner or owners.

(e) A ~~license or registration shall be automatically revoked in 30 days if there is a major change of laboratory directorship or ownership. The~~ license or registration shall be valid for the calendar year or remainder thereof for which it is issued unless revoked or suspended. *A*

license or registration shall be automatically revoked if there is a major change of laboratory directorship or ownership, in which case the clinical laboratory shall be required to obtain a new clinical laboratory license or registration prior to engaging in clinical laboratory practice.

(f) If the department does not within 60 days after the date of receipt of the application issue a license or registration, it shall state the grounds and reasons for its refusal in writing, serving a copy upon the applicant by certified mail addressed to the applicant at his or her last known address.

~~(f)~~

(g) The department shall be notified *in writing by the laboratory owners or directors* within 30 days of any change in ownership, name, location, ~~or~~ *and by the* laboratory *owners and* directors*, 30 days prior to any change in laboratory directors, including any additions or deletions. Laboratory owners and directors to whom the current license or registration is issued shall remain jointly and severally responsible to the department for the operation, maintenance, and conduct of the clinical laboratory and for any violations of this chapter or the regulations adopted thereunder, including any failure to provide the notifications required by this subdivision. In addition, failure of the laboratory owners or directors to notify the department at least 30 days prior to any change in laboratory directors, including any additions or deletions, shall result in the automatic revocation of the clinical laboratory's license or registration.*

(h) The withdrawal of an application for a license or registration or for a renewal of a license, or registration, issuable under this chapter, shall not, after the application has been filed with the department, deprive the department of its authority to institute or continue a proceeding against the applicant for denial of the license, registration, or renewal upon any ground provided by law or to enter an order denying the license, registration, or renewal upon any such ground, unless the department consents in writing to the withdrawal.

(i) The suspension, expiration, or forfeiture by operation of law of a license or registration issued under this chapter, or its suspension, forfeiture, or cancellation by order of the department or by order of a court of law, or its surrender without the written consent of the department, shall not deprive the department of its authority to institute or continue an action against a license or registration issued under this chapter or against the laboratory owner or laboratory director upon any ground provided by law or to enter an order suspending or revoking the license or registration issued under this chapter.

(j) (1) The department shall be notified within 10 days whenever a clinical laboratory ceases operations or suspends clinical laboratory practice for any reason.

(2) If a clinical laboratory ceases operation or suspends clinical laboratory practice, it shall preserve all of its records for a minimum of seven years and shall maintain an ability to provide the results of clinical laboratory tests or examinations performed during its operation when requested pursuant to Section 123148 of the Health and Safety Code. The records preserved shall include all those showing compliance during the laboratory's operation with this chapter and the regulations adopted thereunder, including, but not limited to, records for test performance, test reporting, personnel, and the purchase or lease of supplies or equipment. In addition, all records of tests or examinations classified under the specialties or subspecialties of pathology or cytology shall be retained as required by this chapter, the regulations adopted thereunder or the federal Clinical Laboratory Improvement Amendments of 1988 (42 U.S.C. Sec. 263a), whichever period is longer.

(3) The department or any person injured as a result of a laboratory's abandonment or failure to retain records pursuant to this section may bring an action in a court of proper jurisdiction for the amount of any damages suffered as a result thereof.

(4) Failure to retain records as required by this section shall also subject a laboratory to a civil penalty of one

thousand dollars ($1,000) for each record not retained and the recovery of any department costs.

SEC. 2. Section 1281.1 is added to the Business and Professions Code, to read:

1281.1. It is unlawful for any person, including a person who owns, operates, or directs a clinical laboratory, to provide any form of payment or gratuity for human blood or any other human specimen provided for the purpose of clinical laboratory testing or clinical laboratory practice.

SEC. 3. Section 1282.1 is added to the Business and Professions Code, to read:

1282.1. It is unlawful for any person to solicit, or to provide any form of payment or gratuity to, another person for the procurement of that person's blood, or any other specimen from his or her body, unless the solicitor is serving as the agent of either a clinical laboratory performing tests or examinations for purposes of research or teaching, only, or an entity licensed under Chapter 4 (commencing with Section 1600) of Division 2 of the Health and Safety Code.

SEC. 4. Section 1282.2 is added to the Business and Professions Code, to read:

1282.2. It is unlawful for any person to perform venipuncture, skin puncture, or arterial puncture unless he or she is authorized to do so under this chapter, the regulations adopted thereunder, or under other provisions of law.

SEC. 5. Section 1287 of the Business and Professions Code is amended to read:

1287. *(a)* Any person who violates any provision of this chapter is guilty of a misdemeanor punishable upon conviction by imprisonment in the county jail for a period not exceeding six months or by fine not exceeding one thousand dollars ($1,000) or by both.

(b) Notwithstanding subdivision (a), a violation of Section 1281.1, 1282.1, or 1282.2 is a public offense and is punishable upon a first conviction by imprisonment in the county jail for not more than one year, or by imprisonment in the state prison, or by a fine not

exceeding ten thousand dollars ($10,000), or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment in the state prison.

SEC. 6. Section 1301 of the Business and Professions Code is amended to read:

1301. *(a)* The annual renewal fee *for a clinical laboratory license or registration* set under this chapter shall be paid during the 30-day period before the ~~first day of January of each calendar year~~ *expiration date of the license or registration*. Failure to pay the annual fee in advance during the time the license remains in force shall, ipso facto, work a forfeiture of said license after a period of 60 days from the ~~first day of January of each year~~ *expiration date of the license or registration*.

~~The~~

(b) The department shall give written notice to all ~~licensees~~ *persons licensed pursuant to Sections 1260, 1260.1, 1261, 1261.5, 1262, 1264, or 1270* 30 days in advance of the regular renewal date that a renewal fee has not been paid. In addition, the department shall give written notice to licensed clinical laboratory bioanalysts or doctoral degree specialists and clinical laboratory scientists or limited clinical laboratory scientists by registered or certified mail 90 days in advance of the expiration of the fifth year that a renewal fee has not been paid and if not paid before the expiration of the fifth year of delinquency the licensee may be subject to reexamination.

~~If~~

(c) If the renewal fee is not paid for five or more years, the department may require an examination before reinstating the license, except that no examination shall be required as a condition for reinstatement if the original license was issued without an examination. No examination shall be required for reinstatement if the license was forfeited solely by reason of nonpayment of the renewal fee if the nonpayment was for less than five years.

~~If~~

(d) If the license is not renewed within 60 days after its expiration, the licensee, as a condition precedent to renewal, shall pay the delinquency fee identified in subdivision (*l*) of Section 1300, in addition to the renewal fee in effect on the last preceding regular renewal date. Payment of the delinquency fee will not be necessary if within 60 days of the license expiration date the licensee files with the department an application for inactive status.

SEC. 7. Section 1311 is added to the Business and Professions Code, to read:

1311. The department shall have seven years from the date of discovery by the department of a violation of this chapter or of a regulation adopted thereunder to file an action in a court of competent jurisdiction.

SEC. 8. Section 1320 of the Business and Professions Code is amended to read:

1320. The department may deny, suspend, or revoke any license or registration issued under this chapter for any of the following reasons:

(a) Conduct involving moral turpitude or dishonest reporting of tests.

(b) Violation by the applicant, licensee, or registrant of this chapter or any rule or regulation adopted pursuant thereto.

(c) Aiding, abetting, or permitting the violation of this chapter, the rules or regulations adopted under this chapter or the Medical Practice Act, Chapter 5 (commencing with Section 2000) of Division 2.

(d) Permitting a licensed trainee to perform tests or procure specimens unless under the direct and responsible supervision of a person duly licensed under this chapter or physician and surgeon other than another licensed trainee.

(e) Violation of any provision of this code governing the practice of medicine and surgery.

(f) Proof that an applicant, licensee, or registrant has made false statements in any material regard on the application for a license, registration, or renewal issued under this chapter.

(g) Conduct inimical to the public health, morals, welfare, or safety of the people of the State of California in the maintenance or operation of the premises or services for which a license or registration is issued under this chapter.

(h) ~~Proof that the applicant or licensee has used any degree, or certificate, as a means of qualifying for licensure that has been purchased or procured by barter or by any unlawful means or obtained from any institution that at the time the degree, certificate, or title was obtained was not recognized or accredited by the department of education of the state where the institution is or was located to give training in the field of study in which the degree, certificate, or title is claimed~~ *Conduct that may cause harm to a patient by affecting the integrity of a biological specimen or the clinical laboratory test or examination result, through improper collection, handling, storage, or labeling of the specimen or the erroneous transcription or reporting of test or examination results*.

(i) Violation of any of the prenatal laws or regulations pertaining thereto in Chapter 2 (commencing with Section 120675) of Part 3 of Division 105 of the Health and Safety Code and Article 1 (commencing with Section 1125) of Group 4 of Subchapter 1 of Chapter 2 of Part 1 of Title 17 of the California Code of Regulations.

(j) Knowingly accepting an assignment for clinical laboratory tests or specimens from and the rendering of a report thereon to persons not authorized by law to submit those specimens or assignments.

(k) Rendering a report on clinical laboratory work actually performed in another clinical laboratory without designating clearly the name and address of the laboratory in which the test was performed.

(*l*) Conviction of a felony or of any misdemeanor involving moral turpitude under the laws of any state or of the United States arising out of or in connection with the practice of clinical laboratory technology. The record of conviction or a certified copy thereof shall be conclusive evidence of that conviction.

(m) Unprofessional conduct.

(n) The use of drugs or alcoholic beverages to the extent or in a manner as to be dangerous to a person licensed under this chapter, or any other person to the extent that that use impairs the ability of the licensee to conduct with safety to the public the practice of clinical laboratory technology.

(o) Misrepresentation in obtaining a license or registration.

(p) Performance of, or representation of the laboratory as entitled to perform, a clinical laboratory test or examination or other procedure that is not within the specialties or subspecialties, or category of laboratory procedures authorized by the license or registration.

(q) Refusal of a reasonable request of HCFA, a HCFA agent, the department, or any employee, agent or contractor of the department, for permission to inspect, pursuant to this chapter, the laboratory and its operations and pertinent records during the hours the laboratory is in operation.

(r) Failure to comply with reasonable requests of the department for any information, work, or materials that the department concludes is necessary to determine the laboratory's continued eligibility for its license or registration, or its continued compliance with this chapter or the regulations adopted under this chapter.

(s) Failure to comply with a sanction imposed under Section 1310.

(t) Proof that the applicant or licensee has used any degree or certificate as a means of qualifying for licensure, if the degree or certificate has been purchased or procured by barter or by any unlawful means or obtained from any institution that, at the time the degree, certificate, or title was obtained, was not recognized or accredited by the state department of education of the state where the institution is or was located to give training in the field of study in which the degree, certificate, or title is claimed.

(u) Performance by unlicensed laboratory personnel of any activity that is not authorized by Section 1269.

SEC. 9. Section 1320.5 is added to the Business and Professions Code, to read:

1320.5. A violation of Section 1320 that results in bodily harm to a human being or involves the taking of blood from a minor child or dependent adult shall be punishable by imprisonment in the county jail for not more than one year, or in a state prison for not more than 10 years, or by a fine not exceeding fifty thousand dollars ($50,000) or by both imprisonment and fine.

SEC. 10. Section 14040 of the Welfare and Institutions Code is amended to read:

14040. (a) Each contract for fiscal intermediary services shall allow, to the extent practicable, providers to utilize electronic means for transmitting claims to the fiscal intermediary contractor. Means of transmission, and the manner and format used, shall be approved by the director. In determining which electronic means are acceptable, the director shall consider magnetic tape, computer-to-computer via telephone, diskettes, and any other methods which may become available through technological advancements.

(b) A provider*, as defined in Section 14043.1,* may ~~assign~~*, by written contract do either or both of the following:*

(1) Authorize a billing agent to submit claims, including electronic claims, on behalf of the provider for reimbursement for services, goods, supplies, or merchandise rendered or provided by the provider to a Medi-Cal beneficiary or under the Medi-Cal program.

(2) Assign signature authority for transmission of claims to ~~an authorized representative or~~ *the authorized* billing agent.

(c) The department shall develop reasonable standards for participation *and continued participation* by ~~providers or persons who bill on behalf of providers~~ *billing agents* in the use of claim transmission methods utilized pursuant to this section. These standards shall be designed to ensure that~~ participants are able to~~ *billing agents* submit technically complete claims and *to* reduce the potential for fraud and abuse. A ‘‘technically

complete claim'' means any billing request for payment from a provider or the *billing* agent of ~~a~~ *the* provider, including an original claim, claim inquiry, or appeal, that is submitted on the correct Medi-Cal claim form or electronic billing format, is fully and accurately completed, and includes all information and documentation required to be submitted on or with the claim pursuant to Medi-Cal billing and documentation requirements.

(d) To the extent required by federal and state law, the fiscal intermediary shall retain claim data submitted by providers *or the billing agent of the provider* pursuant to this section. The department shall, however, return to a ~~health care~~ provider *or the billing agent of the provider* original tapes, diskettes, and any other similar devices ~~which~~ *that* are used by the provider *or the billing agent of the provider* pursuant to this section.

(e) In order to reduce the amount of paperwork or attachments which are required to be completed by a provider *or the billing agent of the provider* submitting a ~~bill for services~~ *claim for reimbursement* under this chapter to the fiscal intermediary, the department shall direct the fiscal intermediary to investigate and develop the means to incorporate as much information as possible on the electronic format.

SEC. 11. Section 14040.1 is added to the Welfare and Institutions Code, to read:

14040.1. (a) "Billing agent" or "billing agent of the 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 submits claims on behalf of the provider, as defined in Section 14043.1, for reimbursement for services, goods, supplies, or merchandise rendered or provided directly or indirectly to a Medi-Cal beneficiary or under the Medi-Cal program. As used in this section a billing agent shall not include a nonmanaging salaried employee of a provider.

(b) The department shall establish standards for the registration or continued registration of each billing agent. The standards shall establish time periods, no longer than a year from the date the standards become effective, after which, no person or entity shall submit a claim on behalf of a provider, as defined in Section 14043.1, for reimbursement for services, goods, supplies, or merchandise rendered or provided directly or indirectly by the provider to a Medi-Cal beneficiary or under the Medi-Cal program, unless that person or entity has been registered with the department as a billing agent. The department shall establish the standards for the registration or continued registration of billing agents pursuant to this subdivision by the adoption of emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The adoption of these emergency regulations or readoption of the regulations shall be deemed to be an emergency necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340 of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted or readopted pursuant to this subdivision shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this subdivision shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations.

(c) The department may complete a background check on applicants for registration or continued registration as a billing agent and on those persons who currently act as billing agents, billing intermediaries, authorized representatives, or any other person or entity billing for services rendered under this chapter, for the purpose of verifying the accuracy of information provided by an applicant for registration or continued registration as a billing agent or in order to prevent fraud

and abuse. The background check may include, but not be limited to, onsite inspection, review of business records, and data searches.

(d) As a condition of registration, or continued registration, as a billing agent, an applicant for registration as a billing agent shall provide to the department a surety bond of not less than fifty thousand dollars ($50,000).

(e) A billing agent's compensation for the submission of claims to the Medi-Cal program on behalf of a provider shall be related to the cost of processing the billing, but shall not be related on a percentage or other basis, such as a contingency fee, to the amount that is billed or collected. A billing agent's compensation for the submission of claims to the Medi-Cal program on behalf of a provider shall not be dependent upon the collection of the payment.

(f) Each billing agent shall be liable for ensuring that each claim, for reimbursement for services, goods, supplies, or merchandise rendered or supplied by the provider to a Medi-Cal beneficiary or under the Medi-Cal program, is a technically complete claim, as defined in subdivision (c) of Section 14040.

SEC. 12. Section 14040.5 of the Welfare and Institutions Code is amended to read:

14040.5. (a) Billing ~~intermediaries~~ *agents* shall register with the director and shall obtain ~~an~~ *a unique* identifier ~~code which~~ *prior to submitting any claims for reimbursement. This unique identifier* shall be part of ~~all Medi-Cal claims~~ *each claim for reimbursement* submitted by ~~any~~ *the* billing ~~intermediary~~ *agent*.

(b) *A provider may, by written contract, do either of the following:*

(1) Authorize a billing agent to submit claims, including electronic claims, on behalf of the provider for reimbursement for services, goods, supplies, or merchandise provided by the provider to the Medi-Cal program.

(2) Assign signature authority for transmission of claims by the authorized billing agent. Any provider

using a billing ~~intermediary~~ *agent* to ~~bill~~ *submit claims for reimbursement to* the Medi-Cal program shall, *at least 30 days prior to any claims for reimbursement being submitted by the billing agent,* provide written notification to the director of the name ~~and~~, *including the legal and any fictitious or "doing business as" names used by the billing agent, and* address, *and telephone number* of the billing ~~intermediary~~ *agent*.

(c) (1) Any Medi-Cal claim submitted by a billing ~~intermediary~~ *agent or provider* failing to comply with the requirements of this section *or Section 14040 or 14040.1 or the regulations adopted under these sections*, shall be subject to ~~denial~~ *nonpayment* by the director.

(2) The director may deny, suspend, or ~~withdraw~~ *revoke* the registration *or continued registration* of a billing ~~intermediary~~ *agent* based upon ~~failure~~ *any of the following:*

(A) Failure of the billing agent or provider to comply with this section, ~~or for involvement of a billing intermediary in illegal submission of claims.~~

~~(3) The director may immediately withdraw or suspend the registration of a billing intermediary upon the involvement of~~ *Section 14040 or 14040.1, or the regulations adopted under these sections.*

(B) Determination by the director that *the* billing ~~intermediary in the filing of~~ *agent has submitted a claim containing* false or misleading information ~~on claims submitted for~~ *regarding* services *rendered, or* allegedly rendered, *or regarding goods, supplies, or merchandise furnished or allegedly furnished,* or ~~when a~~ *that the* billing ~~intermediary~~ *agent* has demonstrated a pattern of filing claims which are not technically complete claims as defined in subdivision (c) of Section 14040.

~~(4) Proceedings for suspension or withdrawal of the registration of a billing intermediary pursuant to this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that hearings may be conducted by departmental hearing officers appointed by the director. The director may periodically~~

~~contract with the Office of Administrative Hearings to conduct these hearings.~~

~~(5) The director shall notify the billing intermediary 30 days in advance of a proposed suspension and shall allow the billing intermediary to demonstrate why the suspension notice should not be issued.~~

~~(6) The director shall notify the billing intermediary of the suspension and the effective date thereof and at the same time shall serve the billing intermediary with the accusation. Upon receipt of a notice of defense by the billing intermediary, the director shall set the matter for hearing within 30 days of the receipt of the notice. The suspension shall remain in effect until the hearing is completed and the director has made a final determination on the merits. The suspension shall, however, be deemed vacated if the director fails to make a final determination on the merits within 60 days of the completion of the original hearing.~~

~~(6) This subdivision shall not apply where the suspension of a billing intermediary is based upon the conviction for any crime involving fraud, abuse of the Medi-Cal program, or suspension from the federal Medicare program. In those instances, suspension shall be automatic.~~

~~(d) For purposes of this section, a billing intermediary includes any entity including a partnership, corporation, sole proprietorship, or person which bills Medi-Cal on behalf of a provider pursuant to a contractual relationship with the provider. As used in this section a billing intermediary does not include salaried employees of a provider.~~

~~(e) As used in this section "provider" means any individual, partnership, clinic, group, association, corporation, or institution as defined in Section 51051 of Title 22 of the California Administrative Code, and includes any officer, director, agent, or employee thereof.~~

(C) The determination by the director that the billing agent is under investigation for fraud or abuse, has been convicted of fraud or abuse in a criminal proceeding, found liable for fraud or abuse in a civil proceeding, or

settled a criminal or civil proceeding alleging fraud or abuse.

(3) The director shall notify the billing agent and each provider utilizing the services of the billing agent of the denial, suspension, or revocation of the billing agent's registration or continued registration and the effective date thereof. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of denial, suspension, or revocation pursuant to this subdivision shall be in accordance with Section 14043.65, except that this subdivision shall not apply where the denial, suspension, or revocation of a billing agent's registration or continued registration is based upon conviction for any crime involving fraud or abuse of the Medi-Cal program or the federal medicaid or Medicare programs, or exclusion by the federal government from the medicaid or Medicare programs. In those instances and notwithstanding any other provision of law, the denial, suspension, or revocation shall be automatic and not subject to appeal or hearing.

(d) As used in this section, "provider" has the same meaning as defined in Section 14043.1.

SEC. 13. 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 Medicare program,~~ *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 any state or local agency in this state or any other 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 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.

(b) ''Applicant'' means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, *owners, managing* employees, or agents thereof, that applies to the department for enrollment as a provider in the Medi-Cal program.

(c) ''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 or 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.

(d) ''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.

(e) ''Provider'' means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, *owners, managing* employees, or agents~~ thereof~~ *of any 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.

(f) *''Enrolled or enrollment in the Medi-Cal 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 Medi-Cal beneficiary.

(g) ''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.

~~(g)~~

(h) ''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.

SEC. 14. Section 14043.2 of the Welfare and Institutions Code is amended to read:

14043.2. (a) Whether or not regulations for certification are adopted under Section 14043.15, in order to be enrolled as a provider, or for enrollment as a provider to continue, an applicant or provider may be required to sign a provider agreement and shall disclose all information as required in federal medicaid regulations and any other information required by the department. *Applicants, providers, and persons with an ownership or control interest, as defined in federal medicaid regulations, shall submit their social security number or numbers to the department, to the full extent allowed under federal law.* The director may designate the form of a provider agreement by provider type. Failure to disclose the required information, or the disclosure of false information, shall~~, prior to any hearing,~~ result in denial of the application for enrollment or shall make the provider subject to temporary suspension *from the Medi-Cal program*, which shall include temporary deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program.

(b) The director shall notify the provider of the temporary suspension and deactivation of the provider's Medi-Cal provider number or numbers and the effective date thereof. Notwithstanding Section 100171 of the Health and Safety Code and Section 14123, proceedings after the imposition of sanctions provided for in subdivision (a) shall be in accordance with Section 14043.65.

SEC. 15. Section 14043.34 is added to the Welfare and Institutions Code, to read:

14043.34. (a) As a condition of a pharmacy's participation in the Medi-Cal program, the pharmacy shall have in stock and regularly dispense prescription drugs.

(b) For purposes of this section, "prescription drugs" means any drug unsafe for self use by a person, and includes either of the following:

(1) Any drug that bears the legend: "R_x Only" or "Caution: federal law prohibits dispensing without prescription" or words of similar import.

(2) Any other drug that by federal or state law can be lawfully dispensed by the prescription of a licensed physician and surgeon.

SEC. 16. Section 14043.36 of the Welfare and Institutions Code is amended to read:

14043.36. (a) The department shall not enroll any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program, *or related to neglect or abuse of a patient in connection with the delivery of a health care item or service, or in connection with the interference with or obstruction of any investigation into health care related fraud or abuse or* that has been found ~~guilty of~~ *liable for* fraud or abuse in any civil proceeding, or that has entered into a settlement in ~~lieu of conviction for~~ *a civil or criminal proceeding alleging* fraud or abuse *in any government program*, within the previous ~~five~~ *10* years. In addition, the department may deny enrollment to any applicant that, at the time of application, is under investigation *by any state, local, or federal government agency for fraud or abuse* pursuant to Subpart A (commencing with Section 455.12) of Part 455 of Title 42 of the Code of Federal Regulations. ~~The~~ *Except where there has been a settlement, 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 any state, local, or federal government agency* for fraud or abuse, that provider shall be subject to temporary suspension *from the Medi-Cal program*, which shall include temporary deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program.

(b) The director shall notify the provider of the temporary suspension and deactivation of the provider's Medi-Cal provider number or numbers and the effective

date thereof. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions provided for in subdivision (a) shall be in accordance with Section 14043.65.

SEC. 17. Section 14043.37 of the Welfare and Institutions Code is amended to read:

14043.37. The department may complete a background check on applicants for the purpose of verifying the accuracy of the information provided ~~in the application~~ *to the department for purposes of enrolling in the Medi-Cal program* and in order to prevent fraud and abuse. The background check may include, but *is* not ~~be~~ limited to, the following:

(a) Onsite inspection prior to enrollment.

(b) Review of business records.

(c) Data searches.

SEC. 18. Section 14043.61 is added to the Welfare and Institutions Code, to read:

14043.61. (a) A provider shall be subject to suspension if claims for payment are submitted under any provider number used by the provider to obtain reimbursement from the Medi-Cal program for the services, goods, supplies, or merchandise provided, directly or indirectly, to a Medi-Cal beneficiary, by an individual or entity, including a billing agent, as defined in Section 14040.1, that has been previously suspended, excluded, or otherwise made ineligible to receive, directly or indirectly, reimbursement from the Medi-Cal program and the individual or entity has previously been listed on either the Suspended and Ineligible Provider List, published by the department, to identify suspended and otherwise ineligible providers, or any list published by the federal Office of 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.

(b) Notwithstanding Section 100171 of the Health and Safety Code, the imposition of the sanction provided for in subdivision (a) shall be appealable in accordance with Section 14043.65.

SEC. 19. Section 14043.62 is added to the Welfare and Institutions Code, to read:

14043.62. (a) The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider's mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year. Prior to taking this action the department shall attempt to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted thereunder.

(b) For purposes of this section:

(1) "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.

(2) "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.

(3) "Service or business 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.

SEC. 20. Section 14043.65 of the Welfare and Institutions Code is amended to read:

14043.65. *(a)* Notwithstanding any other provision of law, any applicant whose application for enrollment as a provider or whose certification is~~, denied,~~ *denied;* or any provider who is denied continued enrollment or certification, who has been temporarily suspended,~~, or~~ who has had payments withheld, who has had one or more provider numbers used to obtain reimbursement from

the Medi-Cal program deactivated~~,~~ pursuant to *this article or* Section 14107.11, *or who has had a civil penalty imposed pursuant to Section 14123.25; or any billing agent, as defined in Section 14040, when the billing agent's registration or continued registration has been denied, suspended, or revoked, pursuant to subdivision (c) of Section 14040.5,* may appeal this action by submitting a written appeal, including any supporting evidence, to the director *or the director's designee*. Where the appeal is of a withholding of payment pursuant to Section 14107.11, the appeal to the director *or the director's designee* shall be limited to the issue of the reliability of the *information or* evidence supporting the withhold and shall not encompass fraud or abuse. The appeal procedure shall not include a formal administrative hearing under the Administrative Procedure Act and shall not result in reactivation of any deactivated provider numbers during appeal. An applicant or provider that ~~appeals an action taken~~ *files an appeal* pursuant to this~~ article~~ *section* shall submit *the written appeal along with* all pertinent documents and all other relevant evidence to the director or to the director's designee within 60 days of the date of notification of the department's action. The director or the director's designee shall review all of the relevant materials submitted and shall issue a decision within 90 days of the receipt of the~~ evidence~~ *appeal*. The decision may provide that the action taken should be upheld, continued, or reversed, in whole or in part. The decision of the director or the director's designee shall be final. Any further appeal shall be required to be filed in accordance with Section 1085 of the~~ Civil~~ Code *of Civil Procedure*.

(b) No applicant whose application for enrollment, as a provider, has been denied pursuant to Section 14043.2, 14043.36, or 14043.4 may reapply for a period of three years from the date the application is denied or from the date of final action by the director or the director's designee under this section if the denial is appealed.

SEC. 21. Section 14043.7 of the Welfare and Institutions Code is amended to read:

14043.7. (a) The department may make unannounced visits to any applicant or to any provider for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, or as necessary for the administration of the Medi-Cal program. At the time of the visit, the applicant or provider shall be required to demonstrate an established place of business appropriate and adequate for the services billed or claimed to the Medi-Cal program, as relevant to his or her scope of practice, as indicated by, but not limited to, the following:

(1) Being open and available to the general public.

(2) Having regularly established and posted business hours.

(3) Having adequate supplies in stock on the premises.

(4) Meeting all local laws and ordinances regarding business licensing and operations.

(5) Having the necessary equipment and facilities to carry out day-to-day business for his or her practice.

(b) An unannounced visit pursuant to subdivision (a) shall be prohibited with respect to clinics licensed under Section 1204 of the Health and Safety Code, clinics exempt from licensure under Section 1206 of the Health and Safety Code, health facilities licensed under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, and natural persons licensed or certified under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, unless the department has reason to believe that the provider will defraud or abuse the Medi-Cal program or lacks the organizational or administrative capacity to provide services under the program.

(c) Failure to remediate discrepancies *in information provided to the department or discrepancies* that are discovered as a result of an *announced or* unannounced visit to a provider shall~~, prior to hearing,~~ make the provider subject to temporary suspension *from the*

Medi-Cal program, which shall include temporary deactivation of all provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The director shall notify the provider of the temporary suspension and deactivation of provider numbers, and the effective date thereof. Notwithstanding Section 100171 of the Health and Safety Code, proceedings after the imposition of sanctions in this paragraph shall be in accordance with Section 14043.65.

SEC. 22. Section 14043.75 of the Welfare and Institutions Code is amended to read:

14043.75. The director may, by regulation, adopt, *readopt, repeal, or amend* additional measures to prevent or curtail fraud and abuse. *Regulations adopted, readopted, repealed, or amended pursuant to this section shall be deemed emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). These emergency regulations shall be deemed necessary for the immediate preservation of the public peace, health and safety, or general welfare. Emergency regulations adopted, amended, or repealed pursuant to this section shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations.*

SEC. 23. Section 14100.75 of the Welfare and Institutions Code is amended to read:

14100.75. (a) (1) ~~Any~~ *Each* provider~~ of goods or services~~ *and each applicant, as defined in Section 14043.1, when applying for enrollment and continued enrollment,* shall provide, to the department, a bond, or other security satisfactory to the department, of an amount determined by the department, pursuant to regulations adopted by the department.

(2) The department, in determining the amount of bond or security required by paragraph (1), shall base the

determination on the level of estimated billings, and shall not be less than twenty-five thousand dollars ($25,000).

(b) (1) After three years of continuous operation as a provider, a Medi-Cal provider may apply to the department for an exemption from the requirements of subdivision (a).

(2) The department shall adopt regulations establishing conditions for the approval or denial of applications for exemption pursuant to paragraph (1).

(c) The department shall establish a mechanism to track rates of participation among providers who are subject to the requirement of subdivision (a) to determine if the requirement is a deterrent to Medi-Cal program participation among provider applicants.

(d) Subdivisions (a) and (b) do not apply to ~~individuals who are~~ *natural persons* licensed *or certified* pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, *the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or* to any clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code, to any health facility licensed~~ pursuant to~~ *under Chapter 2 (commencing with* Section~~ 1250~~ *1250) of Division 2* of the Health and Safety Code, or to any provider that is operated by a city, county, school district, county office of education, or state special school.

(e) Nothing in this section shall relieve an applicant or provider of durable medical equipment or home health agency services from complying with subdivisions (a) and (b) of Sections 14100.8 and 14100.9, as applicable.

SEC. 24. Section 14107 of the Welfare and Institutions Code is amended to read:

14107. *(a) (1)* Any person~~ who, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise, knowingly submits false information for the purpose of obtaining greater compensation than that to which he is legally entitled for furnishing services or merchandise, or knowingly submits false information for the purpose of obtaining authorization for furnishing services or~~

~~merchandise under this chapter or Chapter 8 (commencing with Section 14200)~~ *including any applicant or provider as defined in Section 14043.1, or billing agent, as defined in Section 14040.1, who engages in any of the activities identified in subdivision (b)* is punishable by imprisonment ~~in the county jail~~ not longer than ~~one year or in the state prison~~ *10 years*, or by fine not exceeding ~~five thousand dollars ($5,000)~~ *three times the amount of the fraud or improper reimbursement*, or by both ~~such~~ *this* fine and imprisonment.

~~The~~

(2) If the activity results in serious bodily injury to any person, or bodily injury to a person under 18 years of age, or is a threat to the public health, the person shall be fined in accordance with paragraph (1) or imprisoned in the state prison for not more than 20 years, or both. If the activity results in death, the person shall be fined in accordance with paragraph (1), or imprisoned in the state prison for any term of years or for life, or both.

(3) The length of imprisonment under this section shall be determined based on the sentencing guidelines used by the federal government for false or fraudulent claims.

(b) (1) A person, with intent to defraud, presents for allowance or payment any false or fraudulent claim for furnishing services or merchandise under this chapter or Chapter 8 (commencing with Section 14200).

(2) A person knowingly submits false information for the purpose of obtaining greater compensation than that to which he or she is legally entitled for furnishing services or merchandise under this chapter or Chapter 8 (commencing with Section 14200).

(3) A person knowingly submits false information for the purpose of obtaining authorization for furnishing services or merchandise under this chapter or Chapter 8 (commencing with Section 14200).

(4) A person knowingly and willfully executes, or attempts to execute, a scheme or artifice to do either of the following:

(A) Defraud the Medi-Cal program or any other health care program administered by the department or its agents or contractors.

(B) Obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, the Medi-Cal program or any other health care program administered by the department or its agents or contractors, in connection with the delivery of or payment for health care benefits, services, goods, supplies, or merchandise.

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

(1) "Serious bodily injury" means bodily injury that involves any of the following:

(A) A substantial risk of death.

(B) Extreme physical pain.

(C) Protracted and obvious disfigurement.

(D) Protracted loss or impairment of the function of a bodily member, organ, or mental faculty.

(2) "Bodily injury" means any of the following:

(A) A cut, abrasion, bruise, burn, or disfigurement.

(B) Physical pain.

(C) Illness.

(D) Impairment of the function of a bodily member, organ, or mental faculty, no matter how temporary.

(E) Any other injury to the body, no matter how temporary.

(d) (1) Any of the following property of a person, including any applicant or provider as defined in Section 14043.1, who has engaged in any of the activities subject to fine or imprisonment under subdivision (a), shall be subject to the forfeiture provisions of subdivision (e):

(A) Any property, real or personal, involved in a transaction or attempted transaction in violation of this chapter or Chapter 8 (commencing with Section 14200), or any health care program administered by the department, its agents or contractors, or any property traceable to that property.

(B) Any property, real or personal, that constitutes, is derived from, or is traceable to, any proceeds obtained directly or indirectly, from a violation of this chapter or Chapter 8 (commencing with Section 14200), or any health care program administered by the department or its agents or contractors.

(2) Property subject to forfeiture under this section includes, but is not limited to, real property, including things growing on, affixed to, and found in land, and personal property, including tangible and intangible personal property, including rights, privileges, interests, claims, and securities.

(e) All right, title, and interest in the property described in subdivision (d), shall vest in the state upon the commission of the act giving rise to forfeiture under this section. Any such property that is subsequently transferred to another person shall be subject to forfeiture, unless the transferee establishes in a hearing that he or she is a bona fide purchaser for value of the property, who at the time of purchase was reasonably without cause to believe that the property was subject to forfeiture under this section.

(f) Upon application of the state, the court may enter a restraining order or injunction, require the execution of a satisfactory performance bond, or take any other action to preserve the availability of property described in subdivision (d) for forfeiture under this section. Upon the filing of information charging a violation of this chapter or Chapter 8 (commencing with Section 14200), or any health care program administered by the department or its agents or contractors and alleging that the property with respect to which the order is sought would, in the event of a conviction, be subject to forfeiture under this section. Prior to the filing of this information, if, after notice to persons appearing to have an interest in the property and opportunity for a hearing, the court determines that there is substantial probability that the state will prevail on the issue of forfeiture and that failure to enter the order will result in the property being destroyed, removed from the jurisdiction of the court, or

otherwise made unavailable for forfeiture, and the need to preserve the availability of the property through the entry of the requested order outweighs the hardship on any party against whom the order is to be entered.

(g) A temporary restraining order under this section may be entered upon application of the state without notice or opportunity for a hearing when information has not yet been filed with respect to the property, if the state demonstrates that there is probable cause to believe that the property with respect to which the order is sought would, in the event of conviction or if the person enters into a settlement in a civil or criminal proceeding, be subject to forfeiture under this section and that provision of notice will jeopardize the availability of the property for forfeiture. The temporary order shall expire not more than 10 days after the date on which it is entered, unless extended for good cause shown or unless the party against whom it is entered consents to an extension for a longer period. A hearing requested concerning an order entered under this subdivision shall be held at the earliest possible time, and prior to the expiration of the temporary order. The court may receive and consider, at a hearing held pursuant to this subdivision, information and evidence that would be inadmissible under the Evidence Code.

(h) Upon conviction of a person for engaging in the activities subject to fine or imprisonment under subdivision (a), or if the person has entered into a settlement in a civil or criminal proceeding alleging fraud or abuse in the Medi-Cal program or in any other health care program administered by the department or its agents or contractors, the court shall enter a judgment of forfeiture of the property to the state and shall authorize the Attorney General to seize all property ordered forfeited upon such terms and conditions as the court shall deem proper. Following the entry of an order declaring the property forfeited, the court may, upon application of the state, enter appropriate restraining orders or injunctions, require the execution of satisfactory performance bonds, appoint receivers, conservators, appraisers, accountants, or trustees, or take any other

action to protect the interest of the state in the property ordered forfeited. Any income accruing to, or derived from, an enterprise or an interest in an enterprise that has been ordered forfeited under this section may be used to offset ordinary and necessary expenses to the enterprise, as required by law, or as necessary to protect the interests of the state or third parties.

(i) Following the seizure of property ordered forfeited under this section, the Attorney General shall direct the disposition of the property by sale or any other commercially feasible means, making due provision for the rights of any innocent person. Any property right or interest not exercisable by, or transferable for value to, the state, shall expire and shall not revert to the provider, nor shall the provider or any person acting in concert with or on behalf of the provider be eligible to purchase forfeited property at any sale held by the state. Upon application of a person, other than the provider or a person acting in concert with or on behalf of the provider, the court, may restrain or stay the sale or disposition of the property pending the conclusion of any appeal of the case giving rise to the forfeiture, if the applicant demonstrates that proceeding with the sale or disposition of the property will result in irreparable injury, harm, or loss to him or her.

(j) If the Attorney General convenes a state grand jury related to health care fraud or abuse, the grand jury may investigate and indict for any of the activities subject to fine, imprisonment, or asset forfeiture under this section on a statewide basis.

(k) The enforcement remedies provided under this section are not exclusive and shall not preclude the use of any other criminal or civil remedy.

SEC. 25. Section 14107.11 of the Welfare and Institutions Code is amended to read:

14107.11. (a) Upon receipt of reliable *information or* evidence*, including evidence that would be inadmissible under the Evidence Code,* of fraud or willful misrepresentation by a provider *as defined in Section 14043.1,* under the Medi-Cal program *or the*

commencement of a suspension under Section 14123, the department may *do any of the following*:

(1) Collect any Medi-Cal 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). 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 will be returned to a provider with interest if findings are in favor of the provider.

(2) Withhold payment for any goods~~ or~~, services, *supplies, or merchandise,* or any portion thereof~~, from any Medi-Cal 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 subdivision and that the withholding is for a temporary period and will not continue after it is determined that there is insufficient evidence of fraud or willful misrepresentation or when legal proceedings relating to the alleged fraud or willful misrepresentation are complete.

(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~~ *claims for which payment is* being withheld.

(D) Inform the provider of the right to submit written *information or* evidence*, including evidence that would be inadmissible under the Evidence Code,* for consideration by the department.

(3) Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal a withholding of payment 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.

(b) The director may adopt regulations to implement this section as necessary. These regulations may be adopted as emergency regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) Part 1 of Division 3 of Title 2 of the Government Code) and the adoption of the regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The director shall transmit these emergency regulations directly to the Secretary of State for filing and the regulations shall become effective immediately upon filing. Upon completion of the formal regulation adoption process and prior to the expiration of the 120-day duration period of emergency regulations, the director shall transmit directly to the Secretary of State the adopted regulations, the rulemaking file, and the certification of compliance as required by subdivision (e) of Section 11346.1 of the Government Code.

(c) For purposes of this section, ‘‘provider’’ means any individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, employees, or agents thereof, that provide services, goods, supplies, or merchandise, directly or indirectly, to a Medi-Cal beneficiary, and that has been enrolled in the Medi-Cal program.

SEC. 26. Section 14115.5 of the Welfare and Institutions Code is amended to read:

14115.5. *(a)* Moneys payable or rights existing under this chapter 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.

(b) If a provider, as defined in Section 14043.1, is under any investigation for fraud or abuse by any state, local, or federal government agency, the director may withhold the reimbursement of funds due and payable to that provider from the Medi-Cal program or any other health care program administered by the department or its agents or contractors, as assets pending the outcome of the investigation of fraud or abuse. The withholding of payments authorized by this subdivision shall not be subject to Section 14107.11 and, notwithstanding Section 100171 of the Health and Safety Code or any other provision of law, shall not be subject to appeal or hearing.

SEC. 27. Section 14123.25 is added to the Welfare and Institutions Code, to read:

14123.25. (a) In lieu of, or in addition to, the imposition of any other sanction available to it, including the sanctions and penalties authorized under Section 14123.2 or 14171.6, and as the "single state agency" for California vested with authority to administer the Medi-Cal program, the department shall exercise the authority granted to it in Section 1002.2 of Title 42 of the Code of Federal Regulations, and may also impose the mandatory and permissive exclusions identified in Section 1128 of the federal Social Security Act (42 U.S.C. Sec. 1320a-7), and its implementing regulations, and impose civil penalties identified in Section 1128A of the federal Social Security Act (42 U.S.C. Sec. 1320a-7a), and its implementing regulations, against applicants and providers, as defined in Section 14043.1 or against billing agents, as defined in Section 14040.1. The department may also terminate, or refuse to enter into, a provider agreement authorized under Section 14043.2 with an applicant or provider, as defined in Section 14043.1, upon the grounds specified in Section 1866(b)(2) of the federal Social Security Act (42 U.S.C. Sec. 1395cc(b)(2). Notwithstanding Section 100171 of the Health and Safety Code or any other provision of law, any appeal by an applicant, provider, or billing agent of the imposition of a civil penalty, exclusion, or other sanction pursuant to this subdivision shall be in accordance with Section

14043.65, except that where the action is based upon conviction for any crime involving fraud or abuse of the Medi-Cal, medicaid, or Medicare programs, or exclusion by the federal government from the medicaid or Medicare programs the action shall be automatic and not subject to appeal or hearing.

(b) In addition, the department may impose the intermediate sanctions identified in Section 1846 of the Social Security Act (42 U.S.C. Sec. 1395w-2), and its implementing regulations, against any provider that is a clinical laboratory, as defined in Section 1206 of the Business and Professions Code. The imposition and appeal of this intermediate sanction shall be in accordance with Article 8 (commencing with Section 1065) of Chapter 2 of Division 1 of Title 17 of the California Code of Regulations.

SEC. 28. Section 14124.1 of the Welfare and Institutions Code is amended to read:

14124.1. Each provider*, as defined in Section 14043.1,* of health care services rendered ~~to any beneficiary under this chapter~~ *under the Medi-Cal program or any other health care program administered by the department or its agents or contractors,* shall keep and maintain records of each such service rendered, the beneficiary *or person* to whom rendered, the date *the service was rendered,* and such additional information as the department may by regulation require. Records herein required to be kept and maintained shall be retained by the provider for a period of three years from the date the service was rendered.

SEC. 29. Section 14124.2 of the Welfare and Institutions Code is amended to read:

14124.2. (a) *(1)* During normal working hours, the department may make any examination of the books and records of~~ any provider pertaining to services rendered to any beneficiary under this chapter or Chapter 8 (commencing with Section 14200) of this part~~, and may visit and inspect the premises or facilities of~~ any provider~~, *those identified in paragraphs (2) and (3), that* it may deem necessary to carry out the provisions of this chapter

or Chapter 8 (commencing with Section 14200) and regulations adopted thereunder~~. A provider shall furnish this~~, *or the law under which the department or its agents or contractors administer any other health care program.*

(2) Any applicant or provider, as defined in Section 14043.1, pertaining to services, goods, supplies, or merchandise rendered or supplied, directly or indirectly, or to be rendered or supplied, directly or indirectly, to any beneficiary under this chapter or Chapter 8 (commencing with Section 14200).

(3) Any person or entity that provides services, goods, supplies, or merchandise, directly or indirectly, under, or seeks reimbursement from, any other health care program administered by the department or its agents or contractors.

(b) (1) Applicants, providers, or others receiving or seeking reimbursement under the Medi-Cal program or other health care programs administered by the department or its agents or contractors shall provide a reasonable amount of assistance, and furnish information or copies of~~ the~~ records and documentation upon request by the department. Unannounced visits to request this information shall be reserved for those exceptional situations where arrangement of an appointment beforehand is clearly not possible or is clearly inappropriate to the nature of the intended visit. Only those related books and records of each service rendered, the beneficiary to whom rendered, the date, and additional information as the department may by regulation require shall be subject to the requirement of furnishing copies. This information may include records to support and document the recipient's eligibility for services and, to the extent necessary, records to provide proof of the quantity and receipt of the services, and that the services were provided by proper personnel. Providers *and others subject to this section* shall be reimbursed for reasonable photocopying-related expenses as determined by the department. Failure to comply with the~~ request~~ *department's authority under this section* shall be grounds for immediate suspension of

the provider *or others subject to this section* under subdivision (b) of Section 14123 *or under the other health care programs administered by the department or its agents or contractors*.

~~(b)~~

(2) Any copies furnished pursuant to this section shall be used only to investigate and pursue criminal, *civil,* or administrative sanctions for Medi-Cal fraud ~~and~~ *or* abuse ~~or~~, *including* the provision of dental services that are below or less than the standard of acceptable quality as prescribed by subdivision (f) of Section 14123, *or fraud or abuse under any other health care program administered by the department or its agents or contractors* and the copies shall be destroyed when that purpose has been satisfied. This section shall not be construed to prohibit the referral of investigative findings, including copies of books and records, to the appropriate *federal,* state, *or local* licensing, certifying, ~~or~~ regulatory, *or prosecutorial* authority.

(c) For purposes of this section and Section 14124.1~~,~~ ~~"provider" shall, in addition to the provider of health care services~~, *"provider" shall be defined as follows:*

(1) "Provider" shall have the meaning contained in Section 14043.1.

(2) "Provider" shall also include any person or entity under contract with the provider ~~of health care services~~, *as defined in paragraph (1),* to assist in the application process or eligibility determination.

SEC. 30. Section 14170 of the Welfare and Institutions Code is amended to read:

14170. (a) (1) Amounts paid for services provided to Medi-Cal beneficiaries shall be audited by the department in the manner and form prescribed by the department. The department shall maintain adequate controls to ensure responsibility and accountability for the expenditure of federal and state funds. Cost reports and other data submitted by providers to a state agency for the purpose of determining reasonable costs for services or establishing rates of payment shall be considered true and correct unless audited or reviewed

by the department within 18 months after July 1, 1969, the close of the period covered by the report, or after the date of submission of the original or amended report by the provider, whichever is later. Moreover the cost reports and other data for cost reporting periods beginning on January 1, 1972, and thereafter shall be considered true and correct unless audited or reviewed within three years after the close of the period covered by the report, or after the date of submission of the original or amended report by the provider, whichever is later.

(2) *(A)* Nothing in this section shall be construed to limit the correction of cost reports or rates of payment when inaccuracies are determined to be the result of intent to defraud, or when a delay in the completion of an audit is the result of willful acts by the provider or inability to reach agreement on the terms of final settlement.

(B) Nothing in this section shall be construed to preclude the department from further review of cost reports and other data for cost reporting periods beginning on January 1, 1972, after the three-year period contained in paragraph (1) of subdivision (a), where after that time information not customarily contained in these cost reports and other data for the fiscal periods in question indicates the provider may have engaged in practices that have resulted in overreimbursement.

(3) Notwithstanding any other provision of law, nursing facilities and all categories of intermediate care facilities for the developmentally disabled which have received and are receiving funds for salary increases pursuant to Sections 14110.6 and 14110.7 shall maintain payroll and personnel records for examination by auditors from the department and the Labor Commissioner beginning March 1985 until the records have been audited, or until December 31, 1992, whichever occurs first.

(b) Notwithstanding any other provision of law, costs reported for reimbursement purposes relative to Medi-Cal beneficiaries in nursing facilities that are distinct parts of acute care hospitals shall be audited by

the department at least annually. The audits may be performed on a sample basis and, when the sample is statistically reliable, as determined by the department, may be used for ratesetting purposes.

SEC. 31. Section 14170.8 of the Welfare and Institutions Code is amended to read:

14170.8. (a) Notwithstanding any other provision of law, every primary supplier of pharmaceuticals~~ or~~, medical equipment~~ and~~, *or* supplies shall maintain accounting records to demonstrate the manufacture, assembly, purchase, or acquisition and subsequent sale, of any pharmaceuticals, or medical equipment~~ and~~, *or* supplies to ~~Medi-Cal~~ providers, *as defined in Section 14043.1*. 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. For purposes of this section the term ''primary suppliers'' shall mean any manufacturer, principal labeler, *assembler,* wholesaler,~~ and any other primary supplier~~ *or retailer.*

(b) Accounting records maintained pursuant to subdivision (a) shall be subject to audit or examination by the department or~~ the Controller during regular business hours~~ *its agents. This audit or examination may include, but is not limited to, verification of the costs claimed by providers.* These accounting records shall be maintained for three years from the date of sale or the date of service.

(c) This section shall not apply to any clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code or to any manufacturer of prescription drugs registered with the federal Food and Drug Administration in accordance with Section 510 of the Food, Drug, and Cosmetic Act (21 U.S.C. Sec. 360).

SEC. 32. Section 14171.6 of the Welfare and Institutions Code is amended to read:

14171.6. (a) (1) Any provider, as defined in paragraph (3), that obtains reimbursement under this chapter to which it is not entitled shall be subject to interest charges or penalties as specified in this section.

(2) When it is established upon audit that the provider has not received reimbursement to which ~~it~~ *the provider* is entitled, the department shall pay the provider interest assessed at the rate, and in the manner, specified in subdivision ~~(h)~~ *(g)* of Section 14171.

(3) For purposes of this section, ‘‘provider’’ means any provider ~~of services~~, as defined in ~~subdivision (a) of Section 51051 of Title 22 of the California Code of Regulations~~ *Section 14043.1*.

(b) When it is established upon audit that the provider has claimed payments under this chapter to which it is not entitled, the provider shall pay, in addition to the amount improperly received, interest at the rate specified by subdivision (h) of Section 14171.

(c) (1) When it is established upon audit that the provider claimed payments related to services or costs that the department had previously notified the provider in an audit report that the costs or services were not reimbursable, the provider shall pay, in addition to the amount improperly claimed, a penalty of 10 percent of the amount improperly claimed after receipt of the notice, plus the cost of the audit.

(2) In addition to the penalty and costs specified by paragraph (1), interest shall be assessed at the rate specified in subdivision (h) of Section 14171.

(3) Providers that wish to preserve appeal rights or to challenge the department’s positions regarding appeal issues may claim the costs or services and not be reimbursed therefor if they are identified and presented separately on the cost report.

(d) (1) When it is ~~adjudicated~~ *established* that the provider fraudulently claimed and received payments under this chapter, the provider shall pay, in addition to that portion of the claim that was improperly claimed, a penalty of 300 percent of the amount improperly claimed, plus the cost of the audit.

(2) In addition to the penalty and costs specified by paragraph (1), interest shall be assessed at the rate specified by subdivision (h) of Section 14171.

(3) For purposes of this subdivision, a fraudulent claim is a claim upon which the provider has been convicted of fraud upon the Medi-Cal program.

(e) Nothing in this section shall prevent the imposition of any other civil or criminal penalties to which the provider may be liable.

(f) Any appeal to any action taken pursuant to subdivision (b), (c), or (d) is subject to the administrative appeals process provided by Section 14171.

(g) As used in this section, ''cost of the audit'' includes actual hourly wages, travel, and incidental expenses at rates allowable by rules adopted by the State Board of Control and applicable overhead costs that are incurred by employees of the state in administering this chapter with respect to the performance of audits.

(h) This section shall not apply to any clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code, *clinics exempt from licensure under Section 1206 of the Health and Safety Code, health facilities licensed under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, or to any provider that is operated by a city, county, or school district*.

SEC. 33. 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 Waiver 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.

~~(b) The following requirements shall apply to the Family Planning Access Care and Treatment Waiver program identified in subdivision (aa) of Section 14132 and this program:~~

~~(1)~~

(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.

~~(2)~~

(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.

~~(3)~~

(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.

~~(c)~~

(f) The department may complete a background check on clinical provider applicants for the purpose of verifying the accuracy of information provided~~ in the application~~ *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 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.

~~(d)~~

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

(1) Has been convicted of any felony or misdemeanor ~~involving~~ *that involves* fraud or abuse in any government program, that ~~has~~ *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 ~~guilty of~~ *liable for* fraud or abuse in any civil proceeding, or that has entered into a settlement in ~~lieu of conviction for~~ *a civil or criminal proceeding alleging* fraud or abuse~~, within the previous five years. In~~ *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 any local, state, or federal government agency for fraud or abuse*. ~~The~~ *Except where there has been a settlement, 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 any local, state, or federal government agency* for fraud or abuse, that provider shall be subject to immediate disenrollment from the program.

~~(e)~~

(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.

~~(f)~~

(2) A provider shall be subject to disenrollment if claims for payment are submitted under any provider number used by the provider to obtain reimbursement from the program 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 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. 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 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.

~~(g)~~

(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.

~~(h)~~

(l) Upon receipt of reliable *information or* evidence*, including evidence that would be inadmissible under the Evidence 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 Waiver 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 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 Waiver 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 there is insufficient *information or* evidence*, including evidence that would be inadmissible under the Evidence Code,* of fraud or willful misrepresentation 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 *information or* evidence*, including evidence that would be inadmissible under the Evidence 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.

~~(i)~~

(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 Waiver 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~~ thereof~~ *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 Sections 14107 and 14123.25, in accordance with the provisions of those sections.

(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 the costs claimed by providers. 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) (1) 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.

(2) If a provider is under any investigation for fraud or abuse by any state, local, or federal government agency, the director may withhold reimbursement of funds due and payable to that provider from any other program under the administration of the department, as assets pending the outcome of the investigation of fraud and abuse. The withholding permitted pursuant to this section shall not be taken pursuant to Section 14107.11 and, notwithstanding Section 100171 of the Health and Safety Code or any other provision of law, is not subject to appeal or hearing.

SEC. 34. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition

of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~Institutions Code is amended to read:~~

~~14171.6. (a) (1) Any provider, as defined in paragraph (3), that obtains reimbursement under this chapter to which it is not entitled shall be subject to interest charges or penalties as specified in this section.~~

~~(2) When it is established upon audit that the provider has not received reimbursement to which it is entitled, the department shall pay the provider interest assessed at the rate, and in the manner, specified in subdivision (h) of Section 14171.~~

~~(3) For purposes of this section, "provider" means any individual, partnership, group, association, corporation, institution, or entity and the officers, directors, employees, or agents thereof, 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.~~

~~(b) When it is established upon audit that the provider has claimed payments under this chapter to which it is not entitled, the provider shall pay, in addition to the amount improperly received, interest at the rate specified by subdivision (h) of Section 14171.~~

~~(c) (1) When it is established upon audit that the provider claimed payments related to services or costs that the department had previously notified the provider in an audit report that the costs or services were not reimbursable, the provider shall pay, in addition to the amount improperly claimed, a penalty of 10 percent of the amount improperly claimed after receipt of the notice, plus the cost of the audit.~~

~~(2) In addition to the penalty and costs specified by paragraph (1), interest shall be assessed at the rate specified in subdivision (h) of Section 14171.~~

~~(3) Providers that wish to preserve appeal rights or to challenge the department's positions regarding appeal issues may claim the costs or services and not be reimbursed therefor if they are identified and presented separately on the cost report.~~

~~(d) (1) When it is adjudicated that the provider fraudulently claimed and received payments under this chapter, the provider shall pay, in addition to that portion of the claim that was improperly claimed, a penalty of 300 percent of the amount improperly claimed, plus the cost of the audit.~~

~~(2) In addition to the penalty and costs specified by paragraph (1), interest shall be assessed at the rate specified by subdivision (h) of Section 14171.~~

~~(3) For purposes of this subdivision, a fraudulent claim is a claim upon which the provider has been convicted of fraud upon the Medi-Cal program.~~

~~(e) Nothing in this section shall prevent the imposition of any other civil or criminal penalties to which the provider may be liable.~~

~~(f) Any appeal to any action taken pursuant to subdivision (b), (c), or (d) is subject to the administrative appeals process provided by Section 14171.~~

~~(g) As used in this section, ''cost of the audit'' includes actual hourly wages, travel, and incidental expenses at rates allowable by rules adopted by the State Board of Control and applicable overhead costs that are incurred by employees of the state in administering this chapter with respect to the performance of audits.~~

~~(h) This section shall not apply to any clinic licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code.~~

O