SB-1131 Medi-Cal providers: family planning. (2023-2024)

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Senate Bill No. 1131

CHAPTER 880

An act to amend Section 24005 of, and to add Section 24006 to, the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor September 28, 2024. Filed with Secretary of State September 28, 2024.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1131, Gonzalez. Medi-Cal providers: family planning.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

Existing law establishes, under the Medi-Cal program, the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department. Under Family PACT, comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level and who meets other eligibility criteria to receive those services.

Existing law makes the Family PACT Program inoperative if the program is determined to no longer be cost effective, as specified. If the program becomes inoperative, existing law requires all persons who have received, or are eligible to receive, comprehensive clinical family planning services pursuant to Family PACT to receive family planning services under other specified provisions of the Medi-Cal program or under the State-Only Family Planning Program, which is also established within the department.

Existing law requires enrolled providers in the Family PACT Program or the State-Only Family Planning Program to attend a specific orientation approved by the department and requires providers who conduct certain services to have prior training in those services.

This bill would, for the Family PACT Program, require a site certifier of a primary care clinic or affiliate primary care clinic, as those terms are defined, to be a clinician who oversees the provision of Family PACT services and would authorize certain clinic corporations to enroll multiple, but no more than 10, service addresses under one site certifier. The bill would require any orientation or training that the department requires of a site certifier to comply with specified requirements, including, among others, being offered through a virtual platform and being offered at least once every other month.

For purposes of both of the above-described programs, existing law requires the program to disenroll as a program provider any individual who, or any entity that, has a license, certificate, or other approval to provide health care that is revoked or suspended by a federal, California, or other state's licensing, certification, or other approval authority, that is otherwise lost, or that is surrendered while a disciplinary hearing is pending, as specified.

This bill would authorize the department to elect to not disenroll an individual or entity as a program provider if the revocation, suspension, loss, or disciplinary hearing in another state is based solely on conduct that is not deemed to be unprofessional conduct under California law.

Under existing law, a provider is subject to disenrollment if the provider submits claims for payment for the services, goods, supplies, or merchandise provided to a program beneficiary, by an individual or entity that has been previously suspended, excluded, or otherwise made ineligible to receive reimbursement from one of the above-described programs or from the Medi-Cal program and the individual has previously been on one of certain lists, as specified.

Under this bill, a provider would not be subject to disenrollment under that provision if the sole basis for an individual's listing is conduct that is not deemed to be unprofessional conduct under California law.

The bill would condition implementation of the disenrollment exceptions described in the 2 provisions above on receipt of any necessary federal approvals and the availability of federal financial participation.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 24005 of the Welfare and Institutions Code is amended to read:

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

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

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

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

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

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

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

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

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

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

government law enforcement agency for fraud or abuse, that provider shall be subject to immediate disenrollment from the program.

(i) (1) (A) Except as provided in subparagraph (B), 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 that 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.

(B) (i) The department may elect to not disenroll an individual or entity as a provider in the program pursuant to subparagraph (A) if the revocation, suspension, or loss of the individual's or entity's license, certification, or other approval in another state, or if the pending disciplinary hearing during which the individual or entity surrendered the license, certification, or other approval in another state, is based solely on conduct that is not deemed to be unprofessional conduct under California law.

(ii) The department shall seek any federal approvals that it deems necessary to implement this subparagraph. This subparagraph shall be implemented only to the extent that the department obtains any necessary federal approvals and that federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

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

(B) (i) Subparagraph (A) does not apply if the sole basis for an individual's listing on either the Suspended and Ineligible Provider List or any list published by the federal Office of the Inspector General regarding the suspension or exclusion of individuals or entities from the federal Medicare and Medicaid programs, to identify suspended, excluded, or otherwise ineligible providers, is conduct that is not deemed to be unprofessional conduct under California law.

(ii) The department shall request a waiver or any other federal approvals that it deems necessary to implement this subparagraph. This subparagraph shall be implemented only to the extent that the department obtains any necessary federal approvals and that federal financial participation under the Medi-Cal program is available and not otherwise jeopardized.

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

(4) For purposes of this subdivision:

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

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

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

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

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

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

(1) Collect any State-Only Family Planning Program or Family Planning, Access, Care, and Treatment Program overpayment identified through an audit or examination, or any portion thereof from any provider. Notwithstanding Section 100171 of the Health and Safety Code, a provider may appeal the collection of overpayments under this section pursuant to procedures established in Article 5.3 (commencing with Section 14170) of Chapter 7 of Part 3 of Division 9. Overpayments collected under this section shall not be returned to the provider during the pendency of any appeal and may be offset to satisfy audit or appeal findings, if the findings are against the provider. Overpayments shall be returned to a provider with interest if findings are in favor of the provider.

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

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

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

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

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

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

(m) As used in this section:

(1) “Abuse” means either of the following:

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

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

(2) “Fraud” means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themselves 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 other entity, and the officers, directors, owners, managing employees, or agents of any partnership, group, association, corporation, institution, or other entity, that provides services, goods, supplies, or merchandise, directly or indirectly, to a beneficiary and 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 in which 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 Section 14123.2 or 14171.6, the program may impose on providers any or all of the penalties pursuant to Section 14123.25, in accordance with the provisions of that section. In addition, program providers shall be subject to the penalties contained in Section 14107.

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

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

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

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

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

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

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

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

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

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

(u) Providers, or the enrolling entity, shall make available to all applicants and beneficiaries prior to, or concurrent with, enrollment, information on the manner in which to apply for insurance affordability programs, in a manner determined by the State Department of Health Care Services. The information provided shall include the manner in which applications can be submitted for insurance affordability programs, information about the open enrollment periods for the California Health Benefit Exchange, and the continuous enrollment aspect of the Medi-Cal program.

SEC. 2. Section 24006 is added to the Welfare and Institutions Code, to read:

24006. (a) This section applies to the Family Planning, Access, Care, and Treatment (Family PACT) Program identified in subdivision (aa) of Section 14132.

(b) A site certifier shall be a clinician employed by, or contracted with, the primary care clinic or the affiliate primary care clinic and who oversees the provision of Family PACT services at the clinic.

(c) A clinic corporation that operates a primary care clinic and that serves as a parent clinic, as described in Section 1218.1 of the Health and Safety Code, and one or more of its affiliate primary care clinics may enroll multiple, but no more than 10, service addresses under one site certifier.

(d) Any orientation or training that the department requires of a site certifier shall comply with each of the following:

(1) Is offered at least once every other month.

(2) Is offered through a virtual platform.

(3) Is updated at least annually to be consistent with current laws, policies, and medical standards.

(e) As used in this section, the following terms have the following meanings:

(1) "Affiliate primary care clinic" has the same meaning as set forth in Section 1218.1 of the Health and Safety Code.

(2) "Primary care clinic" has the same meaning as set forth in subdivision (a) of Section 1204 of the Health and Safety Code.

(3) "Service address" has the same meaning as set forth in Section 24005.

(4) “Site certifier” means an individual identified by the enrolled or enrolling provider to be responsible for ensuring that all practitioners and personnel providing services on behalf of the Family PACT Program complete and track required trainings approved by the Office of Family Planning within the department on an annual basis.