AB-676 Medi-Cal: unrecovered payments: interest rate. (2025-2026)

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CALIFORNIA LEGISLATURE— 2025–2026 REGULAR SESSION

ASSEMBLY BILL NO. 676

Introduced by Assembly Member Jeff Gonzalez

February 14, 2025

An act to amend Section 14171 of the Welfare and Institutions Code, relating to Medi-Cal.

LEGISLATIVE COUNSEL'S DIGEST

AB 676, as amended, Jeff Gonzalez. Medi-Cal: unrecovered payments: interest rate.

Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and 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 requires the Director of Health Care Services to establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination. Under existing law, if recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of that payment is entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7% per annum, whichever is higher. Under existing law, with exceptions, interest at that same rate is assessed against any unrecovered overpayment due to the department.

In the case of an assessment against any unrecovered overpayment due to the department, this bill would ~~authorize~~ *require* the department to waive the interest, as part of a repayment agreement entered into with the provider, if *the latest date of service for a retroactive payment adjustment or audit period end date for* the unrecovered overpayment occurred 4 or more years before the issuance of the first statement of account status or demand for repayment, ~~after taking into account specified factors.~~ *and the department determines that certain factors apply.* Under the bill, those factors would include, among others, the impact of the repayment amounts on the fiscal solvency of the provider, and whether the overpayment was caused by a policy change or departmental error that was not ~~the fault of~~ *caused by* the billing provider. *The bill would preserve the rights of the department to seek all remedies available at law if a provider defaults on a repayment plan. This bill would authorize the department to implement, interpret, or make specific these provisions, in whole or in part, by means of information notices, all-county letters, or other similar instructions without taking regulatory action.*

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: no

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

SECTION 1. Section 14171 of the Welfare and Institutions Code is amended to read:

14171. (a) The director shall establish administrative appeal processes to review grievances or complaints arising from the findings of an audit or examination made pursuant to Sections 10722 and 14170 and for final settlements, including, in the case of hospitals, the application of Sections 51536, 51537, and 51539 of Title 22 of the California Code of Regulations. All of these processes shall be established by regulation, pursuant to, and consistent with, Section 100171 of the Health and Safety Code.

(b) Different administrative appeal processes may be established by the director for grievances or complaints arising from the determinations of a tentative or final settlement based on audit or examination findings made by or on behalf of the department pursuant to Sections 10722 and 14170. However, consistent with existing practice, no administrative appeal shall be available for tentative settlement of cost reports.

(c) The administrative appeal process established by the director for tentative settlements, including, in the case of hospitals, the application of Sections 51536, 51537, and 51539 of Title 22 of the California Code of Regulations, shall be an informal process that, however, guarantees a provider the right to present any grievance or complaint to the department in writing. Any subsequent hearings shall be conducted in an informal manner and shall be held at the discretion of the department.

(d) The time limitations in subdivisions (e) and (f) for the impartial hearing and the final decisions are mandatory. If the department fails to conduct the hearing or to adopt a final decision thereon within the time limitations provided in subdivisions (e) and (f), the amount of any overpayment that is ultimately determined by the department to be due shall be reduced by 10 percent for each 30-day period, or portion thereof, that the hearing or the decision, or both, are delayed beyond the time limitations provided in subdivisions (e) and (f). However, the time period shall be extended by either of the following:

(1) Delay caused by a provider.

(2) Extensions of time granted a provider at its sole request or at the joint request of the provider and the department.

(e) (1) The administrative appeal process established by the director shall commence with an informal conference with the provider, a representative of the department, and the administrative law judge. The informal conference shall be conducted no later than 90 days after the filing of a timely and specific statement of disputed issues by the provider. The administrative law judge, when appropriate, may assign the administrative appeal to an informal level of review where efforts could be made to resolve facts and issues in dispute in a fair and equitable manner, subject to the requirements of state and federal law. The review conducted at this informal level shall be completed no later than 180 days after the filing of a timely and specific statement of disputed issues by the provider.

(2) This subdivision does not prohibit the provider from presenting any unresolved grievances or complaints at an impartial hearing pursuant to subdivision (a). The impartial hearing shall be conducted no later than 300 days after the filing of a timely and specific statement of disputed issues by the provider.

(3) (A) Subject to subdivision (f), a final decision in a noninstitutional provider appeal shall be adopted within 180 days after the closure of the record of the impartial hearing, and a final decision in an institutional provider appeal shall be adopted within 300 days after the closure of the record of the impartial hearing.

(B) The department shall mail a copy of the adopted decision to all parties within 30 days of the date of adoption of the decision.

(f) If the director intends to modify a proposed decision, on or before the 180th day following the closure of the record of the hearing for noninstitutional providers or the 300th day following the closure of the record of the hearing for institutional providers, the director shall provide written notice of their intention to the parties and shall afford the parties an opportunity to present written argument. Following this notice, on or before the 240th day following the closure of the record of the hearing for noninstitutional providers or the 420th day following closure of the record of the hearing for institutional providers, or within that additional time period as is granted pursuant to the sole request of a provider or at the joint request of the provider and the department, the director shall issue a final decision.

(g) If the recovery of a disallowed payment has been made by the department, a provider who prevails in an appeal of a disallowed payment shall be entitled to interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund, or simple interest at the rate of 7 percent per annum, whichever is higher, commencing on the date the appeal is formally accepted by the department or the date payment is received by the department, whichever is later.

(h) (1) Except as provided in subdivision (i) and paragraph (2), commencing 60 days after issuance of the first statement of account status or demand for repayment resulting from an audit or examination made pursuant to Sections 10722 and 14170, interest at the rate equal to the monthly average received on investments in the Surplus Money Investment Fund during the month the first statement of account status or demand for repayment was issued, or simple interest at the rate of 7 percent per annum, whichever is higher, shall be assessed against any unrecovered overpayment due to the department.

(2) The department ~~may~~ *shall* waive the interest determined pursuant to paragraph (1) as part of a repayment agreement entered into with the provider, if *the latest date of service for a retroactive payment adjustment or audit period end date for* the unrecovered overpayment occurred four or more years before the issuance of the first statement of account status or demand for repayment, ~~after taking into account the following factors:~~ *and in the department's sole discretion, the department determines that all of the following apply:*

~~(A)The importance of the provider to the health care safety net in the community in which the provider provides services to patients.~~

~~(B)The~~

(A) The provider has demonstrated to the department a substantial impact of the repayment amounts on the fiscal solvency of the provider.

~~(C)The ability of the provider to repay the overpayment amounts.~~

~~(D)Whether~~

(B) The provider has demonstrated to the department that the overpayment was caused by a policy change or departmental error that was not ~~the fault of~~ *caused by* the billing provider.

~~(E)Whether waiving the interest would~~

(C) Waiving the interest will not jeopardize the availability of federal funding.

(3) If the provider defaults on any payment owed under a repayment agreement entered into with the department pursuant to paragraph (2), the department may exercise its legal and contractual rights and all remedies available at law, including, but not limited to, offsetting from the amount payable to the provider for services provided under Medi-Cal in an amount equal to the total amounts due under the repayment agreement, and reinstate interest to be assessed as described in paragraph (1). If provider files a petition seeking relief under the United States Bankruptcy Code while under a repayment agreement with the department pursuant to paragraph (2), the department reserves its rights to equitably recoup the amounts payable to the provider for services provided under Medi-Cal to the fullest extent allowable under state and federal law, and to reinstate interest to be assessed as described in paragraph (1).

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this subdivision, in whole or in part, by means of all-county letters, plan letters, provider bulletins, information notices, or other similar instructions, without taking any further regulatory action.

(5) The department's determination whether or not to exercise its discretion under this subdivision shall not be subject to judicial review, except through a writ of mandate under Section 1085 of the Code of Civil Procedure to rectify an abuse of discretion by the department.

(i) (1) Commencing on the day following the last day of the period covered by an audit or examination made pursuant to Sections 10722 and 14170, interest at the rate established under former Section 19269 of the Revenue and Taxation Code that is in effect on the date of the commencement of that interest shall be assessed against any unrecovered overpayment due to the department by providers of durable medical equipment or incontinence supplies.

(2) Interest that accrues under this subdivision for recoupment of an overpayment based on the lack of medical necessity for a previously approved claim shall commence to accrue on the date of written demand by the department.

(j) The final decision of the director shall be reviewable in accordance with Section 1094.5 of the Code of Civil Procedure within six months of the issuance of the director's final decision.