Date of Hearing: April 18, 2023

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 1122 (Bains) – As Amended March 9, 2023

SUBJECT: Medi-Cal provider applications.

SUMMARY: Creates, for purposes of provider enrollment in Medi-Cal, new flexibilities and rights for providers applying for new or continued enrollment in the Medi-Cal program. Specifically, **this bill**:

1) Allows an applicant or provider to submit any primary authoritative source documentation as proof of required information, and requires the Department of Health Care Services (DHCS) to reasonably accept alternative formats and sources of that documentation so long as it is verified as authentic and comes from a primary source, and to the extent not in conflict with federal law.

2) Allows a provider, to the extent not in conflict with federal law, if DHCS fails to provide notice of a remediation period for discrepancies or areas of noncompliance that are reasonably remediable within a 30-day period, to give notice to DHCS that the deficiencies have been remedied within this period of time. Prohibits, in this case, DHCS from denying the application on this basis and requires DHCS to consider the newly submitted information and proceed with consideration of the enrollment.

3) Allows an applicant or provider to submit its application for enrollment up to 30 days before having an established place of business and have its application considered by DHCS.

EXISTING LAW:

1) Establishes the Medi-Cal Program, administered by DHCS, to provide comprehensive health benefits to low-income individuals who meet specified eligibility criteria. [Welfare and Institutions Code (WIC) § 14000 *et seq*.]

2) Establishes requirements, processes, and timelines for the enrollment of providers in the Medi-Cal program. Requires, with limited exceptions, a provider not currently enrolled in the Medi-Cal program, a provider applying for continued enrollment, or a provider not currently enrolled at a location where the provider intends to provide goods or services to a Medi-Cal beneficiary, to submit a complete application package for enrollment, continuing enrollment, or enrollment at a new location or a change in location. [WIC § 14043.26]

3) Requires DHCS to acknowledge an application package has been received within 15 or 30 days, depending on the type of provider. [WIC § 14043.26 (c)]

4) Creates streamlined processes for "preferred providers," as specified, to grant provisional Medi-Cal provider status for up to 18 months, and allows applicants meeting certain criteria, including certain hospital-based physicians, to be granted provisional provider status for up to 12 months after submission and review of a short form application. [WIC § 14043.26 (d) and (e)]

5) Requires DHCS, within 180 days after receiving an application package submitted by a provider, or from the date of the notice to an applicant or provider that the applicant or provider does not qualify as a preferred provider, to give written notice to the applicant or provider that any of the following applies, or on the 181st day grant the applicant or provider provisional provider status for a period no longer than 12 months, effective from the 181st day:
   a) The applicant or provider is being granted provisional provider status for a period of 12 months, effective from the date on the notice;
   b) The application package is incomplete, with the notice identifying additional information or documentation that is needed to complete the application package;
   c) DHCS is conducting background checks, pre-enrollment inspections, or unannounced visits;
   d) The application package is denied for specified reasons; or,
   e) The application package is withdrawn by request of the applicant or provider. [WIC § 14043.26 (f)]

6) Requires DHCS, within 90 days after receiving an application package from a physician or physician group, to give written notice to the applicant or provider that the criteria in 5) a) through e) above applies, or to grant the applicant on the 91st day provisional provider status for a period no longer than 12 months, effective from the 91st day. [WIC § 14043.26 (g)]

7) Requires, if an application package that was noticed as incomplete is not resubmitted with all requested information and documentation and received by the department within 60 days of the date on the notice, the application package to be denied by operation of law. Permits an applicant or provider to reapply by submitting a new application package to be reviewed de novo. [WIC § 14043.26 (h)(2))]

8) Authorizes DHCS to require an applicant or provider to sign a provider agreement and disclose all information as required in federal Medicaid regulations and any other information required by DHCS, and provides that failure to disclose the required information, or the disclosure of false information, results in one of the following:
   a) Denial of the application; or,
   b) Makes the provider subject to temporary suspension from the Medi-Cal program, which includes temporary deactivation of the provider's number or numbers, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program. [WIC § 14043.2]

9) Requires applicants or providers to have an established place of business appropriate and adequate for the services billed or claimed to the Medi-Cal program as relevant to their scope of practice or type of business. [California Code of Regulations (CCR), Title 22, § 51000.60]

FISCAL EFFECT: Unknown. This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, many providers are discouraged from enrolling in Medi-Cal by the friction of the current application process. The author asserts streamlining the provider enrollment process can dramatically expand access to care to Medi-Cal beneficiaries. The author notes this bill is author-sponsored, based on their professional

experience as a physician from Kern County and acute awareness that a lack of Medi-Cal providers adversely effects vulnerable populations.

2) BACKGROUND.

a) Medi-Cal Provider Enrollment. State law governing Medi-Cal and federal law and regulations contain provisions to address fraud. An applicant or provider seeking to provide services in the Medi-Cal program must submit a complete application package for enrollment, continuing enrollment, enrollment at a new location or a change in location. DHCS' Provider Enrollment Division is responsible for the enrollment and re-enrollment of most health care providers in the Medi-Cal program. DHCS indicates its review of a provider's application package is a complex process that requires assessment of many elements of the application, including a review of the required supporting documentation, to determine eligibility for enrollment into the Medi-Cal program. DHCS may conduct a background check of an applicant or provider for the purpose of verifying information. This review may also include an unannounced on-site inspection, a review of business records, and data searches to ensure that the applicant or provider meets enrollment criteria. CCR, Title 22, § 51000 to 51000.75 establishes additional specificity on the enrollment process.

b) Application Processing Timeframes. Existing law establishes notification requirements and timeframes for DHCS application processing that vary depending upon the type of provider. For example, for physicians and physician groups, DHCS acknowledges receipt within 15 days. For applications from provider types other than physicians or physician groups, DHCS acknowledges receipt within 30 days. Physician and physician group applicants are notified in writing of one of the five actions listed below, within 90 days of receipt of an application. Notification of DHCS action to applicants other than a physician or physician group (such as psychologists, physician assistants, nurse practitioners, or podiatrists) remains at 180 days.
DHCS notifies the enrolled provider or applicant that their application is one of the following:

i) Approved for enrollment as a provisional provider;
ii) Incomplete and additional information is required;
iii) Referred for a comprehensive review and background check;
iv) Denied (with the reason(s) for denial); or,
v) Withdrawn by request of the applicant or provider.

Existing law also creates a streamlined processes for certain "preferred providers," who have specified affiliations and a license in good standing, to grant provisional Medi-Cal provider status for up to18 months. It allows applicants meeting certain criteria, including certain hospital-based physicians, to be granted provisional provider status for up to 12 months after submission and review of a short form application. If providers meet certain conditions and remain in good standing at the end of the "provisional provider" period, the provider is enrolled in the Medi-Cal program without designation as a provisional provider.

c) Changes in Recent Years. In November 2016, DHCS began implementation of the Provider Application and Validation for Enrollment (PAVE) system. PAVE is a Commercial Off-the-Shelf software that automates DHCS' Medi-Cal provider enrollment processes and

serves as the enterprise platform for provider enrollment activities. PAVE provides a secure, web-based portal for providers to submit their applications and update their information. PAVE is also used by DHCS to establish and monitor ongoing provider compliance with enrollment requirements. DHCS indicates PAVE has been well-received by the provider community, as it has facilitated enrollment and participation in Medi-Cal and has contributed to the increased number of participating providers.

DHCS indicates business rules within the application have also resulted in a decreased number of deficient applications being submitted, improving the average processing time significantly.

d) Recent Budget Change Proposals. In 2019, DHCS submitted and the Legislature approved an April 1 Budget Change Proposal requesting two-year limited-term funding equivalent to 23 positions and associated expenditure authority. DHCS indicated resources were needed to address an increase in workload due to an increase in provider enrollment applications, including applications from Drug Medi-Cal and Medi-Cal managed care health plan providers. In addition, these positions were to be used to address a backlog at that time of approximately 19,000 applications. The request was funded at $3.2 million ($795,000 General Fund (GF)) for fiscal year (FY) 2019-20 and $2.9 million ($744,000 GF) for FY 2020-21.

In 2021, DHCS requested and received one-year limited-term contract funding in the amount of $7.1 million ($1.8 million GF) for fiscal year 2021-22 for enhancements to the PAVE system, including for adding Medi-Cal Dental providers, Family Planning, Access, Care, and Treatment (Family PACT) providers, and Diabetes Prevention Program providers to PAVE.

e) COVID-19 Flexibilities Ending. Effective March 29, 2023, DHCS has discontinued certain provider enrollment flexibilities authorized by waivers of federal law during the COVID-19 pandemic. Providers who were temporarily and provisionally enrolled under these flexibilities who wish to remain enrolled in fee-for-service (FFS) Medi-Cal following the discontinuation of the flexibilities are required to submit a complete application for their provider type and meet all program requirements if they have not already done so. Providers will have 90 days to submit an application for enrollment via PAVE. Providers who have not submitted an application by June 27, 2023 (90 days after bulletin effective date) will have their temporary enrollment deactivated effective June 28, 2023.

f) Established Place of Business. State regulations (CCR Title 22, § 51000.60) require an applicant or provider to have an "established place of business" appropriate and adequate for the services billed to Medi-Cal, as relevant to their scope of practice or type of business. This bill would allow an applicant or provider to submit an application for enrollment up to 30 days before having an established place of business and have its application considered by DHCS.

Although the established place of business requirement assists DHCS in identifying potential program fraud, DHCS has recently announced exemptions from this requirement, as of March 29, 2023, for two classes of providers: i) remote service providers who offer mental health services exclusively through telehealth; and, ii)

transportation providers located in California. This bill would not change the requirement but would allow applications to begin the process prior to having an established place of business.

g) **Remediating Deficiencies in Applications**. Current law allows DHCS to give written notice that an application package is incomplete and requires the notice to identify additional information or documentation that is needed to complete the application package. If an application package that was noticed as incomplete is not resubmitted with all requested information and documentation and received by DHCS within 60 days of the date on the notice, current law requires the application package to be denied by operation of law and permits the applicant or provider to reapply by submitting a new application package that shall be reviewed "de novo" (beginning with a new application).

3) PREVIOUS LEGISLATION.

a) AB 1524 (Chiu) of 2019 would have shortened DHCS's approval timeline for provider enrollment of student health centers at institutes of higher education for the Medi-Cal and Family PACT, from 180 to 30 days, and required DHCS to grant provisional provider status on the 31st day of a Medi-Cal application. AB 1524 was held on the Suspense File of the Assembly Appropriations Committee.

b) SB 299 (Monning), Chapter 271, Statutes of 2015, exempts health care providers submitting a Medi-Cal provider application package to DHCS from the current notarization requirements if the provider enrolls electronically, clarifies DHCS is required to collect an application fee for continued enrollment, conforms state law to federal regulation by requiring DHCS to designate a provider or applicant as a "high" categorical risk if DHCS lifted a temporary moratorium within the previous six months for the particular provider type submitting the application, and deleted various obsolete provisions of law.

c) SB 1529 (Alquist), Chapter 797, Statutes of 2012, revises screening, enrollment, disenrollment, suspensions, and other sanctions for FFS Medi-Cal providers and suppliers to conform to the requirements of the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111- 152) (collectively known as the Affordable Care Act or ACA).

d) SB 857 (Speier), Chapter 601, Statutes of 2003, made numerous changes to the Medi-Cal program intended to address provider fraud, including establishing new Medi-Cal application requirements for new providers, existing providers at new locations, and providers applying for continued enrollment.

4) AMENDMENTS. Following conversations with committee staff, the author has agreed to amend this bill as follows:

a) **Submitting Documents in Alternative Formats.** The provision allowing an applicant or provider to submit any primary authoritative source documentation as proof of required information has the potential to be problematic. It allows providers to decide in which formats they wish to submit documentation to substantiate their applications, which could lead to inefficient administration and increase program risk. Additionally, because it is framed as a right of the enrolled provider or applicant, it limits DHCS's abilities to define

requirements. In the interest of fairness, program integrity, and preventing waste, fraud and abuse, the state should uniformly describe requirements and apply rules.

However, the author asserts there could be unique instances where legitimate providers have particular business scenarios that make it impossible to comply with the letter of the requirement, but they could provide documentation of a similar level of authenticity that demonstrates program compliance in a slightly different way. Authorizing DHCS to handle these unique scenarios in a flexible manner could allow DHCS to prescribe the process and level of flexibility the state can accept, to welcome legitimate providers while ensuring program integrity. In addition, conditioning implementation on federal approval and ensuring federal matching funds are not jeopardized will ensure the state does not run afoul of federal rules nor put the state GF at risk.

Amendments will authorize DHCS to develop a standard process to allow an applicant or provider to submit an alternative type of primary authoritative source documentation, specify record-keeping requirements, and condition implementation on availability of federal financial participation and any necessary federal approvals.

b) Remediating Deficiencies. Current law requires DHCS to identify any discrepancies or failures found as a result of background checks, preenrollment inspections, or unannounced visits, and whether remediation can be made or not, and if so, the time period within which remediation must be accomplished. Despite this current-law requirement to provide notice of a remediation time period for discrepancies or areas of noncompliance, this bill specifies certain provisions that apply if DHCS fails to provide notice of a remediation time period. Instead of establishing contingencies in case DHCS does not act consistent with current law, the author may wish to work with DHCS to ensure remediation time periods are being provided pursuant to DHCS's obligations under current law. Therefore, amendments will strike this provision of this bill. As this bill moves forward, in order to address concerns around the rigidity of the current-law requirement that a failure to remediate within a specified time period leads to an application denial by operation of law, the author could explore establishing flexibility to allow DHCS to extend time periods for new providers to remediate deficiencies for good cause. This approach would seem to pose limited risk and could improve efficiency for providers and the department in certain cases.

5) POLICY COMMENT. In addition to the amendments listed above, to assure program integrity, the Committee recommends the author seek technical assistance from DHCS on any additional requirements that may be needed.

REGISTERED SUPPORT / OPPOSITION:

Support

Western Center on Law & Poverty

Opposition

None on file.

Analysis Prepared by: Lisa Murawski / HEALTH / (916) 319-2097