## Senate Bill No. 299

CHAPTER 271

An act to amend Sections 14043.1, 14043.15, 14043.25, 14043.28, 14043.36, 14043.38, 14043.4, and 14043.55 of the Welfare and Institutions Code, relating to Medi-Cal, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 4, 2015. Filed with Secretary of State September 4, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 299, Monning. Medi-Cal: provider enrollment.

Existing law provides for 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 requires an applicant or provider, as defined, to submit a complete application package for enrollment, continued enrollment, or enrollment at a new location or a change in location, and generally requires the application package for enrollment, the provider agreement, and all attachments or changes to either that are submitted by specified applicants or providers to be notarized. Existing law requires the department to collect an application fee for enrollment, including enrollment at a new location or a change in location.

This bill would exempt from these notarization requirements any provider that chooses to enroll electronically. The bill would clarify that the department is also required to collect an application fee for continued enrollment.

Existing law authorizes the department to implement a 180-day moratorium on the enrollment of providers in a specified provider of services category, as specified. Existing law requires the State Department of Health Care Services to screen Medi-Cal providers and designate each provider or applicant as "limited," "moderate," or "high" categorical risk. Existing law requires the department to designate a provider or applicant as a "high" categorical risk if specified circumstances occur, including if the federal Centers for Medicare and Medicaid Services lifted a temporary moratorium within the previous 6 months for the particular provider type submitting the application, as specified.

This bill would also require the department to designate a provider or applicant as a "high" categorical risk if the department lifted a temporary moratorium within the previous 6 months for the particular provider type submitting the application.

This bill would also delete various obsolete provisions of law.

This bill would declare that it is to take effect immediately as an urgency statute.

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

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

14043.1. As used in this article:

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

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

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

(b) "Applicant" means an individual, including an ordering, referring, or prescribing individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents thereof, that apply to the department for enrollment as a provider in the Medi-Cal program.

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

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

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

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

(1) A judgment of conviction has been entered against an individual or entity by a federal, state, or local court, regardless of whether there is a posttrial motion, an appeal pending, or the judgment of conviction or other record relating to the criminal conduct has been expunged or otherwise removed.

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

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

(4) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.

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

(h) "Enrolled or enrollment in the Medi-Cal program" means authorized under any processes by the department or its agents or contractors to receive, directly or indirectly, reimbursement for the provision of services, goods, supplies, or merchandise to a Medi-Cal beneficiary.

(i) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

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

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

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

(2) The provider is adding a business address.

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

(2) "Individual physician practice" means a physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California enrolled or enrolling in Medi-Cal as an individual provider who is sole proprietor of his or her practice or is a corporation owned solely by the individual physician and the only physician practitioner is the owner. An individual physician practice may include nonphysician medical practitioners employed and supervised by the physician.

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

(n) "Professionally recognized standards of health care" means statewide or national standards of care, whether in writing or not, that professional peers of the individual or entity whose provision of care is an issue recognize as applying to those peers practicing or providing care within a state. When the United States Department of Health and Human Services has declared a treatment modality not to be safe and effective, practitioners that employ that treatment modality shall be deemed not to meet professionally recognized standards of health care. This subdivision shall not be construed to mean that all other treatments meet professionally recognized standards of care.

(o) "Provider" means an individual, partnership, group, association, corporation, institution, or entity, and the officers, directors, owners, managing employees, or agents of a partnership, group association, corporation, institution, or entity, that provides services, goods, supplies, or merchandise, directly or indirectly, including all ordering, referring, and prescribing, to a Medi-Cal beneficiary and that has been enrolled in the Medi-Cal program.

(p) "Resolution of an investigation for fraud or abuse" means there is no documentation to indicate either that a charge or accusation has been filed against the provider and either (1) the investigation has not been active at any time during the previous 12 months or (2) the department has made a documented good faith effort and has been unable, for a period of 12 months, to contact an investigator or responsible representative of any agency investigating the provider.

(q) "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. 2. Section 14043.15 of the Welfare and Institutions Code is amended to read:

14043.15. (a) The department may adopt regulations for certification of each applicant and each provider in the Medi-Cal program. No certification shall be required for natural persons licensed or certificated under Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act.

(b) (1) An applicant or provider who is a natural person, and is licensed or certificated pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or is a professional corporation, as defined in subdivision (b) of Section 13401 of the Corporations Code, shall comply with Section 14043.26 and shall be enrolled in the Medi-Cal program as either an individual provider or as a rendering provider in a provider group for each application package submitted and approved pursuant to Section 14043.26, notwithstanding that the applicant or provider meets the requirements to qualify as exempt from clinic licensure under subdivision (a) or (m) of Section 1206 of the Health and Safety Code.

(2) A provider enrolled in the Medi-Cal program pursuant to paragraph (1), who has disclosed in the application package for enrollment that the provider's practice includes the rendering of services, goods, supplies, or merchandise solely at one, or at more than one, health facility, as defined in Section 1250 of the Health and Safety Code, or clinic, as defined in Section 1204 of the Health and Safety Code, or medical therapy unit, for purposes of Section 123950 of the Health and Safety Code, or residence of the provider's patient, or office of a physician and surgeon involved in the care and treatment of the provider's patients, shall not be required to enroll at each such health facility, clinic, medical therapy unit, patient's residence, or physician and surgeon's office location and may utilize the business addresses listed on the application for enrollment pursuant to paragraph (1) to claim reimbursement from the Medi-Cal program for services rendered by the provider to Medi-Cal beneficiaries at all of those health facilities, clinics, medical therapy units, residences, or physician offices.

(3) This subdivision shall not be interpreted to allow the violation of any state or federal law governing fiscal intermediaries or Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act. This subdivision does not remove the requirement that each claim for reimbursement from the Medi-Cal program identify the place of service and the rendering, ordering, referring, and prescribing provider, where applicable.

(c) An applicant or provider licensed as a clinic pursuant to Chapter 1 (commencing with Section 1200) of, or a health facility licensed pursuant to Chapter 2 (commencing with Section 1250) of, Division 2 of the Health and Safety Code may be enrolled in the Medi-Cal program as a clinic or a health facility and need not comply with Section 14043.26 if the clinic or health facility is certified by the department to participate in the Medi-Cal program.

(d) An applicant or provider that meets the requirements to qualify as exempt from clinic licensure under subdivisions (b) to (*l*), inclusive, or subdivisions (n) to (p), inclusive, of Section 1206 of the Health and Safety Code shall comply with Section 14043.26 and may be enrolled in the Medi-Cal program as either a clinic or within any other provider category for which the applicant or provider qualifies. An applicant or provider to which any of the clinic licensure exemptions specified in this subdivision apply shall identify the licensure exemption category and document in its application package the legal and factual basis for the clinic license exemption claimed.

(e) Notwithstanding subdivisions (a), (b), (c), and (d), an applicant or provider that meets the requirements to qualify as exempt from clinic licensure pursuant to subdivision (h) of Section 1206 of the Health and Safety Code, including an intermittent site that is operated by a licensed primary care clinic or an affiliated mobile health care unit licensed or approved under Chapter 9 (commencing with Section 1765.101) of Division 2 of the Health and Safety Code, and that is operated by a licensed primary care clinic, and for which intermittent site or mobile health unit the licensed primary care clinic directly or indirectly provides all staffing, protocols, equipment, supplies, and billing services, need not enroll in the Medi-Cal program as a separate provider and need not comply with Section 14043.26 if the licensed primary care clinic operating the applicant, provider clinic, or mobile health care unit has notified the department of its separate locations, premises, intermittent sites, or mobile health care units.

SEC. 3. Section 14043.25 of the Welfare and Institutions Code is amended to read:

14043.25. (a) The application form for enrollment, the provider agreement, and all attachments or changes to either, shall be signed under penalty of perjury.

(b) The department may require that the application form for enrollment, the provider agreement, and all attachments or changes to either, submitted by an applicant or provider licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act, be notarized.

(c) Application forms for enrollment, provider agreements, and all attachments or changes to either, submitted by an applicant or provider not subject to subdivision (b) shall be notarized. This subdivision shall not apply with respect to providers under the In-Home Supportive Services program or any providers that choose to enroll electronically.

(d) The department shall collect an application fee for enrollment, including continued enrollment or enrollment at a new location or a change in location. The application fee shall not be collected from individual physicians or nonphysician practitioners, from providers that are enrolled in Medicare or another state's Medicaid program or Children's Health Insurance Program, from providers that submit proof that they have paid the applicable fee to a Medicare contractor or to another state's Medicaid program, or pursuant to an exemption or waiver pursuant to federal law.

The application fee collected shall be in the amount calculated by the federal Centers for Medicare and Medicaid Services in effect for the calendar year during which the application for enrollment is received by the department.

SEC. 4. Section 14043.28 of the Welfare and Institutions Code is amended to read:

14043.28. (a) (1) If an application package is denied under Section 14043.26 or provisional provider status or preferred provisional provider status is terminated under Section 14043.27, the applicant or provider shall be prohibited from reapplying for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of three years from the date the application package is denied or the provisional provider status is terminated, except as provided otherwise in paragraph (2) of subdivision (h), or paragraph (2) of subdivision (i), of Section 14043.26 and as set forth in this section.

(2) If the application is denied under paragraph (2) of subdivision (h) of Section 14043.26 because the applicant failed to resubmit an incomplete application package or is denied under paragraph (2) of subdivision (i) of Section 14043.26 because the applicant failed to remediate discrepancies, the applicant may resubmit an application in accordance with paragraph (2) of subdivision (h) or paragraph (2) of subdivision (i), respectively.

(3) If the denial of the application package is based upon a conviction for any offense or for any act included in Section 14043.36 or termination of the provisional provider status or preferred provisional provider status is based upon a conviction for any offense or for any act included in paragraph (1) of subdivision (c) of Section 14043.27, the applicant or provider shall be prohibited from reapplying for enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors for a period of 10 years from the date the application package is denied or the provisional provider status or preferred provisional provider status is terminated.

(4) If the denial of the application package is based upon two or more convictions for any offense or for any two or more acts included in Section 14043.36 or termination of the provisional provider status or preferred provisional provider status is based upon two or more convictions for any offense or for any two acts included in paragraph (1) of subdivision (c) of Section 14043.27, the applicant or provider shall be permanently barred from enrollment or continued enrollment in the Medi-Cal program or for participation in any health care program administered by the department or its agents or contractors.

(5) The prohibition in paragraph (1) against reapplying for three years shall not apply if the denial of the application or termination of provisional provider status or preferred provisional provider status is based upon any of the following:

(A) The grounds provided for in paragraph (4), or subparagraph (B) of paragraph (7), of subdivision (c) of Section 14043.27.

(B) The grounds provided for in subdivision (d) of Section 14043.27, if the investigation is closed without any adverse action being taken.

(C) The grounds provided for in paragraph (6) of subdivision (c) of Section 14043.27. However, the department may deny reimbursement for claims submitted while the provider was noncompliant with the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA) (42 U.S.C. Sec. 263a et seq.).

(D) The grounds provided for in subdivision (b) of Section 14043.36 for being terminated or excluded under Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(b) (1) If an application package is denied under subparagraph (A), (B), (D), or (E) of paragraph (4) of subdivision (f) of Section 14043.26, or with respect to a provider described in subparagraph (B) of paragraph (2) of subdivision (h), or subparagraph (B) of paragraph (2) of subdivision (i), of Section 14043.26, or provisional provider status or preferred provisional provider status is terminated based upon any of the grounds stated in subparagraph (A) of paragraph (7), or paragraphs (1), (2), (3), (5), and (8) to (12), inclusive, of subdivision (c) of Section 14043.27, all business addresses of the applicant or provider shall be deactivated and the applicant or provider shall be removed from enrollment in the Medi-Cal program by operation of law.

(2) If the termination of provisional provider status is based upon the grounds stated in subdivision (d) of Section 14043.27 and the investigation is closed without any adverse action being taken, or is based upon the grounds in subparagraph (B) of paragraph (7) of subdivision (c) of Section 14043.27 and the applicant or provider obtains the appropriate license, permits, or approvals covering the period of provisional provider status, the termination taken pursuant to subdivision (c) of Section 14043.27 shall be rescinded, the previously deactivated provider numbers shall be reactivated, and the provider shall be reenrolled in the Medi-Cal program, unless there are other grounds for taking these actions.

(c) Claims that are submitted or caused to be submitted by an applicant or provider who has been suspended from the Medi-Cal program for any reason or who has had its provisional provider status terminated or had its application package for enrollment or continued enrollment denied and all business addresses deactivated may not be paid for services, goods, merchandise, or supplies rendered to Medi-Cal beneficiaries during the period of suspension or termination or after the date all business addresses are deactivated.

SEC. 5. 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 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, within the previous 10 years. In addition, the department may deny enrollment to any applicant that, at the time of application, is under investigation by the department or any state, local, or federal government law enforcement 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 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 state, local, or federal government law enforcement agency for fraud or abuse, that provider shall be subject to temporary suspension from the Medi-Cal program, which shall include temporary deactivation of the provider's number, including all business addresses used by the provider to obtain reimbursement from the Medi-Cal program.

(b) If it is discovered that a provider has been terminated under Medicare or under the Medicaid program or Children's Health Insurance Program in any other state, the provider shall not be enrolled in, or shall be subject to termination from, the Medi-Cal program, which shall include deactivation of the provider's enrolled numbers and all business addresses used to obtain reimbursement from the Medi-Cal program.

(c) The director shall notify in writing the provider of the temporary suspension and deactivation of the provider's number, which shall take effect 15 days from the date of the notification. 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.

(d) A temporary suspension may be lifted when a resolution of an investigation for fraud or abuse occurs.

SEC. 6. Section 14043.38 of the Welfare and Institutions Code is amended to read:

14043.38. (a) Provider types are designated as "limited," "moderate," or "high" categorical risk by the federal government in Section 424.518 of Title 42 of the Code of Federal Regulations. The department shall, at minimum, utilize the federal regulations in determining a provider's or applicant's categorical risk.

(b) In accordance with Section 455.450 of Title 42 of the Code of Federal Regulations, the department shall designate a provider or applicant as a "high" categorical risk if any of the following occur:

(1) The department imposes a payment suspension based on a credible allegation of fraud, waste, or abuse.

(2) The provider or applicant has an existing Medicaid overpayment based on fraud, waste, or abuse.

(3) The provider or applicant has been excluded by the federal Office of the Inspector General or another state's Medicaid program within the previous 10 years.

(4) The department or the federal Centers for Medicare and Medicaid Services lifted a temporary moratorium within the previous six months for the particular provider type submitting the application, the applicant would have been prevented from enrolling based on that previous moratorium, and the applicant applies for enrollment as a provider at any time within six months from the date the moratorium was lifted.

(c) If the department designates a provider or applicant as a "high" categorical risk, the department or its designee shall do both of the following:

(1) Conduct a criminal background check of the following persons:

(A) The provider or applicant. If the provider or applicant is a nonprofit Drug Medi-Cal provider or applicant, the officers and executive director of the provider or applicant.

(B) Any person with a 5-percent or greater direct or indirect ownership interest in the provider or applicant.

(2) Require the following persons to submit a set of fingerprints within 30 days of the department's request, in a manner determined by the department:

(A) The provider or applicant. If the provider or applicant is a nonprofit Drug Medi-Cal provider or applicant, the officers and executive director of the provider or applicant.

(B) Any person with a 5-percent or greater direct or indirect ownership interest in the provider or applicant.

(d) (1) The department shall submit to the Department of Justice fingerprint images and related information required by the Department of Justice of Medi-Cal providers or applicants determined to be a "high" categorical risk pursuant to subdivision (a), and any person with a 5-percent or greater direct or indirect ownership interest in those providers and applicants, for the purposes of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her recognizance pending trial or appeal.

(2) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information received pursuant to this section. The Department of Justice shall review the information returned from the Federal Bureau of Investigation and compile and disseminate a response to the department.

(3) The Department of Justice shall provide a state or federal level response to the department pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(4) The department shall request from the Department of Justice subsequent notification service, as provided pursuant to Section 11105.2 of the Penal Code, for persons described in paragraph (1).

(5) The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this section. That fee shall be paid by the subject of the criminal background check.

(e) For persons subject to the requirements of subdivision (a) of Section 15660, the procedure for obtaining and submitting fingerprints and notification by the Department of Justice of criminal record information set forth in subdivision (c) of Section 15660 shall apply instead of the procedure set forth in subdivision (d).

SEC. 7. Section 14043.4 of the Welfare and Institutions Code is amended to read:

14043.4. If discrepancies are found to exist during the preenrollment period, the department may conduct additional inspections prior to enrollment. Failure of a provider to remediate discrepancies as prescribed by the director may result in denial of the application for enrollment. The department may deactivate all of the provider's business addresses if the department determines that the discrepancies are material to the provider's continued enrollment and the provider's compliance with program requirements at the additional business addresses.

SEC. 8. Section 14043.55 of the Welfare and Institutions Code is amended to read:

14043.55. (a) The department may implement a 180-day moratorium on the enrollment of providers in a specific provider of service category, on a statewide basis or within a geographic area, except that no moratorium shall be implemented on the enrollment of providers who are licensed as clinics under Section 1204 of the Health and Safety Code, health facilities under Chapter 2 (commencing with Section 1250) of the Health and Safety Code, clinics exempt from licensure under Section 1206 of the Health and Safety Code, or 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, when the director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program. This moratorium may be extended or repeated when the director determines this action is necessary to safeguard public funds or to maintain the fiscal integrity of the program. The authority granted in this section shall not be interpreted as a limitation on the authority granted to the department in Section 14105.3.

(b) If the Secretary of the United States Department of Health and Human Services establishes a temporary moratorium on enrollment as described in federal regulations, the department shall establish a corresponding moratorium covering the same period and provider types, even if those provider types would not ordinarily be subject to a moratorium under this section, unless the department determines that the imposition of the moratorium will adversely impact beneficiaries access to medical assistance. A federal moratorium adopted under this subdivision shall not be subject to the director's determinations regarding safeguards of public funds and program integrity or other prerequisites that are necessary to implement a state-initiated moratorium.

SEC. 9. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of

Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

To ensure the state's compliance with the federal Patient Protection and Affordable Care Act (Public Law 111-148) as originally enacted and as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and to maintain services for health care providers, it is necessary that this act take effect immediately.

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