AMENDED IN ASSEMBLY APRIL 30, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 1383

Introduced by Assembly Member Jones

February 27, 2009

An act ~~relating to hospitals,~~ *to add and repeal Articles 5.21 (commencing with Section 14167.1) and 5.22 (commencing with Section 14167.31) of, Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, relating to Medi-Cal, making an appropriation therefor,* and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1383, as amended, Jones. ~~Hospitals: quality assurance fee.~~ *Medi-Cal: hospitals: supplemental payments: coverage dividend fee.*

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. Under existing law, the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, specified hospital reimbursement methodologies are applied in order to maximize the use of federal funds consistent with federal Medicaid law and stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients.

This bill, until January 1, 2011, would require the department to pay specified hospitals supplemental amounts for certain hospital services. This bill would require the Director of Health Care Services to promptly seek the federal approvals and waivers that may be necessary to implement the supplemental payment and obtain federal financial participation to the maximum extent possible for the supplemental payments made pursuant to the above-described provisions.

This bill would, until January 1, 2011, require the department to calculate and impose a coverage dividend fee on certain hospitals, as specified. This bill would require the director to seek federal approval of the fee and provides that if approval is not obtained, the provisions regarding the fee shall become inoperative. The bill would provide that no hospital shall be required to pay the coverage dividend fee to the department unless and until the state receives and maintains federal approval of the fee from the federal Centers for Medicare and Medicaid Services.

This bill would provide that for calendar quarters prior to federal approval of the fee and for the calendar quarter when the department receives notice of federal approval, a hospital shall certify, under penalty of perjury, and to the best of its knowledge, on a form provided by the department, that it has set aside in a separate account an amount equal to the aggregate coverage dividend fee for that hospital, as specified. The bill would require hospitals to, within 30 days after federal approval, to pay the principal amount of the coverage dividend fee set aside in a separate account to the department.

By expanding the definition of the crime of perjury, this bill would create a state-mandated local program.

This bill would require the department, within 10 days of receiving federal approval, to send notice to providers, and publish on its Internet Web site, certain information regarding the coverage dividend fee. This bill would require, upon federal approval, that within 45 days following the beginning of each calendar quarter, commencing with the quarter in which the department receives federal approval and ending with, and including, the calendar quarter ending December 31, 2010, each hospital pay the department the coverage dividend fee, as specified. This bill would authorize the department, if a hospital fails to pay all or part of the coverage dividend fee within 60 days of the date that payment is due, to deduct the unpaid assessment and interest owed from any Medi-Cal payments to the hospital until the full amount is recovered.

This bill would create the Coverage Dividend Revenue Fund in the State Treasury and require the money collected from the coverage dividend fee to be deposited into the fund. The money in the fund would be continuously appropriated without regard to fiscal year for the purpose of making the above-described supplemental reimbursement or expanding health care coverage for children, with the supplemental reimbursement taking priority over the expansion of health care coverage for children.

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

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

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

~~Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified low-income persons. Existing law prescribes procedures for Medi-Cal reimbursement at these facilities. Existing law requires that, as a condition of Medi-Cal program participation, and subject to federal approval, there be imposed a quality assurance fee on skilled nursing facilities, with the moneys collected from these fees to be used for specified purposes under the Medi-Cal program to support quality improvement of long-term care, as prescribed.~~

~~This bill would declare the intent of the Legislature to enact legislation that would impose a fee on hospitals in order to increase federal financial participation in order to increase Medi-Cal payments to hospitals.~~

~~This bill would also require the department to maximize federal funding in Med-Cal payments to hospitals.~~

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

Vote: ⅔. Appropriation: ~~no~~ *yes*. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

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

~~SECTION 1. It is the intent of the Legislature to enact legislation that would impose a fee to be paid by hospitals that shall be used to increase federal financial participation in order to increase Medi-Cal payments to hospitals.~~

~~SEC. 2. The State Department of Health Care Services shall seek to maximize federal funding in Medi-Cal, including funding for hospital reimbursement.~~

SECTION 1. Article 5.21 (commencing with Section 14167.1) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.21. Medi-Cal Hospital Provider Rate Stabilization Act

14167.1. (a) "Designated public hospital" means any one of the following hospitals:

(1) UC Davis Medical Center.

(2) UC Irvine Medical Center.

(3) UC San Diego Medical Center.

(4) UC San Francisco Medical Center.

(5) UC Los Angeles Medical Center, including Santa Monica/UCLA Medical Center.

(6) LA County Harbor/UCLA Medical Center.

(7) LA County Olive View UCLA Medical Center.

(8) LA County Rancho Los Amigos National Rehabilitation Center.

(9) LA County University of Southern California Medical Center.

(10) Alameda County Medical Center.

(11) Arrowhead Regional Medical Center.

(12) Contra Costa Regional Medical Center.

(13) Kern Medical Center.

(14) Natividad Medical Center.

(15) Riverside County Regional Medical Center.

(16) San Francisco General Hospital.

(17) San Joaquin General Hospital.

(18) San Mateo Medical Center.

(19) Santa Clara Valley Medical Center.

(20) Ventura County Medical Center.

(b) "Federal upper payment limit" means the upper payment limit on the applicable category of hospitals pursuant to federal law that will be allowed for purposes of federal financial participation. The federal upper payment limit for hospital outpatient services is as set forth in Section 447.321 of Title 42 of the Code of Federal Regulations. The federal upper payment limit for hospital inpatient services is as set forth in Section 447.272 of Title 42 of the Code of Federal Regulations.

(c) "Hospital inpatient services" means all services covered under the Medi-Cal program and furnished by hospitals to patients who are admitted as hospital inpatients and reimbursed on a fee-for-service basis by the department directly or through its fiscal

intermediary. Hospital inpatient services include outpatient services furnished by a hospital to a patient who is admitted to that hospital within 24 hours of the provision of the outpatient services that are related to the condition for which the patient is admitted. Hospital inpatient services include physician services only if the service is furnished to a hospital inpatient, the physician is compensated by the hospital for the service, and the service is billed to the Medi-Cal program by the hospital under a provider number assigned to the hospital. Hospital inpatient services do not include services for which a managed care health plan is financially responsible.

(d) "Hospital outpatient services" means all services covered under the Medi-Cal program furnished by hospitals to patients who are registered as hospital outpatients and reimbursed by the department on a fee-for-service basis directly or through its fiscal intermediary. Hospital outpatient services include physician services only if the service is furnished to a hospital outpatient, the physician is compensated by the hospital for the service, and the service is billed to the Medi-Cal program by the hospital under a provider number assigned to the hospital. Hospital outpatient services do not include services for which a managed health care plan is financially responsible or services rendered by a hospital-based federally qualified health center that receives reimbursement pursuant to Section 14132.100.

(e) "Implementation date" means the later of the date this article becomes effective or the date all federal approvals or waivers necessary for the implementation of this article become effective.

(f) "Managed care inpatient day" means an acute inpatient day of service covered under the Medi-Cal program for which a managed care health plan is financially responsible and that is covered by a written contract between a managed care health plan and a hospital or a hospital system.

(g) "Managed health care plan" means a health care delivery system that manages the provision of health care and receives prepaid capitated payments from the state in return for providing services to Medi-Cal beneficiaries. Managed health care plans include, but are not limited to, county organized health systems, prepaid health plans and entities contracting with the department to provide services pursuant to two-plan models, and geographic managed care. Entities providing these services contract with the

department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), or Article 2.91 (commencing with Section 14089) of Chapter 7, or Article 1 (commencing with Section 14200) or Article 7 (commencing with Section 14490) of Chapter 8.

(h) "Nondesignated public hospital" means a public hospital that is licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2008, and is defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals.

(i) "Outpatient base rates" means the Medi-Cal payment rates for hospital outpatient services in effect on the date immediately preceding the implementation date.

(j) "Private hospital" means a hospital licensed pursuant to subdivision (a) of Section 1250 of the Health and Safety Code, is not designated as a specialty hospital in the hospital's annual financial disclosure report for the hospital's latest fiscal year ending in 2008, and is a nonpublic hospital, nonpublic-converted hospital, or converted hospital as those terms are defined in paragraphs (26) to (28), inclusive, respectively, of subdivision (a) of Section 14105.98.

(k) "Subject federal fiscal year" means a federal fiscal year that ends after the implementation date and begins before the termination date.

(l) "Termination date" means December 31, 2010.

14167.2. (a) Private hospitals shall be paid supplemental amounts for hospital outpatient services that shall be in addition to any other amounts payable to hospitals with respect to hospital outpatient services and shall not affect any other payments to hospitals.

(b) Medi-Cal rates for hospital outpatient services shall result in aggregate payments equal to the federal upper payment limit.

14167.3. (a) Hospitals shall be paid supplemental amounts for hospital inpatient services that shall be in addition to any other amounts payable to hospitals with respect to hospital inpatient services and shall not affect any other payments to hospitals.

(b) Medi-Cal rates for hospital inpatient services shall result in aggregate payments equal to the federal upper payment limit.

14167.4. Private hospitals, nondesignated public hospitals, and designated public hospitals shall be paid supplemental amounts for hospital services furnished to managed care enrollees pursuant to this section. The supplemental amounts shall be paid directly to the hospitals by the department or its fiscal intermediary in addition to any other amounts payable to hospitals with respect to hospital services furnished to managed care enrollees and shall not affect any other payments to hospitals.

14167.5. The amount of any payments made pursuant to this article to private hospitals, including the amount of payments made pursuant to Sections 14167.2, 14167.3, and 14167.4, shall not be included in the calculation of the numerator or denominator of the low-income percent of the OBRA limit for purposes of disproportionate share hospital replacement fund payments to private hospitals made pursuant to Section 14166.11.

14167.6. (a) The payments made pursuant to Sections 14167.2, 14167.3, and 14167.4 to hospitals for the 2008–09 federal fiscal year shall be made on or before the later of August 31, 2009, or the 30th day following the day on which federal approval is granted.

(b) The payments made pursuant to Sections 14167.2, 14167.3, and 14167.4 to hospitals for 2009–10 federal fiscal year shall be made on a quarterly basis. The amounts payable to a hospital for each quarter shall be one-fourth of the amount payable to the hospital for the entire federal fiscal year. Payments to hospitals for each quarter during the 2009–10 federal fiscal year shall be made on the later of the last day of the second month of the quarter or the 30th day following the day on which federal approval is granted.

(c) The payments made pursuant to Sections 14167.2, 14167.3, and 14167.4 to hospitals for the 2010–11 federal fiscal year shall be made on or before the later of November 30, 2010, or the 30th day following the day on which federal approval is granted.

14167.7. (a) Payment rates for hospital outpatient services furnished by private hospitals and nondesignated public hospitals before October 1, 2011, exclusive of amounts payable under this article, shall not be reduced below the rates in effect on June 30, 2008.

(b) Rates payable to hospitals for hospital inpatient services furnished before October 1, 2011, under contracts negotiated

pursuant to the Selective Provider Contracting Program shall not be reduced below the contract rates in effect on June 1, 2009. This subdivision shall not prohibit changes to the supplemental payments paid to individual hospitals pursuant to Sections 14166.12, 14166.17, and 14166.23. The aggregate supplemental payments made pursuant to Sections 14166.12, 14166.17, and 14166.23 for a state fiscal year that ends after the implementation date and begins before the termination date shall not be less than the aggregate payments made pursuant to Sections 14166.12, 14166.17, and 14166.23 during the 2007–08 state fiscal year.

(c) Payments to private hospitals and nondesignated public hospitals for hospital inpatient services furnished before October 1, 2011, that are not reimbursed pursuant to a contract negotiated pursuant to the Selective Provider Contracting Program, exclusive of amounts payable under this article, shall not be less than the amount of payments that would have been made pursuant to the payment methodology in effect on June 30, 2008.

(d) Payments to hospitals pursuant to Sections 14166.11 and 14166.16 for a state fiscal year that ends after the implementation date and begins before the termination date shall not be less than the payments due under the methodology set forth in those sections in effect for the 2007–08 state fiscal year.

(e) Managed care health plans shall not take into account payments made pursuant to this article in negotiating the amount of payments to hospitals that are not made pursuant to this article.

14167.8. (a) The director shall promptly seek the federal approvals or waivers as may be necessary to implement this article and obtain federal financial participation to the maximum extent possible for the payments made pursuant to this article.

(b) In implementing this article, the department may utilize the services of the Medi-Cal fiscal intermediary through a change order to the fiscal intermediary contract to administer this program, consistent with the requirements of Sections 14104.6, 14104.7, 14104.8, and 14104.9. Contracts entered into with any Medicare fiscal intermediary shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(c)Notwithstanding Section 14167.9, this article shall become inoperative in the event, and on the effective date, of a final judicial determination by any court of appellate jurisdiction or a final

determination by the federal Department of Health and Human Services or the federal Centers for Medicare and Medicaid Services that any element of this article cannot be implemented.

(d) In the event any hospital, or any party on behalf of a hospital, shall initiate a case or proceeding in any state or federal court in which the hospital seeks any relief of any sort whatsoever, including, but not limited to, monetary relief, injunctive relief, declaratory relief, or a writ, based in whole or in part on a contention that any or all of this article is unlawful and may not be lawfully implemented, all of the following shall apply:

(1) No payments shall be made to a hospital pursuant to this article until the case or proceeding is finally resolved, including the final disposition of all appeals.

(2) Any amount computed to be payable to a hospital pursuant to this article for a subject federal fiscal year shall be withheld by the department and shall be paid to the hospital only after the case or proceeding is finally resolved, including the final disposition of all appeals.

14167.9. This article shall remain in effect only until January 1, 2011,, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2011, deletes or extends that date.

SEC. 2. Article 5.22 (commencing with Section 14167.31) is added to Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, to read:

Article 5.22. Hospital Coverage Dividend Fee Act

14167.31. For purposes of this article, "subject federal fiscal year" means a federal fiscal year ending after the effective date of federal approval of Article 5.21 (commencing with Section 14167.1) and beginning before December 31, 2010.

14167.32. (a) There shall be imposed a coverage dividend fee that is consistent with the principle of shared benefit and shared responsibility.

(b) The coverage dividend fee shall be assessed on hospitals, except for designated public hospitals, as defined in subdivision (a) of Section 14167.1, starting on the day that this article becomes effective and shall continue through and including December 31, 2010.

(c) The department shall calculate the amount of the aggregate coverage dividend fee for each hospital within 10 days after the date when this article becomes effective. Within two days of calculating the aggregate coverage dividend fee, the department shall send notice of the amount of the aggregate coverage dividend fee to each hospital.

(d) For calendar quarters prior to federal approval of the implementation of this article and for the calendar quarter when the department receives notice of federal approval of the implementation of this article, the following provisions shall apply:

(1) For the calendar quarters, and partial quarters thereof, between the day that this article becomes effective and September 30, 2009, inclusive, the following provisions shall apply:

(A) If this article becomes effective on or before June 30, 2009, the following provisions shall apply:

(i) On the later of 10 days after this article becomes effective or May 15, 2009, each hospital shall certify, under penalty of perjury, and to the best of its knowledge, on a form provided by the department, that it has set aside in a separate account an amount equal to the aggregate coverage dividend fee for that hospital divided by the number of days from the date that this article becomes effective to September 30, 2009, inclusive, multiplied by the number of days from the date that this article becomes effective to June 30, 2009, inclusive.

(ii) On or before August 15, 2009, each hospital shall certify, under penalty of perjury, and to the best of its knowledge, on a form provided by the department, that it has set aside in a separate account an amount equal to the aggregate coverage dividend fee for that hospital divided by the number of days from the date that this article becomes effective to September 30, 2009, inclusive, multiplied by the number of days from July 1, 2009, to September 30, 2009, inclusive.

(B) If this article is enacted on or after July 1, 2009, on the later of 10 days after this article becomes effective or August 15, 2009, each hospital shall certify, under penalty of perjury, and to the best of its knowledge, on a form provided by the department, that it has set aside in a separate account an amount equal to the aggregate coverage dividend fee for that hospital.

(2) For each calendar quarter beginning on or after October 1, 2009, and ending on or before September 30, 2010, within 45

days following the beginning of each calendar quarter, each hospital shall certify, under penalty of perjury, and to the best of its knowledge, on a form provided by the department, that it has set aside in a separate account an amount equal to the aggregate coverage dividend fee for that hospital divided by four.

(3) For the calendar quarter beginning October 1, 2010, on or before November 15, 2010, each hospital shall certify, under penalty of perjury, and to the best of its knowledge, on a form provided by the department, that it has set aside in a separate account an amount equal to the aggregate coverage dividend fee for that hospital.

(4) All certifications required by this subdivision shall include a certification from each hospital that it has maintained any coverage dividend fee amounts previously set aside in a separate account in that separate account, and that within 30 days after federal approval of the implementation of this article, the hospital shall pay the principal amount of the coverage dividend fee set aside in a separate account to the department pursuant to paragraph (2) of subdivision (e).

(e) Upon federal approval of the implementation of this article, all of the following shall become operative:

(1) Within 10 days following the notice of approval by the federal government of the implementation of this article, the department shall send notice to providers, and publish on its Internet Web site the following information:

(A) The date that the state received notice of federal approval of the implementation of this article.

(B) The percentage of the fee that shall be collected to meet the federal upper payment limit, as defined in subdivision (b) of Section 14167.1.

(C) A notice to each hospital subject to the coverage dividend fee stating all of the following:

(i) That the hospital shall, within 30 days after the date the department received notice of federal approval of the implementation of this article, pay the principal amounts of the coverage dividend fee set aside in a separate account to the department multiplied by the percentage of the fee that will be collected to meet the federal upper payment limit as described in subparagraph (B).

(ii) The total amount of the fee that will be payable by the hospital on the date described in clause (i).

(2) Within 30 days after the date the department receives notice of federal approval, each hospital shall pay the principal amount of the coverage dividend fee the hospital has certified pursuant to subdivision (d) that the hospital has set aside in a separate account to the department multiplied by the percentage of the fee that shall be collected to meet the federal upper payment limit as described in subparagraph (B) of paragraph (1). Any money set aside in a separate account in excess of the amount the hospital is obligated to pay to the department may be returned to the general accounts of each hospital.

(3) Subdivision (d) shall become inoperative beginning the first day of the first calendar quarter following the quarter in which the department receives notice of approval by the federal government of the implementation of this article.

(4) Within 45 days following the beginning of each calendar quarter, commencing with the quarter in which the department receives notice of federal approval and ending with, and including, the calendar quarter ending December 31, 2010, each hospital shall pay to the department the amounts that the hospital would have certified to pay for the relevant quarter pursuant to subdivision (d) multiplied by the percentage of the fee that will be collected to meet the federal upper payment limit described in subparagraph (B) of paragraph (1).

(5) The coverage dividend fee, as paid pursuant to this subdivision, shall be paid by each hospital subject to the fee and paid to the department for deposit in the Coverage Dividend Revenue Fund created pursuant to Section 14167.35. Deposits into the fund may be accepted at any time and shall be credited toward the fiscal year for which they were assessed.

(f) (1) Subdivision (h) shall become inoperative if either of the following situations occur:

(A) The federal Centers for Medicare and Medicaid Services denies approval for the implementation of Article 5.21 (commencing with Section 14167.1) or this article and the methodology specified in Article 5.21 (commencing with Section 14167.1) or this article may not be modified by consulting with the hospital community to obtain federal approval without violating the intent of Article 5.21 (commencing with Section 14167.1) or

this article or modified in a way that is consistent with the conditions of implementation set forth in subdivisions (a) and (c) of Section 14167.36.

(B) The federal Centers for Medicare and Medicaid Services does not approve the implementation of Article 5.21 (commencing with Section 14167.1) or this article on or before January 1, 2012.

(2) If subdivision (h) becomes inoperative pursuant to this subdivision, each hospital subject to the coverage dividend fee shall be released from any certifications made pursuant to subdivision (d) and any amounts previously set aside in a separate account and any interest incurred on those amounts may be returned to the general accounts of each hospital.

(g) In no case shall the aggregate fees collected on an annual fiscal year basis pursuant to this section exceed the maximum percentage of the annual aggregate net patient revenue for hospitals subject to the fee that is prescribed pursuant to federal law and regulations as necessary to preclude a finding that an indirect guarantee has been created.

(h) Interest shall be assessed on coverage dividend fees not paid on the date due at the same rate at which the department assesses interest on Medi-Cal program overpayments to hospitals that are not repaid when due. Interest shall begin to accrue the day after the date the payment was due and shall be deposited in the Coverage Dividend Revenue Fund.

(i) When a hospital fails to pay all or part of the coverage dividend fee within 60 days of the date that payment is due, the department may deduct the unpaid assessment and interest owed from any Medi-Cal payments to the hospital until the full amount is recovered. Any deduction shall be made only after written notice to the hospital and may be taken over a period of time. All amounts deducted by the department pursuant to this subdivision shall be deposited in the Coverage Dividend Revenue Fund.

(j) In accordance with the provisions of the Medicaid state plan, the payment of the coverage dividend fee shall be considered as an allowable cost for Medi-Cal cost reporting and reimbursement purposes.

(k) The department shall work in consultation with the hospital community to implement the coverage dividend fee.

(l) The department shall offer to enter into a contract with each hospital subject to the coverage dividend fee, or to amend existing

contracts with the hospital, that obligates the department to use the proceeds of the coverage dividend fee solely for the purposes set forth in this article and to comply with all of its obligations set forth in Article 5.21 (commencing with Section 14167.1) and this article, including, but not limited to, its obligation to continue prior reimbursement levels. Each contract shall also provide that the hospital's obligation to pay the coverage dividend fee shall be contingent on the department performing its obligations under the contract. Each contract shall be binding on the department and enforceable by the hospitals regardless of whether the hospitals have given adequate consideration in return for the department's obligations.

14167.35. (a) The Coverage Dividend Revenue Fund is hereby created in the State Treasury. Interest earned on deposits in the fund shall be retained in the fund for purposes specified in subdivision (c).

(b) All fees and interest required to be paid to the state pursuant to this article shall be paid in the form of remittances payable to the department. The department shall directly transmit the payments to the Treasurer to be deposited in the Coverage Dividend Revenue Fund.

(c) All funds in the Coverage Dividend Revenue Fund, together with any interest, and penalties, shall be used only for the following purposes in the following order of priority, subject to the requirements of subdivision (d):

(1) To make increased payments to hospitals pursuant to Article 5.21 (commencing with Section 14167.1).

(2) To pay for the expansion of health care coverage for children beyond existing levels.

(d) No portion of the Coverage Dividend Revenue Fund shall be used in support of the administration of the department except that these fees may be used in combination with federal funds to fund the actual cost of collecting the fee.

(e) Notwithstanding Section 13340 of the Government Code, the Coverage Dividend Revenue Fund shall be continuously appropriated for the purposes described in subdivision (c) without regard to fiscal year.

(f) The department shall request approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article. In making this request, the

department shall seek specific approval from the federal Centers for Medicare and Medicaid Services to exempt providers identified in this article as exempt from the fees specified, including the submission, as may be necessary, of a request for waiver of the broad based requirement, waiver of the uniform tax requirement, or both, pursuant to Section 433.68(e)(1) and (e)(2) of Title 42 of the Code of Federal Regulations.

(g) Any methodology specified in Article 5.21 (commencing with Section 14167.1) and this article may be modified by the department, in consultation with the hospital community, to the extent necessary to meet the requirements of federal law or regulations or to obtain federal approval, provided the modifications do not violate the intent of Article 5.21 (commencing with Section 14167.1) or this article and are not inconsistent with the conditions of implementation set forth in subdivisions (a) and (c) of Section 14167.36.

(h) The department, in consultation with the hospital community, shall make retrospective adjustments, as necessary, to the amounts calculated pursuant to Section 14167.32 in order to ensure compliance with the federal limits set forth in Section 433.68 of Title 42 of the Code of Federal Regulations or elsewhere in federal law.

14167.36. (a) This article shall only be implemented so long as the following conditions are met:

(1) The coverage dividend fee is established in a manner consistent with this article.

(2) The coverage dividend fee is deposited, including any interest on the fee after collection by the department, in a segregated fund apart from the General Fund.

(3) The proceeds of the coverage dividend fee, including any interest, penalties, and related federal reimbursement, are only used for the purposes set forth in this article.

(b) No hospital shall be required to pay the coverage dividend fee to the department unless and until the state receives and maintains federal approval of the coverage dividend fee and Article 5.21 (commencing with Section 14167.1) from the federal Centers for Medicare and Medicaid Services.

(c) Hospitals shall be required to pay the coverage dividend fee to the department as set forth in this article only as long as all of the following conditions are met:

(1) The federal Centers for Medicare and Medicaid Services allows the use of the coverage dividend fee as set forth in this article.

(2) The Medi-Cal Provider Rate Stabilization Act (Article 5.21 (commencing with Section 14167.1)) is enacted and remains in effect and hospitals are reimbursed the increased rates beginning on the implementation date, as defined in subdivision (e) of Section 14167.1.

(3) The full amount of the coverage dividend fee assessed and collected pursuant to this article remains available only for the purposes specified in this article.

(d) Notwithstanding subdivisions (a), (b), and (c) of this section and Section 14167.38, in the event of a final judicial determination made by any state or federal court that is not appealed, or by a court of appellate jurisdiction that is not further appealed, in any action by any party, or a final determination by the administrator of the federal Centers for Medicare and Medicaid Services, that the coverage dividend fee assessed and collected pursuant to this article cannot be implemented, this article shall become inoperative.

14167.37. (a) The director shall seek federal approval of each element of this article. If after seeking federal approval, federal approval is not obtained, this article shall become inoperative.

(b) Each and every report or informational submission required from providers pursuant to this article shall contain a legal verification to be signed by the provider verifying under penalty of perjury that the information provided is true and correct, and that any information in supporting documents submitted by the provider is true and correct.

14167.38. This article shall remain in effect only until January 1, 2011, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2011, deletes or extends that date.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

~~SEC. 3.~~

SEC. 4. 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:

In order to make the necessary statutory changes to increase Medi-Cal payments to hospitals and improve ~~access'~~ *access*, at the earliest possible time, so as to allow this act to be operative as soon as approval from the ~~United States Center~~ *federal Centers* for Medicare and Medicaid Services is obtained by the State Department of Health Care Services, it is necessary that this act take effect immediately.

O