

REFERENCE TITLE: AHCCCS; payment system; reform

State of Arizona
Senate
Forty-ninth Legislature
First Regular Session
2009

SB 1417

Introduced by
Senators Leff, Allen C

AN ACT

AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 36-2902.03 AND 36-2904.01; AMENDING SECTIONS 36-2903, 36-2903.01 AND 36-2904, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Title 36, chapter 29, article 1, Arizona Revised Statutes,
3 is amended by adding section 36-2902.03, to read:

4 36-2902.03. Hospital reimbursement advisory council;
5 membership; compensation; duties; report

6 A. THE HOSPITAL REIMBURSEMENT ADVISORY COUNCIL IS ESTABLISHED
7 CONSISTING OF THE FOLLOWING MEMBERS:

8 1. THE DIRECTOR OR THE DIRECTOR'S DESIGNEE, WHO SHALL SERVE AS A
9 NONVOTING MEMBER AND WHOSE PRESENCE IS NOT COUNTED TO DETERMINE THE PRESENCE
10 OF A QUORUM.

11 2. SIX REPRESENTATIVES OF HOSPITALS IN THIS STATE WHO ARE APPOINTED BY
12 THE DIRECTOR FROM A LIST SUBMITTED BY A NONPROFIT TRADE ORGANIZATION
13 REPRESENTING HOSPITALS IN THIS STATE. FROM THIS LIST THE DIRECTOR SHALL
14 APPOINT:

15 (a) ONE REPRESENTATIVE OF THE HOSPITAL THAT HAD THE GREATEST NUMBER OF
16 SYSTEM PATIENT DAYS IN THE PRECEDING FISCAL YEAR AND THAT IS LOCATED IN A
17 COUNTY WITH A POPULATION OF ONE MILLION OR MORE PERSONS.

18 (b) ONE REPRESENTATIVE OF THE HOSPITAL THAT HAD THE GREATEST NUMBER OF
19 SYSTEM PATIENT DAYS IN THE PRECEDING FISCAL YEAR AND THAT IS LOCATED IN A
20 COUNTY WITH A POPULATION OF LESS THAN ONE MILLION PERSONS BUT FIVE HUNDRED
21 THOUSAND OR MORE PERSONS.

22 (c) ONE REPRESENTATIVE OF THE HOSPITAL THAT HAS MORE THAN ONE HUNDRED
23 LICENSED BEDS AND THAT HAD THE HIGHEST RATIO OF SYSTEM PATIENT DAYS TO THE
24 TOTAL NUMBER OF ALL PATIENT DAYS IN THE PRECEDING FISCAL YEAR.

25 (d) ONE REPRESENTATIVE OF THE HOSPITAL THAT HAD THE GREATEST NUMBER OF
26 SYSTEM PATIENT DAYS DURING THE PRECEDING FISCAL YEAR AND THAT IS LOCATED IN A
27 COUNTY WITH A POPULATION OF LESS THAN FIVE HUNDRED THOUSAND PERSONS.

28 (e) ONE REPRESENTATIVE OF EITHER A HOSPITAL THAT HAS ONE HUNDRED OR
29 FEWER LICENSED BEDS AND THAT IS LOCATED IN A COUNTY WITH A POPULATION OF LESS
30 THAN FIVE HUNDRED THOUSAND PERSONS OR A HOSPITAL THAT IS LICENSED AS A
31 CRITICAL ACCESS HOSPITAL.

32 (f) ONE REPRESENTATIVE OF THE HOSPITAL THAT SPECIALIZES IN PEDIATRIC
33 SERVICES AND THAT HAD THE GREATEST NUMBER OF SYSTEM PATIENT DAYS IN THE
34 PRECEDING FISCAL YEAR.

35 3. SIX MEMBERS WHO REPRESENT INDIVIDUAL CONTRACTORS, AT LEAST ONE OF
36 WHOM PROVIDES HEALTH CARE SERVICES TO MEMBERS IN A COUNTY WITH FEWER THAN
37 FIVE HUNDRED THOUSAND PERSONS. THE DIRECTOR SHALL APPOINT THESE MEMBERS AND
38 SHALL ENSURE BALANCED REPRESENTATION AMONG CONTRACTORS.

39 4. ONE MEMBER WHO IS AN ECONOMIST WITH EXPERTISE IN HEALTH CARE
40 ECONOMICS AND PUBLIC AND PRIVATE HOSPITAL REIMBURSEMENT AND WHO IS FAMILIAR
41 WITH THE HEALTH CARE MARKET IN THIS STATE. THE DIRECTOR SHALL APPOINT THIS
42 MEMBER.

43 5. ONE MEMBER FROM AN ORGANIZATION REPRESENTING BUSINESSES IN THIS
44 STATE WHO IS NOT EMPLOYED BY A HEALTH CARE ORGANIZATION. THE DIRECTOR SHALL
45 APPOINT THIS MEMBER.

1 B. COUNCIL MEMBERS APPOINTED PURSUANT TO SUBSECTION A, PARAGRAPHS 2,
2 3, 4 AND 5 SERVE STAGGERED THREE-YEAR TERMS ENDING JUNE 30.

3 C. COUNCIL MEMBERS ARE NOT ELIGIBLE TO RECEIVE COMPENSATION BUT PUBLIC
4 MEMBERS ARE ELIGIBLE FOR REIMBURSEMENT OF EXPENSES PURSUANT TO TITLE 38,
5 CHAPTER 4, ARTICLE 2.

6 D. ON OR BEFORE SEPTEMBER 1, 2009, AND AT LEAST EVERY THREE YEARS
7 THEREAFTER, THE COUNCIL SHALL EVALUATE THE INPATIENT AND OUTPATIENT HOSPITAL
8 REIMBURSEMENT SYSTEM ESTABLISHED PURSUANT TO THIS ARTICLE AND ISSUES
9 AFFECTING THE DELIVERY, AVAILABILITY AND COST OF HOSPITAL SERVICES IN THIS
10 STATE. THE COUNCIL SHALL ENGAGE A CONSULTANT OR CONSULTANTS TO PERFORM
11 EVALUATIONS PURSUANT TO THIS SUBSECTION AS NECESSARY. THE EVALUATION SHALL
12 INCLUDE:

13 1. AN ANALYSIS OF THE RELATIONSHIP BETWEEN THE INPATIENT AND
14 OUTPATIENT REIMBURSEMENT RATES AND PAYMENTS PROVIDED PURSUANT TO THIS
15 ARTICLE, THE ACTUAL COSTS HOSPITALS INCUR IN TREATING PATIENTS ENROLLED
16 PURSUANT TO THIS ARTICLE AND THE ADEQUACY OF THE RATES AND PAYMENTS TO COVER
17 THOSE COSTS.

18 2. AN ANALYSIS OF CHANGES IN MEDICAL PRACTICE PATTERNS, TECHNOLOGY,
19 WORKFORCE SUPPLY, POPULATION GROWTH AND HOSPITAL UNCOMPENSATED CARE AND OTHER
20 CHANGES IN THE HEALTH CARE MARKET AFFECTING THE COST AND DELIVERY OF
21 HOSPITAL SERVICES IN THIS STATE.

22 3. AN ANALYSIS OF THE AVAILABILITY OF HEALTH CARE SERVICES TO MEMBERS
23 AND MEMBERS' ACCESS TO HEALTH CARE SERVICES PROVIDED PURSUANT TO THIS
24 ARTICLE.

25 4. AN ANALYSIS OF OTHER HOSPITAL REIMBURSEMENT METHODOLOGIES THAT:

26 (a) SIMPLIFY PAYMENTS TO HOSPITAL PROVIDERS AND INCREASE CONTRACTOR
27 EFFICIENCY IN CLAIMS PAYMENT.

28 (b) MINIMIZE MANUAL ADJUDICATION OF CLAIMS AND FACILITATE ELECTRONIC
29 CLAIMS PAYMENT.

30 5. THE EFFECT OF PAYMENT POLICIES ESTABLISHED PURSUANT TO THIS ARTICLE
31 ON THE DELIVERY, AVAILABILITY AND COST OF HEALTH CARE SERVICES BOTH PROVIDED
32 PURSUANT TO THIS ARTICLE AND PROVIDED OTHER THAN PURSUANT TO THIS ARTICLE,
33 INCLUDING THE COST AND AVAILABILITY OF COMMERCIAL HEALTH INSURANCE IN THIS
34 STATE.

35 6. THE EFFECT ON MEDICAL TRENDS IN BOTH THE ACUTE AND LONG-TERM CARE
36 PROGRAMS FROM CURRENT PAYMENT POLICIES AND ANY PAYMENT POLICIES ESTABLISHED
37 PURSUANT TO THIS ARTICLE.

38 E. ON OR BEFORE SEPTEMBER 1 OF EACH YEAR THAT AN EVALUATION IS
39 REQUIRED PURSUANT TO SUBSECTION D, THE COUNCIL SHALL SUBMIT A REPORT OF ITS
40 FINDINGS AND RECOMMENDATIONS TO THE GOVERNOR, THE PRESIDENT OF THE SENATE,
41 THE SPEAKER OF THE HOUSE OF REPRESENTATIVES, THE CHAIRPERSON OF THE JOINT
42 LEGISLATIVE BUDGET COMMITTEE AND THE CHAIRPERSONS OF THE HOUSE AND SENATE
43 HEALTH COMMITTEES. THE COUNCIL SHALL PROVIDE A COPY OF EACH REPORT TO THE
44 SECRETARY OF STATE AND THE DIRECTOR OF THE ARIZONA STATE LIBRARY, ARCHIVES
45 AND PUBLIC RECORDS.

1 F. THE COUNCIL SHALL MEET AT LEAST TWICE EACH YEAR TO REVIEW ISSUES
2 RELATED TO THE RATES AND PAYMENTS FOR, AS WELL AS THE DELIVERY, AVAILABILITY
3 AND COST OF, HOSPITAL SERVICES PROVIDED PURSUANT TO THIS ARTICLE AND MAKE
4 RECOMMENDATIONS TO THE DIRECTOR AS NECESSARY.

5 G. THE DIRECTOR MAY ESTABLISH ADDITIONAL PROVIDER COUNCILS AS
6 NECESSARY TO STUDY POLICIES AND PROCEDURES REGARDING REIMBURSEMENT OF
7 PROVIDERS PURSUANT TO THIS ARTICLE.

8 H. THE DIRECTOR SHALL SERVE AS THE CHAIRPERSON OF THE COUNCIL.

9 Sec. 2. Section 36-2903, Arizona Revised Statutes, is amended to read:

10 36-2903. Arizona health care cost containment system;
11 administrator; powers and duties of director and
12 administrator; exemption from attorney general
13 representation; definition

14 A. The Arizona health care cost containment system is established
15 consisting of contracts with contractors for the provision of hospitalization
16 and medical care coverage to members. Except as specifically required by
17 federal law and by section 36-2909, the system is only responsible for
18 providing care on or after the date that the person has been determined
19 eligible for the system, and is only responsible for reimbursing the cost of
20 care rendered on or after the date that the person was determined eligible
21 for the system.

22 B. An agreement may be entered into with an independent contractor,
23 subject to title 41, chapter 23, to serve as the statewide administrator of
24 the system. The administrator has full operational responsibility, subject
25 to supervision by the director, for the system, which may include any or all
26 of the following:

27 1. Development of county-by-county implementation and operation plans
28 for the system that include reasonable access to hospitalization and medical
29 care services for members.

30 2. Contract administration and oversight of contractors, including
31 certification instead of licensure for title XVIII and title XIX purposes.

32 3. Provision of technical assistance services to contractors and
33 potential contractors.

34 4. Development of a complete system of accounts and controls for the
35 system, including provisions designed to ensure that covered health and
36 medical services provided through the system are not used unnecessarily or
37 unreasonably, including but not limited to inpatient behavioral health
38 services provided in a hospital. Periodically the administrator shall
39 compare the scope, utilization rates, utilization control methods and unit
40 prices of major health and medical services provided in this state in
41 comparison with other states' health care services to identify any
42 unnecessary or unreasonable utilization within the system. The administrator
43 shall periodically assess the cost effectiveness and health implications of
44 alternate approaches to the provision of covered health and medical services

- 1 through the system in order to reduce unnecessary or unreasonable
2 utilization.
- 3 5. Establishment of peer review and utilization review functions for
4 all contractors.
- 5 6. Assistance in the formation of medical care consortiums to provide
6 covered health and medical services under the system for a county.
- 7 7. Development and management of a contractor payment system.
- 8 8. Establishment and management of a comprehensive system for assuring
9 the quality of care delivered by the system.
- 10 9. Establishment and management of a system to prevent fraud by
11 members, subcontracted providers of care, contractors and noncontracting
12 providers.
- 13 10. Coordination of benefits provided under this article to any member.
14 The administrator may require that contractors and noncontracting providers
15 are responsible for the coordination of benefits for services provided under
16 this article. Requirements for coordination of benefits by noncontracting
17 providers under this section are limited to coordination with standard health
18 insurance and disability insurance policies and similar programs for health
19 coverage.
- 20 11. Development of a health education and information program.
- 21 12. Development and management of an enrollment system.
- 22 13. Establishment and maintenance of a claims resolution procedure to
23 ensure that ninety per cent of the clean FACILITY claims AND NINETY PER CENT
24 OF THE CLEAN PROFESSIONAL CLAIMS shall be paid within thirty days of receipt,
25 and THAT ninety-nine per cent of the remaining clean FACILITY claims AND
26 NINETY-NINE PER CENT OF CLEAN PROFESSIONAL CLAIMS shall be paid within ninety
27 days of receipt AND THAT THE TIMELY PAYMENT STANDARDS PRESCRIBED PURSUANT TO
28 SECTION 36-2904.01 ARE SATISFIED. THE ADMINISTRATION SHALL DEVELOP RULES TO
29 FACILITATE AND INCENTIVIZE HOSPITAL SUBMISSION OF TIMELY CLEAN CLAIMS TO
30 CONTRACTORS, INCLUDING REQUIREMENTS FOR NOTIFICATION AND AUTHORIZATION FOR
31 SERVICES AND CLAIMS RESUBMISSION TIME FRAMES. For the purposes of this
32 paragraph, "clean claims" has the same meaning as prescribed in section
33 36-2904, subsection G.
- 34 14. Establishment of standards for the coordination of medical care and
35 patient transfers pursuant to section 36-2909, subsection B.
- 36 15. Establishment of a system to implement medical child support
37 requirements, as required by federal law. The administration may enter into
38 an intergovernmental agreement with the department of economic security to
39 implement this paragraph.
- 40 16. Establishment of an employee recognition fund.
- 41 17. Establishment of an eligibility process to determine whether a
42 medicare low income subsidy is available to persons who want to apply for a
43 subsidy as authorized by title XVIII.
- 44 C. If an agreement is not entered into with an independent contractor
45 to serve as statewide administrator of the system pursuant to subsection B of

1 this section, the director shall ensure that the operational responsibilities
2 set forth in subsection B of this section are fulfilled by the administration
3 and other contractors as necessary.

4 D. If the director determines that the administrator will fulfill some
5 but not all of the responsibilities set forth in subsection B of this
6 section, the director shall ensure that the remaining responsibilities are
7 fulfilled by the administration and other contractors as necessary.

8 E. The administrator or any direct or indirect subsidiary of the
9 administrator is not eligible to serve as a contractor.

10 F. Except for reinsurance obtained by contractors, the administrator
11 shall coordinate benefits provided under this article to any eligible person
12 who is covered by workers' compensation, disability insurance, a hospital and
13 medical service corporation, a health care services organization, an
14 accountable health plan or any other health or medical or disability
15 insurance plan including coverage made available to persons defined as
16 eligible by section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e),
17 or who receives payments for accident-related injuries, so that any costs for
18 hospitalization and medical care paid by the system are recovered from any
19 other available third party payors. The administrator may require that
20 contractors and noncontracting providers are responsible for the coordination
21 of benefits for services provided under this article. Requirements for
22 coordination of benefits by noncontracting providers under this section are
23 limited to coordination with standard health insurance and disability
24 insurance policies and similar programs for health coverage. The system
25 shall act as payor of last resort for persons eligible pursuant to section
26 36-2901, paragraph 6, subdivision (a), section 36-2974 or section 36-2981,
27 paragraph 6 unless specifically prohibited by federal law. By operation of
28 law, eligible persons assign to the system and a county rights to all types
29 of medical benefits to which the person is entitled, including first party
30 medical benefits under automobile insurance policies based on the order of
31 priorities established pursuant to section 36-2915. The state has a right to
32 subrogation against any other person or firm to enforce the assignment of
33 medical benefits. ~~The provisions of~~ This subsection ~~are~~ IS controlling over
34 the provisions of any insurance policy that provides benefits to an eligible
35 person if the policy is inconsistent with ~~the provisions of~~ this subsection.

36 G. Notwithstanding subsection E of this section, the administrator may
37 subcontract distinct administrative functions to one or more persons who may
38 be contractors within the system.

39 H. The director shall require as a condition of a contract with any
40 contractor that all records relating to contract compliance are available for
41 inspection by the administrator and the director subject to subsection I of
42 this section and that such records be maintained by the contractor for five
43 years. The director shall also require that these records be made available
44 by a contractor on request of the secretary of the United States department
45 of health and human services, or its successor agency.

1 I. Subject to existing law relating to privilege and protection, the
2 director shall prescribe by rule the types of information that are
3 confidential and circumstances under which such information may be used or
4 released, including requirements for physician-patient confidentiality.
5 Notwithstanding any other provision of law, such rules shall be designed to
6 provide for the exchange of necessary information among the counties, the
7 administration and the department of economic security for the purposes of
8 eligibility determination under this article. Notwithstanding any law to the
9 contrary, a member's medical record shall be released without the member's
10 consent in situations or suspected cases of fraud or abuse relating to the
11 system to an officer of the state's certified Arizona health care cost
12 containment system fraud control unit who has submitted a written request for
13 the medical record.

14 J. The director shall prescribe rules that specify methods for:

15 1. The transition of members between system contractors and
16 noncontracting providers.

17 2. The transfer of members and persons who have been determined
18 eligible from hospitals that do not have contracts to care for such persons.

19 K. The director shall adopt rules that set forth procedures and
20 standards for use by the system in requesting county long-term care for
21 members or persons determined eligible.

22 L. To the extent that services are furnished pursuant to this article,
23 and unless otherwise required pursuant to this chapter, a contractor is not
24 subject to ~~the provisions of~~ title 20.

25 M. As a condition of the contract with any contractor, the director
26 shall require contract terms as necessary in the judgment of the director to
27 ensure adequate performance and compliance with all applicable federal laws
28 by the contractor of the provisions of each contract executed pursuant to
29 this chapter. Contract provisions required by the director shall include at
30 a minimum the maintenance of deposits, performance bonds, financial reserves
31 or other financial security. The director may waive requirements for the
32 posting of bonds or security for contractors that have posted other security,
33 equal to or greater than that required by the system, with a state agency for
34 the performance of health service contracts if funds would be available from
35 such security for the system on default by the contractor. The director may
36 also adopt rules for the withholding or forfeiture of payments to be made to
37 a contractor by the system for the failure of the contractor to comply with a
38 provision of the contractor's contract with the system or with the adopted
39 rules. The director may also require contract terms allowing the
40 administration to operate a contractor directly under circumstances specified
41 in the contract. The administration shall operate the contractor only as
42 long as it is necessary to assure delivery of uninterrupted care to members
43 enrolled with the contractor and accomplish the orderly transition of those
44 members to other system contractors, or until the contractor reorganizes or
45 otherwise corrects the contract performance failure. The administration

1 shall not operate a contractor unless, before that action, the administration
2 delivers notice to the contractor and provides an opportunity for a hearing
3 in accordance with procedures established by the director. Notwithstanding
4 the provisions of a contract, if the administration finds that the public
5 health, safety or welfare requires emergency action, it may operate as the
6 contractor on notice to the contractor and pending an administrative hearing,
7 which it shall promptly institute.

8 N. The administration for the sole purpose of matters concerning and
9 directly related to the Arizona health care cost containment system and the
10 Arizona long-term care system is exempt from section 41-192.

11 O. Notwithstanding subsection F of this section, if the administration
12 determines that according to federal guidelines it is more cost-effective for
13 a person defined as eligible under section 36-2901, paragraph 6, subdivision
14 (a) to be enrolled in a group health insurance plan in which the person is
15 entitled to be enrolled, the administration may pay all of that person's
16 premiums, deductibles, coinsurance and other cost sharing obligations for
17 services covered under section 36-2907. The person shall apply for
18 enrollment in the group health insurance plan as a condition of eligibility
19 under section 36-2901, paragraph 6, subdivision (a).

20 P. The total amount of state monies that may be spent in any fiscal
21 year by the administration for health care shall not exceed the amount
22 appropriated or authorized by section 35-173 for all health care
23 purposes. This article does not impose a duty on an officer, agent or
24 employee of this state to discharge a responsibility or to create any right
25 in a person or group if the discharge or right would require an expenditure
26 of state monies in excess of the expenditure authorized by legislative
27 appropriation for that specific purpose.

28 Q. Notwithstanding section 36-470, a contractor or program contractor
29 may receive laboratory tests from a laboratory or hospital-based laboratory
30 for a system member enrolled with the contractor or program contractor
31 subject to all of the following requirements:

32 1. The contractor or program contractor shall provide a written
33 request to the laboratory in a format mutually agreed to by the laboratory
34 and the requesting health plan or program contractor. The request shall
35 include the member's name, the member's plan identification number, the
36 specific test results that are being requested and the time periods and the
37 quality improvement activity that prompted the request.

38 2. The laboratory data may be provided in written or electronic format
39 based on the agreement between the laboratory and the contractor or program
40 contractor. If there is no contract between the laboratory and the
41 contractor or program contractor, the laboratory shall provide the requested
42 data in a format agreed to by the noncontracted laboratory.

43 3. The laboratory test results provided to the member's contractor or
44 program contractor shall only be used for quality improvement activities
45 authorized by the administration and health care outcome studies required by

1 the administration. The contractors and program contractors shall maintain
2 strict confidentiality about the test results and identity of the member as
3 specified in contractual arrangements with the administration and pursuant to
4 state and federal law.

5 4. The administration, after collaboration with the department of
6 health services regarding quality improvement activities, may prohibit the
7 contractors and program contractors from receiving certain test results if
8 the administration determines that a serious potential exists that the
9 results may be used for purposes other than those intended for the quality
10 improvement activities. The department of health services shall consult with
11 the clinical laboratory licensure advisory committee established by section
12 36-465 before providing recommendations to the administration on certain test
13 results and quality improvement activities.

14 5. The administration shall provide contracted laboratories and the
15 department of health services with an annual report listing the quality
16 improvement activities that will require laboratory data. The report shall
17 be updated and distributed to the contracting laboratories and the department
18 of health services when laboratory data is needed for new quality improvement
19 activities.

20 6. A laboratory that complies with a request from the contractor or
21 program contractor for laboratory results pursuant to this section is not
22 subject to civil liability for providing the data to the contractor or
23 program contractor. The administration, the contractor or a program
24 contractor that uses data for reasons other than quality improvement
25 activities is subject to civil liability for this improper use.

26 R. For the purposes of this section, "quality improvement activities"
27 means those requirements, including health care outcome studies specified in
28 federal law or required by the centers for medicare and medicaid services or
29 the administration, to improve health care outcomes.

30 Sec. 3. Section 36-2903.01, Arizona Revised Statutes, is amended to
31 read:

32 36-2903.01. Additional powers and duties; report

33 A. The director of the Arizona health care cost containment system
34 administration may adopt rules that provide that the system may withhold or
35 forfeit payments to be made to a noncontracting provider by the system if the
36 noncontracting provider fails to comply with this article, the provider
37 agreement or rules that are adopted pursuant to this article and that relate
38 to the specific services rendered for which a claim for payment is made.

39 B. The director shall:

40 1. Prescribe uniform forms to be used by all contractors. The rules
41 shall require a written and signed application by the applicant or an
42 applicant's authorized representative, or, if the person is incompetent or
43 incapacitated, a family member or a person acting responsibly for the
44 applicant may obtain a signature or a reasonable facsimile and file the
45 application as prescribed by the administration.

1 2. Enter into an interagency agreement with the department to
2 establish a streamlined eligibility process to determine the eligibility of
3 all persons defined pursuant to section 36-2901, paragraph 6,
4 subdivision (a). At the administration's option, the interagency agreement
5 may allow the administration to determine the eligibility of certain persons,
6 including those defined pursuant to section 36-2901, paragraph 6,
7 subdivision (a).

8 3. Enter into an intergovernmental agreement with the department to:
9 (a) Establish an expedited eligibility and enrollment process for all
10 persons who are hospitalized at the time of application.

11 (b) Establish performance measures and incentives for the department.

12 (c) Establish the process for management evaluation reviews that the
13 administration shall perform to evaluate the eligibility determination
14 functions performed by the department.

15 (d) Establish eligibility quality control reviews by the
16 administration.

17 (e) Require the department to adopt rules, consistent with the rules
18 adopted by the administration for a hearing process, that applicants or
19 members may use for appeals of eligibility determinations or
20 redeterminations.

21 (f) Establish the department's responsibility to place sufficient
22 eligibility workers at federally qualified health centers to screen for
23 eligibility and at hospital sites and level one trauma centers to ensure that
24 persons seeking hospital services are screened on a timely basis for
25 eligibility for the system, including a process to ensure that applications
26 for the system can be accepted on a twenty-four hour basis, seven days a
27 week.

28 (g) Withhold payments based on the allowable sanctions for errors in
29 eligibility determinations or redeterminations or failure to meet performance
30 measures required by the intergovernmental agreement.

31 (h) Recoup from the department all federal fiscal sanctions that
32 result from the department's inaccurate eligibility determinations. The
33 director may offset all or part of a sanction if the department submits a
34 corrective action plan and a strategy to remedy the error.

35 4. By rule establish a procedure and time frames for the intake of
36 grievances and requests for hearings, for the continuation of benefits and
37 services during the appeal process and for a grievance process at the
38 contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and
39 41-1092.05, the administration shall develop rules to establish the procedure
40 and time frame for the informal resolution of grievances and appeals. A
41 grievance that is not related to a claim for payment of system covered
42 services shall be filed in writing with and received by the administration or
43 the prepaid capitated provider or program contractor not later than sixty
44 days after the date of the adverse action, decision or policy implementation
45 being grieved. A grievance that is related to a claim for payment of system

1 covered services must be filed in writing and received by the administration
2 or the prepaid capitated provider or program contractor within twelve months
3 after the date of service, within twelve months after the date that
4 eligibility is posted or within sixty days after the date of the denial of a
5 timely claim submission, whichever is later. A grievance for the denial of a
6 claim for reimbursement of services may contest the validity of any adverse
7 action, decision, policy implementation or rule that related to or resulted
8 in the full or partial denial of the claim. A policy implementation may be
9 subject to a grievance procedure, but it may not be appealed for a hearing.
10 The administration is not required to participate in a mandatory settlement
11 conference if it is not a real party in interest. In any proceeding before
12 the administration, including a grievance or hearing, persons may represent
13 themselves or be represented by a duly authorized agent who is not charging a
14 fee. A legal entity may be represented by an officer, partner or employee
15 who is specifically authorized by the legal entity to represent it in the
16 particular proceeding.

17 5. Apply for and accept federal funds available under title XIX of the
18 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section
19 1396 (1980)) in support of the system. The application made by the director
20 pursuant to this paragraph shall be designed to qualify for federal funding
21 primarily on a prepaid capitated basis. Such funds may be used only for the
22 support of persons defined as eligible pursuant to title XIX of the social
23 security act or the approved section 1115 waiver.

24 6. At least thirty days before the implementation of a policy or a
25 change to an existing policy relating to reimbursement, provide notice to
26 interested parties. Parties interested in receiving notification of policy
27 changes shall submit a written request for notification to the
28 administration.

29 C. The director is authorized to apply for any federal funds available
30 for the support of programs to investigate and prosecute violations arising
31 from the administration and operation of the system. Available state funds
32 appropriated for the administration and operation of the system may be used
33 as matching funds to secure federal funds pursuant to this subsection.

34 D. The director may adopt rules or procedures to do the following:

35 1. Authorize advance payments based on estimated liability to a
36 contractor or a noncontracting provider after the contractor or
37 noncontracting provider has submitted a claim for services and before the
38 claim is ultimately resolved. The rules shall specify that any advance
39 payment shall be conditioned on the execution before payment of a contract
40 with the contractor or noncontracting provider that requires the
41 administration to retain a specified percentage, which shall be at least
42 twenty per cent, of the claimed amount as security and that requires
43 repayment to the administration if the administration makes any overpayment.

44 2. Defer liability, in whole or in part, of contractors for care
45 provided to members who are hospitalized on the date of enrollment or under

1 other circumstances. Payment shall be on a capped fee-for-service basis for
2 services other than hospital services and at the rate established pursuant to
3 subsection G or H of this section for hospital services or at the rate paid
4 by the health plan, whichever is less.

5 3. Deputize, in writing, any qualified officer or employee in the
6 administration to perform any act that the director by law is empowered to do
7 or charged with the responsibility of doing, including the authority to issue
8 final administrative decisions pursuant to section 41-1092.08.

9 4. Notwithstanding any other law, require persons eligible pursuant to
10 section 36-2901, paragraph 6, subdivision (a), section 36-2931, paragraph 5
11 and section 36-2981, paragraph 6 to be financially responsible for any cost
12 sharing requirements established in a state plan or a section 1115 waiver and
13 approved by the centers for medicare and medicaid services. Cost sharing
14 requirements may include copayments, coinsurance, deductibles, enrollment
15 fees and monthly premiums for enrolled members, including households with
16 children enrolled in the Arizona long-term care system.

17 E. The director shall adopt rules that further specify the medical
18 care and hospital services that are covered by the system pursuant to section
19 36-2907.

20 F. In addition to the rules otherwise specified in this article, the
21 director may adopt necessary rules pursuant to title 41, chapter 6 to carry
22 out this article. Rules adopted by the director pursuant to this subsection
23 shall consider the differences between rural and urban conditions on the
24 delivery of hospitalization and medical care.

25 G. For inpatient hospital admissions and all outpatient hospital
26 services before March 1, 1993, the administration shall reimburse a
27 hospital's adjusted billed charges according to the following procedures:

28 1. The director shall adopt rules that, for services rendered from and
29 after September 30, 1985 until October 1, 1986, define "adjusted billed
30 charges" as that reimbursement level that has the effect of holding constant
31 whichever of the following is applicable:

32 (a) The schedule of rates and charges for a hospital in effect on
33 April 1, 1984 as filed pursuant to chapter 4, article 3 of this title.

34 (b) The schedule of rates and charges for a hospital that became
35 effective after May 31, 1984 but before July 2, 1984, if the hospital's
36 previous rate schedule became effective before April 30, 1983.

37 (c) The schedule of rates and charges for a hospital that became
38 effective after May 31, 1984 but before July 2, 1984, limited to five per
39 cent over the hospital's previous rate schedule, and if the hospital's
40 previous rate schedule became effective on or after April 30, 1983 but before
41 October 1, 1983. For the purposes of this paragraph, "constant" means equal
42 to or lower than.

43 2. The director shall adopt rules that, for services rendered from and
44 after September 30, 1986, define "adjusted billed charges" as that
45 reimbursement level that has the effect of increasing by four per cent a

1 hospital's reimbursement level in effect on October 1, 1985 as prescribed in
2 paragraph 1 of this subsection. Beginning January 1, 1991, the Arizona
3 health care cost containment system administration shall define "adjusted
4 billed charges" as the reimbursement level determined pursuant to this
5 section, increased by two and one-half per cent.

6 3. In no event shall a hospital's adjusted billed charges exceed the
7 hospital's schedule of rates and charges filed with the department of health
8 services and in effect pursuant to chapter 4, article 3 of this title.

9 4. For services rendered the administration shall not pay a hospital's
10 adjusted billed charges in excess of the following:

11 (a) If the hospital's bill is paid within thirty days of the date the
12 bill was received, eighty-five per cent of the adjusted billed charges.

13 (b) If the hospital's bill is paid any time after thirty days but
14 within sixty days of the date the bill was received, ninety-five per cent of
15 the adjusted billed charges.

16 (c) If the hospital's bill is paid any time after sixty days of the
17 date the bill was received, one hundred per cent of the adjusted billed
18 charges.

19 5. The director shall define by rule the method of determining when a
20 hospital bill will be considered received and when a hospital's billed
21 charges will be considered paid. Payment received by a hospital from the
22 administration pursuant to this subsection or from a contractor either by
23 contract or pursuant to section 36-2904, subsection I shall be considered
24 payment of the hospital bill in full, except that a hospital may collect any
25 unpaid portion of its bill from other third party payors or in situations
26 covered by title 33, chapter 7, article 3.

27 H. For inpatient hospital admissions and outpatient hospital services
28 on and after March 1, 1993 the administration shall adopt rules for the
29 reimbursement of hospitals according to the following procedures:

30 1. For inpatient hospital stays, the administration shall use a
31 prospective tiered per diem methodology, using hospital peer groups if
32 analysis shows that cost differences can be attributed to independently
33 definable features that hospitals within a peer group share. In peer
34 grouping the administration may consider such factors as length of stay
35 differences and labor market variations. If there are no cost differences,
36 the administration shall implement a stop loss-stop gain or similar
37 mechanism. Any stop loss-stop gain or similar mechanism shall ensure that
38 the tiered per diem rates assigned to a hospital do not represent less than
39 ninety per cent of its 1990 base year costs or more than one hundred ten per
40 cent of its 1990 base year costs, adjusted by an audit factor, during the
41 period of March 1, 1993 through September 30, 1994. The tiered per diem
42 rates set for hospitals shall represent no less than eighty-seven and
43 one-half per cent or more than one hundred twelve and one-half per cent of
44 its 1990 base year costs, adjusted by an audit factor, from October 1, 1994
45 through September 30, 1995 and no less than eighty-five per cent or more than

1 one hundred fifteen per cent of its 1990 base year costs, adjusted by an
2 audit factor, from October 1, 1995 through September 30, 1996. For the
3 periods after September 30, 1996 no stop loss-stop gain or similar mechanisms
4 shall be in effect. An adjustment in the stop loss-stop gain percentage may
5 be made to ensure that total payments do not increase as a result of this
6 provision. If peer groups are used the administration shall establish
7 initial peer group designations for each hospital before implementation of
8 the per diem system. The administration may also use a negotiated rate
9 methodology. The tiered per diem methodology may include separate
10 consideration for specialty hospitals that limit their provision of services
11 to specific patient populations, such as rehabilitative patients or children.
12 The initial per diem rates shall be based on hospital claims and encounter
13 data for dates of service November 1, 1990 through October 31, 1991 and
14 processed through May of 1992.

15 2. For rates effective on October 1, 1994, and annually thereafter,
16 the administration shall adjust tiered per diem payments for inpatient
17 hospital care by the data resources incorporated market basket index for
18 prospective payment system hospitals. For rates effective beginning on
19 October 1, 1999, the administration shall adjust payments to reflect changes
20 in length of stay for the maternity and nursery tiers.

21 3. Through June 30, 2004, for outpatient hospital services, the
22 administration shall reimburse a hospital by applying a hospital specific
23 outpatient cost-to-charge ratio to the covered charges. Beginning on July 1,
24 2004 through June 30, 2005, the administration shall reimburse a hospital by
25 applying a hospital specific outpatient cost-to-charge ratio to covered
26 charges. If the hospital increases its charges for outpatient services filed
27 with the Arizona department of health services pursuant to chapter 4, article
28 3 of this title, by more than 4.7 per cent for dates of service effective on
29 or after July 1, 2004, the hospital specific cost-to-charge ratio will be
30 reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7
31 per cent, the effective date of the increased charges will be the effective
32 date of the adjusted Arizona health care cost containment system
33 cost-to-charge ratio. The administration shall develop the methodology for a
34 capped fee-for-service schedule and a statewide cost-to-charge ratio. Any
35 covered outpatient service not included in the capped fee-for-service
36 schedule shall be reimbursed by applying the statewide cost-to-charge ratio
37 that is based on the services not included in the capped fee-for-service
38 schedule. Beginning on July 1, 2005, the administration shall reimburse
39 clean claims with dates of service on or after July 1, 2005, based on the
40 capped fee-for-service schedule or the statewide cost-to-charge ratio
41 established pursuant to this paragraph. The administration may make
42 additional adjustments to the outpatient hospital rates established pursuant
43 to this section based on other factors, including the number of beds in the
44 hospital, specialty services available to patients and the geographic
45 location of the hospital.

1 4. Except if submitted under an electronic claims submission system, a
2 hospital bill is considered received for purposes of this paragraph on
3 initial receipt of the legible, error-free claim form by the administration
4 if the claim includes the following error-free documentation in legible form:

- 5 (a) An admission face sheet.
- 6 (b) An itemized statement.
- 7 (c) An admission history and physical.
- 8 (d) A discharge summary or an interim summary if the claim is split.
- 9 (e) An emergency record, if admission was through the emergency room.
- 10 (f) Operative reports, if applicable.
- 11 (g) A labor and delivery room report, if applicable.

12 Payment received by a hospital from the administration pursuant to this
13 subsection or from a contractor either by contract or pursuant to section
14 36-2904, subsection I is considered payment by the administration or the
15 contractor of the administration's or contractor's liability for the hospital
16 bill. A hospital may collect any unpaid portion of its bill from other third
17 party payors or in situations covered by title 33, chapter 7, article 3.

18 5. For services rendered on and after October 1, 1997, the
19 administration shall pay a hospital's rate established according to this
20 section subject to the following:

21 (a) If the hospital's bill is paid within thirty days of the date the
22 bill was received, the administration shall pay ninety-nine per cent of the
23 rate.

24 (b) If the hospital's bill is paid after thirty days but within sixty
25 days of the date the bill was received, the administration shall pay one
26 hundred per cent of the rate.

27 (c) If the hospital's bill is paid any time after sixty days of the
28 date the bill was received, the administration shall pay one hundred per cent
29 of the rate plus a fee of one per cent per month for each month or portion of
30 a month following the sixtieth day of receipt of the bill until the date of
31 payment.

32 6. In developing the reimbursement methodology, if a review of the
33 reports filed by a hospital pursuant to section 36-125.04 indicates that
34 further investigation is considered necessary to verify the accuracy of the
35 information in the reports, the administration may examine the hospital's
36 records and accounts related to the reporting requirements of section
37 36-125.04. The administration shall bear the cost incurred in connection
38 with this examination unless the administration finds that the records
39 examined are significantly deficient or incorrect, in which case the
40 administration may charge the cost of the investigation to the hospital
41 examined.

42 7. Except for privileged medical information, the administration shall
43 make available for public inspection the cost and charge data and the
44 calculations used by the administration to determine payments under the
45 tiered per diem system, provided that individual hospitals are not identified

1 by name. The administration shall make the data and calculations available
2 for public inspection during regular business hours and shall provide copies
3 of the data and calculations to individuals requesting such copies within
4 thirty days of receipt of a written request. The administration may charge a
5 reasonable fee for the provision of the data or information.

6 8. The prospective tiered per diem payment methodology for inpatient
7 hospital services shall include a mechanism for the prospective payment of
8 inpatient hospital capital related costs. The capital payment shall include
9 hospital specific and statewide average amounts. For tiered per diem rates
10 beginning on October 1, 1999, the capital related cost component is frozen at
11 the blended rate of forty per cent of the hospital specific capital cost and
12 sixty per cent of the statewide average capital cost in effect as of
13 January 1, 1999 and as further adjusted by the calculation of tier rates for
14 maternity and nursery as prescribed by law. The administration shall adjust
15 the capital related cost component by the data resources incorporated market
16 basket index for prospective payment system hospitals.

17 9. For graduate medical education programs:

18 (a) Beginning September 30, 1997, the administration shall establish a
19 separate graduate medical education program to reimburse hospitals that had
20 graduate medical education programs that were approved by the administration
21 as of October 1, 1999. The administration shall separately account for
22 monies for the graduate medical education program based on the total
23 reimbursement for graduate medical education reimbursed to hospitals by the
24 system in federal fiscal year 1995-1996 pursuant to the tiered per diem
25 methodology specified in this section. The graduate medical education
26 program reimbursement shall be adjusted annually by the increase or decrease
27 in the index published by the global insight hospital market basket index for
28 prospective hospital reimbursement. Subject to legislative appropriation, on
29 an annual basis, each qualified hospital shall receive a single payment from
30 the graduate medical education program that is equal to the same percentage
31 of graduate medical education reimbursement that was paid by the system in
32 federal fiscal year 1995-1996. Any reimbursement for graduate medical
33 education made by the administration shall not be subject to future
34 settlements or appeals by the hospitals to the administration. The monies
35 available under this subdivision shall not exceed the fiscal year 2005-2006
36 appropriation adjusted annually by the increase or decrease in the index
37 published by the global insight hospital market basket index for prospective
38 hospital reimbursement, except for monies distributed for expansions pursuant
39 to subdivision (b) of this paragraph.

40 (b) The monies available for graduate medical education programs
41 pursuant to this subdivision shall not exceed the fiscal year 2006-2007
42 appropriation adjusted annually by the increase or decrease in the index
43 published by the global insight hospital market basket index for prospective
44 hospital reimbursement. Graduate medical education programs eligible for
45 such reimbursement are not precluded from receiving reimbursement for funding

1 under subdivision (c) of this paragraph. Beginning July 1, 2006, the
2 administration shall distribute any monies appropriated for graduate medical
3 education above the amount prescribed in subdivision (a) of this paragraph in
4 the following order or priority:

5 (i) For the direct costs to support the expansion of graduate medical
6 education programs established before July 1, 2006 at hospitals that do not
7 receive payments pursuant to subdivision (a) of this paragraph. These
8 programs must be approved by the administration.

9 (ii) For the direct costs to support the expansion of graduate medical
10 education programs established on or before October 1, 1999. These programs
11 must be approved by the administration.

12 (c) The administration shall distribute to hospitals any monies
13 appropriated for graduate medical education above the amount prescribed in
14 subdivisions (a) and (b) of this paragraph for the following purposes:

15 (i) For the direct costs of graduate medical education programs
16 established or expanded on or after July 1, 2006. These programs must be
17 approved by the administration.

18 (ii) For a portion of additional indirect graduate medical education
19 costs for programs that are located in a county with a population of less
20 than five hundred thousand persons at the time the residency position was
21 created or for a residency position that includes a rotation in a county with
22 a population of less than five hundred thousand persons at the time the
23 residency position was established. These programs must be approved by the
24 administration.

25 (d) The administration shall develop, by rule, the formula by which
26 the monies are distributed.

27 (e) Each graduate medical education program that receives funding
28 pursuant to subdivision (b) or (c) of this paragraph shall identify and
29 report to the administration the number of new residency positions created by
30 the funding provided in this paragraph, including positions in rural areas.
31 The program shall also report information related to the number of funded
32 residency positions that resulted in physicians locating their practice in
33 this state. The administration shall report to the joint legislative budget
34 committee by February 1 of each year on the number of new residency positions
35 as reported by the graduate medical education programs.

36 (f) Beginning July 1, 2007, local, county and tribal governments may
37 provide monies in addition to any state general fund monies appropriated for
38 graduate medical education in order to qualify for additional matching
39 federal monies for programs or positions in a specific locality and costs
40 incurred pursuant to a specific contract between the administration and
41 providers or other entities to provide graduate medical education services as
42 an administrative activity. These programs, positions and administrative
43 graduate medical education services must be approved by the administration
44 and the centers for medicare and medicaid services. The administration shall
45 report to the president of the senate, the speaker of the house of

1 representatives and the director of the joint legislative budget committee on
2 or before July 1 of each year on the amount of money contributed and number
3 of residency positions funded by local, county and tribal governments,
4 including the amount of federal matching monies used.

5 (g) Any funds appropriated but not allocated by the administration for
6 subdivision (b) or (c) of this paragraph may be reallocated if funding for
7 either subdivision is insufficient to cover appropriate graduate medical
8 education costs.

9 (h) For the purposes of this paragraph, "graduate medical education
10 program" means a program, including an approved fellowship, that prepares a
11 physician for the independent practice of medicine by providing didactic and
12 clinical education in a medical discipline to a medical student who has
13 completed a recognized undergraduate medical education program.

14 10. The prospective tiered per diem payment methodology for inpatient
15 hospital services shall include a mechanism for the payment of claims with
16 extraordinary operating costs per day. For tiered per diem rates effective
17 beginning on October 1, 1999, outlier cost thresholds are frozen at the
18 levels in effect on January 1, 1999 and adjusted annually by the
19 administration by the global insight hospital market basket index for
20 prospective payment system hospitals. Beginning with dates of service on or
21 after October 1, 2007, the administration shall phase in the use of the most
22 recent statewide urban and statewide rural average medicare cost-to-charge
23 ratios or centers for medicare and medicaid services approved cost-to-charge
24 ratios to qualify and pay extraordinary operating costs. Cost-to-charge
25 ratios shall be updated annually. Routine maternity charges are not eligible
26 for outlier reimbursement. The administration shall complete full
27 implementation of the phase-in on or before October 1, 2009.

28 11. Notwithstanding section 41-1005, subsection A, paragraph 9, the
29 administration shall adopt rules pursuant to title 41, chapter 6 establishing
30 the methodology for determining the prospective tiered per diem payments.

31 I. The director may adopt rules that specify enrollment procedures,
32 including notice to contractors of enrollment. The rules may provide for
33 varying time limits for enrollment in different situations. The
34 administration shall specify in contract when a person who has been
35 determined eligible will be enrolled with that contractor and the date on
36 which the contractor will be financially responsible for health and medical
37 services to the person.

38 J. The administration may make direct payments to hospitals for
39 hospitalization and medical care provided to a member in accordance with this
40 article and rules. The director may adopt rules to establish the procedures
41 by which the administration shall pay hospitals pursuant to this subsection
42 if a contractor fails to make timely payment to a hospital. Such payment
43 shall be at a level determined pursuant to section 36-2904, subsection H
44 or I. The director may withhold payment due to a contractor in the amount of

1 any payment made directly to a hospital by the administration on behalf of a
2 contractor pursuant to this subsection.

3 K. The director shall establish a special unit within the
4 administration for the purpose of monitoring the third party payment
5 collections required by contractors and noncontracting providers pursuant to
6 section 36-2903, subsection B, paragraph 10 and subsection F and section
7 36-2915, subsection E. The director shall determine by rule:

8 1. The type of third party payments to be monitored pursuant to this
9 subsection.

10 2. The percentage of third party payments that is collected by a
11 contractor or noncontracting provider and that the contractor or
12 noncontracting provider may keep and the percentage of such payments that the
13 contractor or noncontracting provider may be required to pay to the
14 administration. Contractors and noncontracting providers must pay to the
15 administration one hundred per cent of all third party payments that are
16 collected and that duplicate administration fee-for-service payments. A
17 contractor that contracts with the administration pursuant to section
18 36-2904, subsection A may be entitled to retain a percentage of third party
19 payments if the payments collected and retained by a contractor are reflected
20 in reduced capitation rates. A contractor may be required to pay the
21 administration a percentage of third party payments that are collected by a
22 contractor and that are not reflected in reduced capitation rates.

23 L. The administration shall establish procedures to apply to the
24 following if a provider that has a contract with a contractor or
25 noncontracting provider seeks to collect from an individual or financially
26 responsible relative or representative a claim that exceeds the amount that
27 is reimbursed or should be reimbursed by the system:

28 1. On written notice from the administration or oral or written notice
29 from a member that a claim for covered services may be in violation of this
30 section, the provider that has a contract with a contractor or noncontracting
31 provider shall investigate the inquiry and verify whether the person was
32 eligible for services at the time that covered services were provided. If
33 the claim was paid or should have been paid by the system, the provider that
34 has a contract with a contractor or noncontracting provider shall not
35 continue billing the member.

36 2. If the claim was paid or should have been paid by the system and
37 the disputed claim has been referred for collection to a collection agency or
38 referred to a credit reporting bureau, the provider that has a contract with
39 a contractor or noncontracting provider shall:

40 (a) Notify the collection agency and request that all attempts to
41 collect this specific charge be terminated immediately.

42 (b) Advise all credit reporting bureaus that the reported delinquency
43 was in error and request that the affected credit report be corrected to
44 remove any notation about this specific delinquency.

1 (c) Notify the administration and the member that the request for
2 payment was in error and that the collection agency and credit reporting
3 bureaus have been notified.

4 3. If the administration determines that a provider that has a
5 contract with a contractor or noncontracting provider has billed a member for
6 charges that were paid or should have been paid by the administration, the
7 administration shall send written notification by certified mail or other
8 service with proof of delivery to the provider that has a contract with a
9 contractor or noncontracting provider stating that this billing is in
10 violation of federal and state law. If, twenty-one days or more after
11 receiving the notification, a provider that has a contract with a contractor
12 or noncontracting provider knowingly continues billing a member for charges
13 that were paid or should have been paid by the system, the administration may
14 assess a civil penalty in an amount equal to three times the amount of the
15 billing and reduce payment to the provider that has a contract with a
16 contractor or noncontracting provider accordingly. Receipt of delivery
17 signed by the addressee or the addressee's employee is prima facie evidence
18 of knowledge. Civil penalties collected pursuant to this subsection shall be
19 deposited in the state general fund. Section 36-2918, subsections C, D and
20 F, relating to the imposition, collection and enforcement of civil penalties,
21 apply to civil penalties imposed pursuant to this paragraph.

22 M. The administration may conduct postpayment review of all claims
23 paid by the administration and may recoup any monies erroneously paid. The
24 director may adopt rules that specify procedures for conducting postpayment
25 review. A contractor may conduct a postpayment review of all claims paid by
26 the contractor and may recoup monies that are erroneously paid. **A CONTRACTOR
27 MUST OBTAIN ADVANCE APPROVAL FROM THE ADMINISTRATION BEFORE INITIATING A
28 RECOUPMENT ON A HOSPITAL OR PHYSICIAN CLAIM MORE THAN TWELVE MONTHS AFTER THE
29 DATE THE CLAIM WAS ORIGINALLY PAID. THE ADMINISTRATION SHALL ADOPT RULES THAT
30 PRESCRIBE CIRCUMSTANCES IN WHICH A CONTRACTOR MAY INITIATE A RECOUPMENT ON A
31 HOSPITAL OR PHYSICIAN CLAIM THAT IS PAID MORE THAN TWELVE MONTHS AFTER THE
32 DATE THE CLAIM WAS ORIGINALLY PAID.**

33 N. The director or the director's designee may employ and supervise
34 personnel necessary to assist the director in performing the functions of the
35 administration.

36 O. The administration may contract with contractors for obstetrical
37 care who are eligible to provide services under title XIX of the social
38 security act.

39 P. Notwithstanding any other law, on federal approval the
40 administration may make disproportionate share payments to private hospitals,
41 county operated hospitals, including hospitals owned or leased by a special
42 health care district, and state operated institutions for mental disease
43 beginning October 1, 1991 in accordance with federal law and subject to
44 legislative appropriation. If at any time the administration receives
45 written notification from federal authorities of any change or difference in

1 the actual or estimated amount of federal funds available for
2 disproportionate share payments from the amount reflected in the legislative
3 appropriation for such purposes, the administration shall provide written
4 notification of such change or difference to the president and the minority
5 leader of the senate, the speaker and the minority leader of the house of
6 representatives, the director of the joint legislative budget committee, the
7 legislative committee of reference and any hospital trade association within
8 this state, within three working days not including weekends after receipt of
9 the notice of the change or difference. In calculating disproportionate
10 share payments as prescribed in this section, the administration may use
11 either a methodology based on claims and encounter data that is submitted to
12 the administration from contractors or a methodology based on data that is
13 reported to the administration by private hospitals and state operated
14 institutions for mental disease. The selected methodology applies to all
15 private hospitals and state operated institutions for mental disease
16 qualifying for disproportionate share payments.

17 Q. Notwithstanding any law to the contrary, the administration may
18 receive confidential adoption information to determine whether an adopted
19 child should be terminated from the system.

20 R. The adoption agency or the adoption attorney shall notify the
21 administration within thirty days after an eligible person receiving services
22 has placed that person's child for adoption.

23 S. If the administration implements an electronic claims submission
24 system, it may adopt procedures pursuant to subsection H of this section
25 requiring documentation different than prescribed under subsection H,
26 paragraph 4 of this section.

27 Sec. 4. Section 36-2904, Arizona Revised Statutes, is amended to read:

28 36-2904. Prepaid capitation coverage; requirements; long-term
29 care; dispute resolution; award of contracts;
30 notification; report

31 A. The administration may expend public funds appropriated for the
32 purposes of this article and shall execute prepaid capitated health services
33 contracts, pursuant to section 36-2906, with group disability insurers,
34 hospital and medical service corporations, health care services organizations
35 and any other appropriate public or private persons, including county-owned
36 and operated facilities, for health and medical services to be provided under
37 contract with contractors. The administration may assign liability for
38 eligible persons and members through contractual agreements with contractors.
39 If there is an insufficient number of qualified bids for prepaid capitated
40 health services contracts for the provision of hospitalization and medical
41 care within a county, the director may:

42 1. Execute discount advance payment contracts, pursuant to section
43 36-2906 and subject to section 36-2903.01, for hospital services.

44 2. Execute capped fee-for-service contracts for health and medical
45 services, other than hospital services. Any capped fee-for-service contract

1 shall provide for reimbursement at a level of not to exceed a capped
2 fee-for-service schedule adopted by the administration.

3 B. During any period in which services are needed and no contract
4 exists, the director may do either of the following:

5 1. Pay noncontracting providers for health and medical services, other
6 than hospital services, on a capped fee-for-service basis for members and
7 persons who are determined eligible. However, the state shall not pay any
8 amount for services that exceeds a maximum amount set forth in a capped
9 fee-for-service schedule adopted by the administration.

10 2. Pay a hospital subject to the reimbursement level limitation
11 prescribed in section 36-2903.01.

12 If health and medical services are provided in the absence of a contract, the
13 director shall continue to attempt to procure by the bid process as provided
14 in section 36-2906 contracts for such services as specified in this
15 subsection.

16 C. Payments to contractors shall be made monthly or quarterly and may
17 be subject to contract provisions requiring the retention of a specified
18 percentage of the payment by the director, a reserve fund or other contract
19 provisions by which adjustments to the payments are made based on utilization
20 efficiency, including incentives for maintaining quality care and minimizing
21 unnecessary inpatient services. Reserve funds withheld from contractors
22 shall be distributed to contractors who meet performance standards
23 established by the director. Any reserve fund established pursuant to this
24 subsection shall be established as a separate account within the Arizona
25 health care cost containment system fund.

26 D. Except as prescribed in subsection E of this section, a member
27 defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a)
28 may select, to the extent practicable as determined by the administration,
29 from among the available contractors of hospitalization and medical care and
30 may select a primary care physician or primary care practitioner from among
31 the primary care physicians and primary care practitioners participating in
32 the contract in which the member is enrolled. The administration shall
33 provide reimbursement only to entities that have a provider agreement with
34 the administration and that have agreed to the contractual requirements of
35 that agreement. Except as provided in sections 36-2908 and 36-2909, the
36 system shall only provide reimbursement for any health or medical services or
37 costs of related services provided by or under referral from the primary care
38 physician or primary care practitioner participating in the contract in which
39 the member is enrolled. The director shall establish requirements as to the
40 minimum time period that a member is assigned to specific contractors in the
41 system.

42 E. For a member defined as eligible pursuant to section 36-2901,
43 paragraph 6, subdivision (a), item (v) the director shall enroll the member
44 with an available contractor located in the geographic area of the member's
45 residence. The member may select a primary care physician or primary care

1 practitioner from among the primary care physicians or primary care
2 practitioners participating in the contract in which the member is enrolled.
3 The system shall only provide reimbursement for health or medical services or
4 costs of related services provided by or under referral from a primary care
5 physician or primary care practitioner participating in the contract in which
6 the member is enrolled. The director shall establish requirements as to the
7 minimum time period that a member is assigned to specific contractors in the
8 system.

9 F. If a person who has been determined eligible but who has not yet
10 enrolled in the system receives emergency services, the director shall
11 provide by rule for the enrollment of the person on a priority basis. If a
12 person requires system covered services on or after the date the person is
13 determined eligible for the system but before the date of enrollment, the
14 person is entitled to receive these services in accordance with rules adopted
15 by the director, and the administration shall pay for the services pursuant
16 to section 36-2903.01 or, as specified in contract, with the contractor
17 pursuant to the subcontracted rate or this section.

18 G. The administration shall not pay claims for system covered services
19 that are initially submitted more than six months after the date of the
20 service for which payment is claimed or after the date that eligibility is
21 posted, whichever date is later, or that are submitted as clean claims more
22 than twelve months after the date of service for which payment is claimed or
23 after the date that eligibility is posted, whichever date is later, except
24 for claims submitted for reinsurance pursuant to section 36-2906, subsection
25 C, paragraph 6. The administration shall not pay claims for system covered
26 services that are submitted by contractors for reinsurance after the time
27 period specified in the contract. The director may adopt rules or require
28 contractual provisions that prescribe requirements and time limits for
29 submittal of and payment for those claims. Notwithstanding any other
30 provision of this article, if a claim that gives rise to a contractor's claim
31 for reinsurance or deferred liability is the subject of an administrative
32 grievance or appeal proceeding or other legal action, the contractor shall
33 have at least sixty days after an ultimate decision is rendered to submit a
34 claim for reinsurance or deferred liability. Contractors that contract with
35 the administration pursuant to subsection A of this section shall not pay
36 claims for system covered services that are initially submitted BY PROVIDERS
37 OTHER THAN HOSPITALS more than six months after the date of the service for
38 which payment is claimed or after the date that eligibility is posted,
39 whichever date is later, or that are submitted as clean claims more than
40 twelve months after the date of the service for which payment is claimed or
41 after the date that eligibility is posted, whichever date is later.
42 CONTRACTORS SHALL NOT PAY HOSPITALS FOR COVERED SERVICES THAT ARE INITIALLY
43 RECEIVED MORE THAN SIX MONTHS AFTER THE DATE OF THE SERVICE FOR WHICH PAYMENT
44 IS CLAIMED OR AFTER THE DATE THAT ELIGIBILITY IS POSTED OR THREE MONTHS AFTER
45 A PRIMARY PAYOR INITIALLY DENIES OR PAYS A CLAIM IF THE HOSPITAL SUBMITTED

1 THE CLAIM TO THE PRIMARY PAYOR WITHIN SIX MONTHS FROM THE DATE OF SERVICE,
2 WHICHEVER DATE IS LATER, OR THAT ARE RECEIVED AS CLEAN CLAIMS MORE THAN
3 TWELVE MONTHS AFTER THE DATE OF SERVICE FOR WHICH PAYMENT IS CLAIMED OR AFTER
4 THE DATE THAT ELIGIBILITY IS POSTED OR THREE MONTHS AFTER A PRIMARY PAYOR
5 DENIES OR PAYS A CLAIM IF THE HOSPITAL SUBMITTED THE CLAIM TO THE PRIMARY
6 PAYOR WITHIN SIX MONTHS FROM THE DATE OF SERVICE, WHICHEVER DATE IS LATER.
7 THE ADMINISTRATION SHALL ADOPT RULES THAT PRESCRIBE INFORMATION THAT MUST BE
8 INCLUDED IN A HOSPITAL OR PHYSICIAN CLAIM FOR IT TO BE CONSIDERED A CLEAN
9 CLAIM. For the purposes of this subsection:

10 1. "Clean claims" means claims that may be processed without obtaining
11 additional information AS PRESCRIBED BY THE BOARD BY RULE from the
12 subcontracted provider of care, from a noncontracting provider or from a
13 third party but does not include claims under investigation for fraud or
14 abuse or claims under review for medical necessity.

15 2. "Date of service" for a hospital ~~inpatient means the date of~~
16 ~~discharge of the~~ patient PAYMENT HAS THE SAME MEANING PRESCRIBED IN SECTION
17 36-2904.01.

18 3. "RECEIVED", AS IT RELATES TO A HOSPITAL OR PHYSICIAN CLAIM, HAS THE
19 SAME MEANING PRESCRIBED IN SECTION 36-2904.01.

20 ~~3.~~ 4. "Submitted" means the date the claim is received by the
21 administration or the prepaid capitated provider, whichever is applicable, as
22 established by the date stamp on the face of the document or other record of
23 receipt.

24 H. In any county having a population of five hundred thousand or fewer
25 persons, a hospital that executes a subcontract other than a capitation
26 contract with a contractor for the provision of hospital and medical services
27 pursuant to this article shall offer a subcontract to any other contractor
28 providing services to that portion of the county and to any other person that
29 plans to become a contractor in that portion of the county. If such a
30 hospital executes a subcontract other than a capitation contract with a
31 contractor for the provision of hospital and medical services pursuant to
32 this article, the hospital shall adopt uniform criteria to govern the
33 reimbursement levels paid by all contractors with whom the hospital executes
34 such a subcontract. Reimbursement levels offered by hospitals to contractors
35 pursuant to this subsection may vary among contractors only as a result of
36 the number of bed days purchased by the contractors, the amount of financial
37 deposit required by the hospital, if any, or the schedule of performance
38 discounts offered by the hospital to the contractor for timely payment of
39 claims.

40 I. ~~This subsection applies to inpatient hospital admissions and to~~
41 ~~outpatient hospital services on and after March 1, 1993.~~ The director may
42 negotiate at any time with a hospital on behalf of a contractor for services
43 provided pursuant to this article. If a contractor negotiates with a
44 hospital for services provided pursuant to this article, the following
45 procedures apply:

1 1. The director shall require any contractor to reimburse hospitals
2 for services provided under this article based on reimbursement levels that
3 do not in the aggregate exceed those established pursuant to section
4 36-2903.01, ~~NOT INCLUDING ANY PENALTY PAYMENTS THAT ARE REQUIRED PURSUANT TO~~
5 ~~SECTION 36-2904.01, SUBSECTION E~~, and under terms on which the contractor and
6 the hospital agree. However, a hospital and a contractor may agree on a
7 different payment methodology than the methodology prescribed by the director
8 pursuant to section 36-2903.01. The director by rule shall prescribe:

9 (a) The time limits for any negotiation between the contractor and the
10 hospital.

11 (b) The ability of the director to review and approve or disapprove
12 the reimbursement levels and terms agreed on by the contractor and the
13 hospital.

14 ~~(c) That if a contractor and a hospital do not agree on reimbursement~~
15 ~~levels and terms as required by this subsection, the reimbursement levels~~
16 ~~established pursuant to section 36-2903.01 apply.~~

17 ~~(d) That, except if submitted under an electronic claims submission~~
18 ~~system, a hospital bill is considered received for purposes of subdivision~~
19 ~~(f) on initial receipt of the legible, error-free claim form by the~~
20 ~~contractor if the claim includes the following error-free documentation in~~
21 ~~legible form:~~

22 ~~(i) An admission face sheet.~~

23 ~~(ii) An itemized statement.~~

24 ~~(iii) An admission history and physical.~~

25 ~~(iv) A discharge summary or an interim summary if the claim is split.~~

26 ~~(v) An emergency record, if admission was through the emergency room.~~

27 ~~(vi) Operative reports, if applicable.~~

28 ~~(vii) A labor and delivery room report, if applicable.~~

29 (c) THAT PAYMENTS TO A HOSPITAL OR A PHYSICIAN FROM A CONTRACTOR WILL
30 BE MADE PURSUANT TO THE TIMELY PAY PROVISIONS OF SECTION 36-2904.01.

31 ~~(e)~~ (d) That payment received by a hospital from a contractor is
32 considered payment by the contractor of the contractor's liability for the
33 hospital bill. A hospital may collect any unpaid portion of its bill from
34 other third party payors or in situations covered by title 33, chapter 7,
35 article 3.

36 ~~(f) That a contractor shall pay for services rendered on and after~~
37 ~~October 1, 1997 under any reimbursement level according to paragraph 1 of~~
38 ~~this subsection subject to the following:~~

39 ~~(i) If the hospital's bill is paid within thirty days of the date the~~
40 ~~bill was received, the contractor shall pay ninety-nine per cent of the rate.~~

41 ~~(ii) If the hospital's bill is paid after thirty days but within sixty~~
42 ~~days of the date the bill was received, the contractor shall pay one hundred~~
43 ~~per cent of the rate.~~

44 ~~(iii) If the hospital's bill is paid any time after sixty days of the~~
45 ~~date the bill was received, the contractor shall pay one hundred per cent of~~

1 ~~the rate plus a fee of one per cent per month for each month or portion of a~~
2 ~~month following the sixtieth day of receipt of the bill until the date of~~
3 ~~payment.~~

4 (e) THAT IF A HOSPITAL'S CLAIM OR A PORTION OF A HOSPITAL'S CLAIM IS
5 PAID WITHIN THIRTY DAYS AFTER THE CLAIM IS RECEIVED BY THE CONTRACTOR, THE
6 CONTRACTOR SHALL PAY NINETY-NINE PER CENT OF THE AMOUNT OWED ON THE CLAIM OR
7 NINETY-NINE PER CENT OF THE PORTION OF THE AMOUNT OWED ON THE CLAIM.

8 2. IF A CONTRACTOR AND A HOSPITAL DO NOT AGREE ON REIMBURSEMENT LEVELS
9 AND TERMS AS REQUIRED BY THIS SUBSECTION, THE REIMBURSEMENT LEVELS
10 ESTABLISHED PURSUANT TO SECTION 36-2903.01 AND THE TIMELY PAY PROVISIONS
11 ESTABLISHED PURSUANT TO SECTION 36-2904.01 APPLY.

12 ~~2.~~ 3. In any county having a population of five hundred thousand or
13 fewer persons, a hospital that executes a subcontract other than a capitation
14 contract with a provider for the provision of hospital and medical services
15 pursuant to this article shall offer a subcontract to any other provider
16 providing services to that portion of the county and to any other person that
17 plans to become a provider in that portion of the county. If a hospital
18 executes a subcontract other than a capitation contract with a provider for
19 the provision of hospital and medical services pursuant to this article, the
20 hospital shall adopt uniform criteria to govern the reimbursement levels paid
21 by all providers with whom the hospital executes a subcontract.

22 J. If there is an insufficient number of, or an inadequate member
23 capacity in, contracts awarded to contractors, the director, in order to
24 deliver covered services to members enrolled or expected to be enrolled in
25 the system within a county, may negotiate and award, without bid, a contract
26 with a health care services organization holding a certificate of authority
27 pursuant to title 20, chapter 4, article 9. The director shall require a
28 health care services organization contracting under this subsection to comply
29 with section 36-2906.01. The term of the contract shall not extend beyond
30 the next bid and contract award process as provided in section 36-2906 and
31 shall be no greater than capitation rates paid to contractors in the same
32 county or counties pursuant to section 36-2906. Contracts awarded pursuant
33 to this subsection are exempt from the requirements of title 41, chapter 23.

34 K. A contractor may require that a subcontracting or noncontracting
35 provider shall be paid for covered services, other than hospital services,
36 according to the capped fee-for-service schedule adopted by the director
37 pursuant to subsection A, paragraph 2 of this section or subsection B,
38 paragraph 1 of this section or at lower rates as may be negotiated by the
39 contractor.

40 L. The director shall require any contractor to have a plan to notify
41 members of reproductive age either directly or through the parent or legal
42 guardian, whichever is most appropriate, of the specific covered family
43 planning services available to them and a plan to deliver those services to
44 members who request them. The director shall ensure that these plans include
45 provisions for written notification, other than the member handbook, and

1 verbal notification during a member's visit with the member's primary care
2 physician or primary care practitioner.

3 M. The director shall adopt a plan to notify members of reproductive
4 age who receive care from a contractor who elects not to provide family
5 planning services of the specific covered family planning services available
6 to them and to provide for the delivery of those services to members who
7 request them. Notification may be directly to the member, or through the
8 parent or legal guardian, whichever is most appropriate. The director shall
9 ensure that the plan includes provisions for written notification, other than
10 the member handbook, and verbal notification during a member's visit with the
11 member's primary care physician or primary care practitioner.

12 N. The director shall prepare a report that represents a statistically
13 valid sample and that indicates the number of children age two by contractor
14 who received the immunizations recommended by the national centers for
15 disease control and prevention while enrolled as members. The report shall
16 indicate each type of immunization and the number and percentage of enrolled
17 children in the sample age two who received each type of immunization. The
18 report shall be done by contract year and shall be delivered to the governor,
19 the president of the senate and the speaker of the house of representatives
20 no later than April 1, 2004 and every second year thereafter.

21 ~~O. If the administration implements an electronic claims submission~~
22 ~~system it may adopt procedures pursuant to subsection I, paragraph 1 of this~~
23 ~~section requiring documentation different than prescribed under subsection I,~~
24 ~~paragraph 1, subdivision (d) of this section.~~

25 O. THE ADMINISTRATION SHALL DEVELOP A PLAN TO IMPLEMENT AN ELECTRONIC
26 CLAIMS SUBMISSION SYSTEM THAT REQUIRES CONTRACTORS, HOSPITALS AND PHYSICIANS
27 TO BE ABLE TO SUBMIT, RECEIVE, ADJUDICATE AND PAY ELECTRONIC CLAIMS.

28 P. THE ADMINISTRATION SHALL ESTABLISH A PROCESS TO RECEIVE AND
29 ACKNOWLEDGE INFORMAL COMPLAINTS FROM PROVIDERS THAT HAVE ATTEMPTED TO RESOLVE
30 ISSUES WITH CONTRACTORS REGARDING CLAIMS SUBMISSION, PROCESSING OR PAYMENT.

31 Sec. 5. Title 36, chapter 29, article 1, Arizona Revised Statutes, is
32 amended by adding section 36-2904.01, to read:

33 36-2904.01. Claims; timely payment; penalties; performance
34 summary; definitions

35 A. EXCEPT AS PROVIDED IN SUBSECTION B OF THIS SECTION, NOT LATER THAN
36 THIRTY DAYS AFTER A HOSPITAL OR PHYSICIAN CLAIM IS RECEIVED BY A CONTRACTOR,
37 THE CONTRACTOR SHALL DETERMINE IF THE CLAIM IS PAYABLE. IF THE CONTRACTOR
38 DETERMINES THAT THE ENTIRE HOSPITAL OR PHYSICIAN CLAIM IS PAYABLE, THE
39 CONTRACTOR SHALL PAY THE AMOUNT OWED NOT LATER THAN THIRTY DAYS AFTER A CLAIM
40 IS RECEIVED BY THE CONTRACTOR. IF THE CONTRACTOR DETERMINES THAT THE PORTION
41 OF THE CLAIM IS PAYABLE, THE CONTRACTOR SHALL PAY THE PORTION OF THE AMOUNT
42 OWED THAT IS NOT IN DISPUTE AND NOTIFY THE HOSPITAL OR PHYSICIAN THROUGH A
43 REMITTANCE DOCUMENT OF THE SPECIFIC REASON THE REMAINING PORTION OF THE
44 AMOUNT OWED WILL NOT BE PAID. UNLESS OTHERWISE PRESCRIBED IN RULE BY THE
45 ADMINISTRATION, IF THE CONTRACTOR DETERMINES THAT THE CLAIM OR A PORTION OF

1 THE CLAIM IS NOT PAYABLE, THE CONTRACTOR SHALL NOTIFY THE HOSPITAL OR
2 PHYSICIAN THROUGH A REMITTANCE DOCUMENT OF THE SPECIFIC REASON THE AMOUNT
3 OWED WILL NOT BE PAID NOT LATER THAN THIRTY DAYS AFTER THE CLAIM IS RECEIVED
4 BY THE CONTRACTOR. THE ADMINISTRATION SHALL DEVELOP RULES THAT PRESCRIBE
5 STANDARD REMITTANCE ADVICE CODES THAT CONTRACTORS MUST USE TO NOTIFY
6 HOSPITALS OR PHYSICIANS WHEN THE AMOUNT BILLED ON A CLAIM WILL BE REDUCED OR
7 NOT PAID.

8 B. IF AFTER RECEIVING A CLAIM FROM A HOSPITAL A CONTRACTOR NEEDS
9 ADDITIONAL INFORMATION FROM THE BILLING HOSPITAL TO DETERMINE IF A CLAIM IS
10 PAYABLE, THE CONTRACTOR, NOT LATER THAN THE THIRTIETH DAY AFTER THE
11 CONTRACTOR RECEIVES THE CLAIM, SHALL REQUEST IN WRITING THAT THE HOSPITAL OR
12 PHYSICIAN PROVIDE THE NECESSARY ADDITIONAL INFORMATION. THE REQUEST FOR
13 ADDITIONAL INFORMATION MUST DESCRIBE WITH SPECIFICITY THE INFORMATION
14 REQUESTED, MUST REQUEST ONLY INFORMATION THAT IS RELEVANT AND NECESSARY TO
15 THE PAYMENT DETERMINATION OF THE SPECIFIC CLAIM AND MAY NOT REQUEST
16 INFORMATION ALREADY AVAILABLE TO THE CONTRACTOR. A HOSPITAL OR PHYSICIAN IS
17 NOT REQUIRED TO PROVIDE ADDITIONAL INFORMATION IN ANY NONELECTRONIC FORMAT IF
18 THE INFORMATION IS AVAILABLE AND ACCESSIBLE TO THE CONTRACTOR IN AN
19 ELECTRONIC FORMAT. IF ON RECEIVING ADDITIONAL INFORMATION REQUESTED UNDER
20 THIS SUBSECTION THE CONTRACTOR DETERMINES THAT THERE WAS AN ERROR IN PAYMENT
21 OF THE CLAIM, THE CONTRACTOR MAY RECOVER ANY OVERPAYMENT PURSUANT TO SECTION
22 36-2903.01, SUBSECTION M. THE ADMINISTRATION SHALL DEVELOP RULES REGARDING A
23 CONTRACTOR'S REQUEST FOR ADDITIONAL INFORMATION. THE RULES SHALL PRESCRIBE:

- 24 1. THE TYPES OF ADDITIONAL INFORMATION THAT MAY BE REQUESTED.
- 25 2. LIMITATIONS ON MULTIPLE REQUESTS FOR ADDITIONAL INFORMATION.
- 26 3. THE ENTITY RESPONSIBLE FOR THE COSTS OF PROVIDING THE ADDITIONAL
27 INFORMATION.
- 28 4. TIME FRAMES BY WHICH THE CONTRACTOR SHALL DETERMINE IF A CLAIM IS
29 PAYABLE AFTER RECEIPT OF ADDITIONAL INFORMATION.

30 C. A HOSPITAL OR PHYSICIAN CLAIM IS CONSIDERED TO HAVE BEEN PAID ON
31 THE DATE OF THE ELECTRONIC FUNDS TRANSFER. IF AN ELECTRONIC FUNDS TRANSFER
32 IS NOT AVAILABLE, THE DATE OF PAYMENT IS THE DATE INDICATED ON THE
33 DISBURSEMENT CHECK.

34 D. A CONTRACTOR SHALL MAKE ALL UTILIZATION REVIEW POLICIES AND ALL
35 CLAIM PROCESSING POLICIES AND PROCEDURES AFFECTING HOSPITAL OR PHYSICIAN
36 PAYMENTS AVAILABLE IN AN ELECTRONIC FORMAT AND SHALL ENSURE THAT ALL
37 CONTRACTED AND NONCONTRACTED HOSPITALS OR PHYSICIANS HAVE ELECTRONIC ACCESS
38 TO THE INFORMATION. IF THE CONTRACTOR DETERMINES THAT A POLICY OR PROCEDURE
39 IS PROPRIETARY AND THAT PROVIDING THE POLICY OR PROCEDURE WOULD CAUSE HARM TO
40 THE CONTRACTOR OR IF THE DISCLOSURE BY THE CONTRACTOR IS PROHIBITED BY A
41 LICENSING OR OTHER AGREEMENT WITH A THIRD PARTY, THE CONTRACTOR SHALL INSTEAD
42 IDENTIFY THE POLICY OR PROCEDURE THAT WILL NOT BE MADE AVAILABLE AND THE
43 REASON FOR NOT MAKING IT AVAILABLE, AND SHALL DESCRIBE HOW THE POLICY IS USED
44 OR APPLIED. IF A HOSPITAL OR PHYSICIAN REQUESTS SUCH A POLICY IN ORDER TO
45 EVALUATE A CONTRACTOR'S DENIAL OR REDUCTION OF A SPECIFIC CLAIM, THE

1 CONTRACTOR SHALL PROVIDE EITHER A COPY OF THE POLICY OR PROCEDURE ON WHICH
2 THE DENIAL OR REDUCTION IS BASED OR A COMPLETE DESCRIPTION OF ITS CONTENTS.
3 A CONTRACTOR SHALL UPDATE THIS INFORMATION TO REFLECT CURRENT POLICIES AND
4 PROCEDURES WITHIN THIRTY DAYS AFTER THE DATE OF ANY CHANGE IN POLICY OR
5 PROCEDURE. THIS SECTION DOES NOT REQUIRE A PROVIDER THAT DOES NOT HAVE A
6 CONTRACT WITH A CONTRACTOR TO COMPLY WITH A CONTRACTOR'S POLICIES AND
7 PROCEDURES UNLESS OTHERWISE REQUIRED BY LAW OR THE ADMINISTRATION. THE
8 POLICIES AND PROCEDURES SHALL BE CONSISTENT WITH THE TERMS OF THE
9 CONTRACTOR'S PREPAID CAPITATED CONTRACT WITH THE ADMINISTRATION, THE
10 ADMINISTRATION'S POLICIES AND PROCEDURES THAT APPLY TO CONTRACTORS AND THE
11 CONTRACTOR'S POLICIES AND PROCEDURES SUBMITTED TO AND APPROVED BY THE
12 ADMINISTRATION.

13 E. BEGINNING OCTOBER 1, 2009 OR ON THE ADOPTION OF RULES AS REQUIRED
14 BY THIS SECTION, WHICHEVER IS LATER, IF A NONELECTRONIC CLEAN HOSPITAL OR
15 PHYSICIAN CLAIM IS PAYABLE BUT THE CONTRACTOR DOES NOT PAY THE FULL AMOUNT
16 OWED WITHIN SIXTY DAYS AFTER THE CLAIM IS RECEIVED, THE CONTRACTOR SHALL PAY
17 A PENALTY. IF THE CONTRACTOR PAYS THE FULL AMOUNT OWED AFTER THE SIXTIETH
18 DAY AND ON OR BEFORE THE NINETIETH DAY FOLLOWING THE DATE THE CLAIM WAS
19 RECEIVED, THE CONTRACTOR SHALL PAY THE HOSPITAL OR THE PHYSICIAN THE AMOUNT
20 OWED, PLUS A PENALTY OF ONE PER CENT OF THE AMOUNT OWED PER MONTH FOR EACH
21 MONTH OR PORTION OF THE MONTH UNTIL THE DATE OF PAYMENT. IF THE CONTRACTOR
22 MAKES THE PAYMENT AFTER THE NINETIETH DAY AND ON OR BEFORE THE ONE HUNDRED
23 TWENTIETH DAY FOLLOWING THE DATE THE CLAIM WAS RECEIVED, THE CONTRACTOR SHALL
24 PAY THE HOSPITAL OR THE PHYSICIAN THE AMOUNT OWED, PLUS A PENALTY OF ONE AND
25 ONE-HALF PER CENT OF THE AMOUNT OWED PER MONTH FOR EACH MONTH OR PORTION OF
26 THE MONTH UNTIL THE DATE OF PAYMENT. IF THE CONTRACTOR PAYS THE AMOUNT OWED
27 OR THE BALANCE OF THE AMOUNT OWED ON A CLAIM AFTER THE ONE HUNDRED TWENTIETH
28 DAY FOLLOWING THE DATE THE CLAIM WAS RECEIVED, THE CONTRACTOR SHALL PAY THE
29 HOSPITAL OR THE PHYSICIAN THE AMOUNT OWED PLUS A PENALTY OF TWO PER CENT OF
30 THE AMOUNT OWED PER MONTH OR PORTION OF THE MONTH UNTIL THE DATE OF PAYMENT.

31 F. IF A CONTRACTOR PAYS THE FULL AMOUNT OWED ON AN ELECTRONIC CLEAN
32 HOSPITAL OR PHYSICIAN CLAIM AND MAKES THE PAYMENT AFTER THE SIXTIETH DAY
33 FOLLOWING THE DATE THE CLAIM WAS RECEIVED, THE CONTRACTOR SHALL PAY THE
34 HOSPITAL OR PHYSICIAN THE AMOUNT OWED, PLUS A PENALTY OF TWO PER CENT OF THE
35 AMOUNT OWED PER MONTH FOR EACH MONTH OR PORTION OF THE MONTH UNTIL THE DATE
36 OF PAYMENT.

37 G. THE ADMINISTRATION SHALL WORK WITH AFFECTED STAKEHOLDERS, INCLUDING
38 HOSPITALS, PHYSICIANS AND HEALTH PLANS, TO DEVELOP RULES THAT DEFINE PARTIAL
39 PAYMENT AND PRESCRIBE CIRCUMSTANCES IN WHICH THE CONTRACTOR IS REQUIRED TO
40 PAY THE HOSPITAL OR THE PHYSICIAN A PENALTY FOR PARTIAL PAYMENT OF A CLAIM.

41 H. A CONTRACTOR IS NOT LIABLE FOR A PENALTY UNDER SUBSECTION E OF THIS
42 SECTION IF THE FAILURE TO PAY THE CLAIM IS A RESULT OF AN EMERGENCY DECLARED
43 BY THE GOVERNOR THAT SUBSTANTIALLY INTERFERES WITH THE NORMAL BUSINESS
44 OPERATIONS OF THE CONTRACTOR.

1 I. SUBSECTION E OF THIS SECTION DOES NOT RELIEVE THE CONTRACTOR OF THE
2 OBLIGATION TO PAY THE REMAINING UNPAID AMOUNT OWED THE HOSPITAL OR THE
3 PHYSICIAN.

4 J. A CONTRACTOR THAT PAYS A PENALTY PURSUANT TO SUBSECTION E OF THIS
5 SECTION SHALL CLEARLY INDICATE ON THE EXPLANATION OF PAYMENT STATEMENT THE
6 AMOUNT OF THE PAYMENT THAT IS THE AMOUNT OWED AND THE AMOUNT THAT IS PAID AS
7 A PENALTY.

8 K. THE ADMINISTRATION SHALL WORK WITH AFFECTED STAKEHOLDERS, INCLUDING
9 HOSPITALS, PHYSICIANS AND HEALTH PLANS, TO IMPLEMENT TIMELY PAY PENALTIES FOR
10 CLAIMS IN WHICH CONTRACTOR PRACTICES RESULT IN UNNECESSARY APPEALS OR
11 IMPROPER DENIALS OR DELAY PAYMENT.

12 L. THE ADMINISTRATION SHALL DEVELOP A PROCESS THAT PRESCRIBES
13 SANCTIONS AND TIME FRAMES FOR SANCTIONS THAT MAY BE IMPOSED ON CONTRACTORS
14 THAT VIOLATE THE TIMELY PAY REQUIREMENTS IN THIS SECTION AND THE AGGREGATE
15 CLAIM PAYMENT STANDARDS PRESCRIBED IN SECTION 36-2903, SUBSECTION B,
16 PARAGRAPH 13. THE SANCTIONS MAY INCLUDE MONETARY PENALTIES, THE CAPPING OF
17 NEW ENROLLMENT AND OTHER SANCTIONS THE ADMINISTRATION DEEMS APPROPRIATE.

18 M. WITHIN THIRTY DAYS AFTER THE DETERMINATION OF EACH CONTRACTOR'S
19 COMPLIANCE WITH THE AGGREGATE CLAIM PAYMENT STANDARDS PURSUANT TO SECTION
20 36-2903, SUBSECTION B, PARAGRAPH 13, THE DIRECTOR SHALL PUBLISH THE
21 COMPLIANCE RESULTS FOR EACH CONTRACTOR FOR FACILITIES AND PROFESSIONALS.

22 N. ON OR BEFORE DECEMBER 1 OF EACH YEAR, THE ADMINISTRATION SHALL
23 PUBLISH A SUMMARY OF THE TIMELY PAY PERFORMANCE OF EACH OF ITS CONTRACTORS
24 THAT INCLUDES THE NUMBER OF HOSPITAL AND PHYSICIAN CLAIMS EACH CONTRACTOR
25 PAID SIXTY DAYS OR MORE AFTER THE DATE OF RECEIPT OF THE CLAIM. THE
26 ADMINISTRATION SHALL MAKE THE SUMMARY AVAILABLE ON ITS WEBSITE.

27 O. A CONTRACTOR SHALL ACCOUNT FOR ANY PENALTY PAID PURSUANT TO THIS
28 SECTION AS AN ADMINISTRATIVE EXPENSE.

29 P. THE ADMINISTRATION SHALL ESTABLISH A POLICY THAT PRESCRIBES NOTICE
30 AND IMPLEMENTATION TIME FRAMES FOR CHANGES MADE TO THE CLAIMS PAYMENT SYSTEM.
31 THE ADMINISTRATION SHALL MAKE THE POLICY AVAILABLE TO CONTRACTORS, HOSPITALS
32 AND PHYSICIANS.

33 Q. THE ADMINISTRATION SHALL WORK WITH AFFECTED STAKEHOLDERS, INCLUDING
34 HOSPITALS, PHYSICIANS AND HEALTH PLANS, TO DEVELOP RULES PRESCRIBING THE DATE
35 OF RECEIPT FOR NONELECTRONIC CLAIMS.

36 R. FOR THE PURPOSES OF THIS SECTION:

37 1. "AMOUNT OWED" MEANS THE AMOUNT PAYABLE BY A CONTRACTOR UNDER THE
38 TERMS OF AN AGREEMENT BETWEEN THE CONTRACTOR AND THE HOSPITAL OR PHYSICIAN
39 UNDER SECTION 36-2904, SUBSECTION I, PARAGRAPH 1 OR THE AMOUNT PAYABLE BY A
40 CONTRACTOR TO A NONCONTRACTED HOSPITAL UNDER THE TERMS OF SECTION 36-2904,
41 SUBSECTION I, PARAGRAPH 1, SUBDIVISION (c).

42 2. "DATE OF SERVICE" FOR A HOSPITAL INPATIENT OR PHYSICIAN PATIENT
43 MEANS THE DATE OF DISCHARGE OF THE PATIENT.

44 3. "RECEIVED" MEANS THE DATE OF THE ELECTRONIC VERIFICATION OF RECEIPT
45 BY THE ADMINISTRATION OR CONTRACTOR. IF THE CLAIM OR ATTACHMENT TO THE CLAIM

1 IS NOT SUBMITTED ELECTRONICALLY, THE DATE OF RECEIPT SHALL BE DEFINED BY THE
2 ADMINISTRATION IN RULE.

3 Sec. 6. Initial terms of members of the hospital reimbursement
4 advisory council

5 A. Notwithstanding section 36-2902.03, Arizona Revised Statutes, as
6 added by this act, the initial terms of members of the hospital reimbursement
7 advisory council are:

- 8 1. Four terms ending June 30, 2010.
- 9 2. Five terms ending June 30, 2011.
- 10 3. Five terms ending June 30, 2012.

11 B. The director shall make all subsequent appointments as prescribed
12 by statute.

13 Sec. 7. AHCCCS; temporary exemption from rule making

14 For the purposes of this act, the Arizona health care cost containment
15 system administration is exempt from the rule making requirements of title
16 41, chapter 6, Arizona Revised Statutes, until December 31, 2010. The
17 administration shall hold at least one public hearing to receive public
18 comments before implementing the rules pursuant to this section.