

REFERENCE TITLE: budget reconciliation; health; welfare; 2008-2009

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

SB 1004

Introduced by
Senators Burns, Gorman, Gray C

AN ACT

REPEALING SECTION 36-797, ARIZONA REVISED STATUTES; AMENDING SECTIONS 36-2903.01, 36-2907 AND 46-292, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-2907.02; REPEALING SECTIONS 36-2907.10, 36-2907.11 AND 36-2907.12, ARIZONA REVISED STATUTES; REPEALING TITLE 46, CHAPTER 2, ARTICLE 2, ARIZONA REVISED STATUTES; AMENDING LAWS 2008, CHAPTER 288, SECTIONS 10, 11 AND 13; RELATING TO HEALTH AND WELFARE BUDGET RECONCILIATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Health crisis fund; repeal; reversion

3 A. Section 36-797, Arizona Revised Statutes, is repealed.

4 B. Any monies remaining in the health crisis fund on the effective
5 date of this act revert to the state general fund.

6 Sec. 2. Section 36-2903.01, Arizona Revised Statutes, is amended to
7 read:

8 36-2903.01. Additional powers and duties; report

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

15 B. The director shall:

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

22 2. Enter into an interagency agreement with the department to
23 establish a streamlined eligibility process to determine the eligibility of
24 all persons defined pursuant to section 36-2901, paragraph 6,
25 subdivision (a). At the administration's option, the interagency agreement
26 may allow the administration to determine the eligibility of certain persons,
27 including those defined pursuant to section 36-2901, paragraph 6,
28 subdivision (a).

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

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

33 (c) Establish the process for management evaluation reviews that the
34 administration shall perform to evaluate the eligibility determination
35 functions performed by the department.

36 (d) Establish eligibility quality control reviews by the
37 administration.

38 (e) Require the department to adopt rules, consistent with the rules
39 adopted by the administration for a hearing process, that applicants or
40 members may use for appeals of eligibility determinations or
41 redeterminations.

42 (f) Establish the department's responsibility to place sufficient
43 eligibility workers at federally qualified health centers to screen for
44 eligibility and at hospital sites and level one trauma centers to ensure that
45 persons seeking hospital services are screened on a timely basis for

1 eligibility for the system, including a process to ensure that applications
2 for the system can be accepted on a twenty-four hour basis, seven days a
3 week.

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

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

11 4. By rule establish a procedure and time frames for the intake of
12 grievances and requests for hearings, for the continuation of benefits and
13 services during the appeal process and for a grievance process at the
14 contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and
15 41-1092.05, the administration shall develop rules to establish the procedure
16 and time frame for the informal resolution of grievances and appeals. A
17 grievance that is not related to a claim for payment of system covered
18 services shall be filed in writing with and received by the administration or
19 the prepaid capitated provider or program contractor not later than sixty
20 days after the date of the adverse action, decision or policy implementation
21 being grieved. A grievance that is related to a claim for payment of system
22 covered services must be filed in writing and received by the administration
23 or the prepaid capitated provider or program contractor within twelve months
24 after the date of service, within twelve months after the date that
25 eligibility is posted or within sixty days after the date of the denial of a
26 timely claim submission, whichever is later. A grievance for the denial of a
27 claim for reimbursement of services may contest the validity of any adverse
28 action, decision, policy implementation or rule that related to or resulted
29 in the full or partial denial of the claim. A policy implementation may be
30 subject to a grievance procedure, but it may not be appealed for a hearing.
31 The administration is not required to participate in a mandatory settlement
32 conference if it is not a real party in interest. In any proceeding before
33 the administration, including a grievance or hearing, persons may represent
34 themselves or be represented by a duly authorized agent who is not charging a
35 fee. A legal entity may be represented by an officer, partner or employee
36 who is specifically authorized by the legal entity to represent it in the
37 particular proceeding.

38 5. Apply for and accept federal funds available under title XIX of the
39 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section
40 1396 (1980)) in support of the system. The application made by the director
41 pursuant to this paragraph shall be designed to qualify for federal funding
42 primarily on a prepaid capitated basis. Such funds may be used only for the
43 support of persons defined as eligible pursuant to title XIX of the social
44 security act or the approved section 1115 waiver.

1 6. At least thirty days before the implementation of a policy or a
2 change to an existing policy relating to reimbursement, provide notice to
3 interested parties. Parties interested in receiving notification of policy
4 changes shall submit a written request for notification to the
5 administration.

6 7. IN ADDITION TO THE COST SHARING REQUIREMENTS SPECIFIED IN
7 SUBSECTION D, PARAGRAPH 4 OF THIS SECTION:

8 (a) CHARGE MONTHLY PREMIUMS UP TO THE MAXIMUM AMOUNT ALLOWED BY
9 FEDERAL LAW TO ALL POPULATIONS OF ELIGIBLE PERSONS WHO MAY BE CHARGED.

10 (b) IMPLEMENT THIS PARAGRAPH TO EXTENT PERMITTED UNDER THE FEDERAL
11 DEFICIT REDUCTION ACT OF 2005 AND OTHER FEDERAL LAWS, SUBJECT TO THE APPROVAL
12 OF FEDERAL WAIVER AUTHORITY AND TO THE EXTENT THAT ANY CHANGES IN THE COST
13 SHARING REQUIREMENTS UNDER THIS PARAGRAPH WOULD PERMIT THIS STATE TO RECEIVE
14 ANY ENHANCED FEDERAL MATCHING RATE.

15 C. The director is authorized to apply for any federal funds available
16 for the support of programs to investigate and prosecute violations arising
17 from the administration and operation of the system. Available state funds
18 appropriated for the administration and operation of the system may be used
19 as matching funds to secure federal funds pursuant to this subsection.

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

21 1. Authorize advance payments based on estimated liability to a
22 contractor or a noncontracting provider after the contractor or
23 noncontracting provider has submitted a claim for services and before the
24 claim is ultimately resolved. The rules shall specify that any advance
25 payment shall be conditioned on the execution before payment of a contract
26 with the contractor or noncontracting provider that requires the
27 administration to retain a specified percentage, which shall be at least
28 twenty per cent, of the claimed amount as security and that requires
29 repayment to the administration if the administration makes any overpayment.

30 2. Defer liability, in whole or in part, of contractors for care
31 provided to members who are hospitalized on the date of enrollment or under
32 other circumstances. Payment shall be on a capped fee-for-service basis for
33 services other than hospital services and at the rate established pursuant to
34 subsection G or H of this section for hospital services or at the rate paid
35 by the health plan, whichever is less.

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

40 4. Notwithstanding any other law, require persons eligible pursuant to
41 section 36-2901, paragraph 6, subdivision (a), ~~AND~~ AND section 36-2931,
42 paragraph 5 ~~and section 36-2981, paragraph 6~~ to be financially responsible
43 for any cost sharing requirements established in a state plan or a section
44 1115 waiver and approved by the centers for medicare and medicaid services.
45 Cost sharing requirements may include copayments, coinsurance, deductibles,

1 enrollment fees and monthly premiums for enrolled members, including
2 households with children enrolled in the Arizona long-term care system.

3 E. The director shall adopt rules that further specify the medical
4 care and hospital services that are covered by the system pursuant to section
5 36-2907.

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

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

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

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

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

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

29 2. The director shall adopt rules that, for services rendered from and
30 after September 30, 1986, define "adjusted billed charges" as that
31 reimbursement level that has the effect of increasing by four per cent a
32 hospital's reimbursement level in effect on October 1, 1985 as prescribed in
33 paragraph 1 of this subsection. Beginning January 1, 1991, the Arizona
34 health care cost containment system administration shall define "adjusted
35 billed charges" as the reimbursement level determined pursuant to this
36 section, increased by two and one-half per cent.

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

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

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

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

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

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

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

18 1. For inpatient hospital stays, the administration shall use a
19 prospective tiered per diem methodology, using hospital peer groups if
20 analysis shows that cost differences can be attributed to independently
21 definable features that hospitals within a peer group share. In peer
22 grouping the administration may consider such factors as length of stay
23 differences and labor market variations. If there are no cost differences,
24 the administration shall implement a stop loss-stop gain or similar
25 mechanism. Any stop loss-stop gain or similar mechanism shall ensure that
26 the tiered per diem rates assigned to a hospital do not represent less than
27 ninety per cent of its 1990 base year costs or more than one hundred ten per
28 cent of its 1990 base year costs, adjusted by an audit factor, during the
29 period of March 1, 1993 through September 30, 1994. The tiered per diem
30 rates set for hospitals shall represent no less than eighty-seven and
31 one-half per cent or more than one hundred twelve and one-half per cent of
32 its 1990 base year costs, adjusted by an audit factor, from October 1, 1994
33 through September 30, 1995 and no less than eighty-five per cent or more than
34 one hundred fifteen per cent of its 1990 base year costs, adjusted by an
35 audit factor, from October 1, 1995 through September 30, 1996. For the
36 periods after September 30, 1996 no stop loss-stop gain or similar mechanisms
37 shall be in effect. An adjustment in the stop loss-stop gain percentage may
38 be made to ensure that total payments do not increase as a result of this
39 provision. If peer groups are used the administration shall establish
40 initial peer group designations for each hospital before implementation of
41 the per diem system. The administration may also use a negotiated rate
42 methodology. The tiered per diem methodology may include separate
43 consideration for specialty hospitals that limit their provision of services
44 to specific patient populations, such as rehabilitative patients or children.
45 The initial per diem rates shall be based on hospital claims and encounter

1 data for dates of service November 1, 1990 through October 31, 1991 and
2 processed through May of 1992.

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

9 3. Through June 30, 2004, for outpatient hospital services, the
10 administration shall reimburse a hospital by applying a hospital specific
11 outpatient cost-to-charge ratio to the covered charges. Beginning on July 1,
12 2004 through June 30, 2005, the administration shall reimburse a hospital by
13 applying a hospital specific outpatient cost-to-charge ratio to covered
14 charges. If the hospital increases its charges for outpatient services filed
15 with the Arizona department of health services pursuant to chapter 4, article
16 3 of this title, by more than 4.7 per cent for dates of service effective on
17 or after July 1, 2004, the hospital specific cost-to-charge ratio will be
18 reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7
19 per cent, the effective date of the increased charges will be the effective
20 date of the adjusted Arizona health care cost containment system
21 cost-to-charge ratio. The administration shall develop the methodology for a
22 capped fee-for-service schedule and a statewide cost-to-charge ratio. Any
23 covered outpatient service not included in the capped fee-for-service
24 schedule shall be reimbursed by applying the statewide cost-to-charge ratio
25 that is based on the services not included in the capped fee-for-service
26 schedule. Beginning on July 1, 2005, the administration shall reimburse
27 clean claims with dates of service on or after July 1, 2005, based on the
28 capped fee-for-service schedule or the statewide cost-to-charge ratio
29 established pursuant to this paragraph. The administration may make
30 additional adjustments to the outpatient hospital rates established pursuant
31 to this section based on other factors, including the number of beds in the
32 hospital, specialty services available to patients and the geographic
33 location of the hospital.

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

- 38 (a) An admission face sheet.
- 39 (b) An itemized statement.
- 40 (c) An admission history and physical.
- 41 (d) A discharge summary or an interim summary if the claim is split.
- 42 (e) An emergency record, if admission was through the emergency room.
- 43 (f) Operative reports, if applicable.
- 44 (g) A labor and delivery room report, if applicable.

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

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

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

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

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

21 6. In developing the reimbursement methodology, if a review of the
22 reports filed by a hospital pursuant to section 36-125.04 indicates that
23 further investigation is considered necessary to verify the accuracy of the
24 information in the reports, the administration may examine the hospital's
25 records and accounts related to the reporting requirements of section
26 36-125.04. The administration shall bear the cost incurred in connection
27 with this examination unless the administration finds that the records
28 examined are significantly deficient or incorrect, in which case the
29 administration may charge the cost of the investigation to the hospital
30 examined.

31 7. Except for privileged medical information, the administration shall
32 make available for public inspection the cost and charge data and the
33 calculations used by the administration to determine payments under the
34 tiered per diem system, provided that individual hospitals are not identified
35 by name. The administration shall make the data and calculations available
36 for public inspection during regular business hours and shall provide copies
37 of the data and calculations to individuals requesting such copies within
38 thirty days of receipt of a written request. The administration may charge a
39 reasonable fee for the provision of the data or information.

40 8. The prospective tiered per diem payment methodology for inpatient
41 hospital services shall include a mechanism for the prospective payment of
42 inpatient hospital capital related costs. The capital payment shall include
43 hospital specific and statewide average amounts. For tiered per diem rates
44 beginning on October 1, 1999, the capital related cost component is frozen at
45 the blended rate of forty per cent of the hospital specific capital cost and

1 sixty per cent of the statewide average capital cost in effect as of
2 January 1, 1999 and as further adjusted by the calculation of tier rates for
3 maternity and nursery as prescribed by law. The administration shall adjust
4 the capital related cost component by the data resources incorporated market
5 basket index for prospective payment system hospitals.

6 9. For graduate medical education programs:

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

29 (b) The monies available for graduate medical education programs
30 pursuant to this subdivision shall not exceed the fiscal year 2006-2007
31 appropriation adjusted annually by the increase or decrease in the index
32 published by the global insight hospital market basket index for prospective
33 hospital reimbursement. Graduate medical education programs eligible for
34 such reimbursement are not precluded from receiving reimbursement for funding
35 under subdivision (c) of this paragraph. Beginning July 1, 2006, the
36 administration shall distribute any monies appropriated for graduate medical
37 education above the amount prescribed in subdivision (a) of this paragraph in
38 the following order or priority:

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

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

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

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

7 (ii) For a portion of additional indirect graduate medical education
8 costs for programs that are located in a county with a population of less
9 than five hundred thousand persons at the time the residency position was
10 created or for a residency position that includes a rotation in a county with
11 a population of less than five hundred thousand persons at the time the
12 residency position was established. These programs must be approved by the
13 administration.

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

16 (e) Each graduate medical education program that receives funding
17 pursuant to subdivision (b) or (c) of this paragraph shall identify and
18 report to the administration the number of new residency positions created by
19 the funding provided in this paragraph, including positions in rural areas.
20 The program shall also report information related to the number of funded
21 residency positions that resulted in physicians locating their practice in
22 this state. The administration shall report to the joint legislative budget
23 committee by February 1 of each year on the number of new residency positions
24 as reported by the graduate medical education programs.

25 (f) Beginning July 1, 2007, local, county and tribal governments may
26 provide monies in addition to any state general fund monies appropriated for
27 graduate medical education in order to qualify for additional matching
28 federal monies for programs or positions in a specific locality and costs
29 incurred pursuant to a specific contract between the administration and
30 providers or other entities to provide graduate medical education services as
31 an administrative activity. These programs, positions and administrative
32 graduate medical education services must be approved by the administration
33 and the centers for medicare and medicaid services. The administration shall
34 report to the president of the senate, the speaker of the house of
35 representatives and the director of the joint legislative budget committee on
36 or before July 1 of each year on the amount of money contributed and number
37 of residency positions funded by local, county and tribal governments,
38 including the amount of federal matching monies used.

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

43 (h) For the purposes of this paragraph, "graduate medical education
44 program" means a program, including an approved fellowship, that prepares a
45 physician for the independent practice of medicine by providing didactic and

1 clinical education in a medical discipline to a medical student who has
2 completed a recognized undergraduate medical education program.

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

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

20 I. The director may adopt rules that specify enrollment procedures,
21 including notice to contractors of enrollment. The rules may provide for
22 varying time limits for enrollment in different situations. The
23 administration shall specify in contract when a person who has been
24 determined eligible will be enrolled with that contractor and the date on
25 which the contractor will be financially responsible for health and medical
26 services to the person.

27 J. The administration may make direct payments to hospitals for
28 hospitalization and medical care provided to a member in accordance with this
29 article and rules. The director may adopt rules to establish the procedures
30 by which the administration shall pay hospitals pursuant to this subsection
31 if a contractor fails to make timely payment to a hospital. Such payment
32 shall be at a level determined pursuant to section 36-2904, subsection H
33 or I. The director may withhold payment due to a contractor in the amount of
34 any payment made directly to a hospital by the administration on behalf of a
35 contractor pursuant to this subsection.

36 K. The director shall establish a special unit within the
37 administration for the purpose of monitoring the third party payment
38 collections required by contractors and noncontracting providers pursuant to
39 section 36-2903, subsection B, paragraph 10 and subsection F and section
40 36-2915, subsection E. The director shall determine by rule:

41 1. The type of third party payments to be monitored pursuant to this
42 subsection.

43 2. The percentage of third party payments that is collected by a
44 contractor or noncontracting provider and that the contractor or
45 noncontracting provider may keep and the percentage of such payments that the

1 contractor or noncontracting provider may be required to pay to the
2 administration. Contractors and noncontracting providers must pay to the
3 administration one hundred per cent of all third party payments that are
4 collected and that duplicate administration fee-for-service payments. A
5 contractor that contracts with the administration pursuant to section
6 36-2904, subsection A may be entitled to retain a percentage of third party
7 payments if the payments collected and retained by a contractor are reflected
8 in reduced capitation rates. A contractor may be required to pay the
9 administration a percentage of third party payments that are collected by a
10 contractor and that are not reflected in reduced capitation rates.

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

16 1. On written notice from the administration or oral or written notice
17 from a member that a claim for covered services may be in violation of this
18 section, the provider that has a contract with a contractor or noncontracting
19 provider shall investigate the inquiry and verify whether the person was
20 eligible for services at the time that covered services were provided. If
21 the claim was paid or should have been paid by the system, the provider that
22 has a contract with a contractor or noncontracting provider shall not
23 continue billing the member.

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

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

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

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

36 3. If the administration determines that a provider that has a
37 contract with a contractor or noncontracting provider has billed a member for
38 charges that were paid or should have been paid by the administration, the
39 administration shall send written notification by certified mail or other
40 service with proof of delivery to the provider that has a contract with a
41 contractor or noncontracting provider stating that this billing is in
42 violation of federal and state law. If, twenty-one days or more after
43 receiving the notification, a provider that has a contract with a contractor
44 or noncontracting provider knowingly continues billing a member for charges
45 that were paid or should have been paid by the system, the administration may

1 assess a civil penalty in an amount equal to three times the amount of the
2 billing and reduce payment to the provider that has a contract with a
3 contractor or noncontracting provider accordingly. Receipt of delivery
4 signed by the addressee or the addressee's employee is prima facie evidence
5 of knowledge. Civil penalties collected pursuant to this subsection shall be
6 deposited in the state general fund. Section 36-2918, subsections C, D and
7 F, relating to the imposition, collection and enforcement of civil penalties,
8 apply to civil penalties imposed pursuant to this paragraph.

9 M. The administration may conduct postpayment review of all claims
10 paid by the administration and may recoup any monies erroneously paid. The
11 director may adopt rules that specify procedures for conducting postpayment
12 review. A contractor may conduct a postpayment review of all claims paid by
13 the contractor and may recoup monies that are erroneously paid.

14 N. The director or the director's designee may employ and supervise
15 personnel necessary to assist the director in performing the functions of the
16 administration.

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

20 P. Notwithstanding any other law, on federal approval the
21 administration may make disproportionate share payments to private hospitals,
22 county operated hospitals, including hospitals owned or leased by a special
23 health care district, and state operated institutions for mental disease
24 beginning October 1, 1991 in accordance with federal law and subject to
25 legislative appropriation. If at any time the administration receives
26 written notification from federal authorities of any change or difference in
27 the actual or estimated amount of federal funds available for
28 disproportionate share payments from the amount reflected in the legislative
29 appropriation for such purposes, the administration shall provide written
30 notification of such change or difference to the president and the minority
31 leader of the senate, the speaker and the minority leader of the house of
32 representatives, the director of the joint legislative budget committee, the
33 legislative committee of reference and any hospital trade association within
34 this state, within three working days not including weekends after receipt of
35 the notice of the change or difference. In calculating disproportionate
36 share payments as prescribed in this section, the administration may use
37 either a methodology based on claims and encounter data that is submitted to
38 the administration from contractors or a methodology based on data that is
39 reported to the administration by private hospitals and state operated
40 institutions for mental disease. The selected methodology applies to all
41 private hospitals and state operated institutions for mental disease
42 qualifying for disproportionate share payments.

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

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

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

8 Sec. 3. Section 36-2907, Arizona Revised Statutes, is amended to read:
9 36-2907. Covered health and medical services; modifications;
10 related delivery of service requirements

11 A. Unless modified pursuant to this section, contractors shall provide
12 the following medically necessary health and medical services:

13 1. Inpatient hospital services that are ordinarily furnished by a
14 hospital for the care and treatment of inpatients and that are provided under
15 the direction of a physician or a primary care practitioner. For the
16 purposes of this section, inpatient hospital services ~~excludes~~ EXCLUDE
17 services in an institution for tuberculosis or mental diseases unless
18 authorized under an approved section 1115 waiver.

19 2. Outpatient health services that are ordinarily provided in
20 hospitals, clinics, offices and other health care facilities by licensed
21 health care providers. Outpatient health services include services provided
22 by or under the direction of a physician or a primary care practitioner but
23 do not include occupational therapy, PHYSICAL THERAPY or speech therapy for
24 eligible persons who are twenty-one years of age or older.

25 3. Other laboratory and x-ray services ordered by a physician or a
26 primary care practitioner.

27 4. Medications that are ordered on prescription by a physician or a
28 dentist licensed pursuant to title 32, chapter 11. ~~Beginning January 1,~~
29 ~~2006,~~ Persons who are dually eligible for title XVIII and title XIX services
30 must obtain available medications through a medicare licensed or certified
31 medicare advantage prescription drug plan, a medicare prescription drug plan
32 or any other entity authorized by medicare to provide a medicare part D
33 prescription drug benefit.

34 ~~5. Emergency dental care and extractions for persons who are at least~~
35 ~~twenty-one years of age.~~

36 ~~6. Medical supplies, equipment and prosthetic devices, not including~~
37 ~~hearing aids, ordered by a physician or a primary care practitioner or~~
38 ~~dentures ordered by a dentist licensed pursuant to title 32, chapter 11.~~
39 ~~Suppliers of durable medical equipment shall provide the administration with~~
40 ~~complete information about the identity of each person who has an ownership~~
41 ~~or controlling interest in their business and shall comply with federal~~
42 ~~bonding requirements in a manner prescribed by the administration.~~

43 ~~7.~~ 5. For persons who are at least twenty-one years of age, treatment
44 of medical conditions of the eye, excluding eye examinations for prescriptive

1 lenses, ~~and~~ the provision of prescriptive lenses AND OPTOMETRIST SERVICES
2 FOLLOWING CATARACT SURGERY.

3 ~~8-~~ 6. Early and periodic health screening and diagnostic services as
4 required by section 1905(r) of title XIX of the social security act for
5 members who are under twenty-one years of age.

6 ~~9-~~ 7. Family planning services that do not include abortion or
7 abortion counseling. If a contractor elects not to provide family planning
8 services, this election does not disqualify the contractor from delivering
9 all other covered health and medical services under this chapter. In that
10 event, the administration may contract directly with another contractor,
11 including an outpatient surgical center or a noncontracting provider, to
12 deliver family planning services to a member who is enrolled with the
13 contractor that elects not to provide family planning services.

14 ~~10. Podiatry services performed by a podiatrist licensed pursuant to~~
15 ~~title 32, chapter 7 and ordered by a primary care physician or primary care~~
16 ~~practitioner.~~

17 ~~11. Nonexperimental transplants approved for title XIX reimbursement.~~

18 ~~12-~~ 8. Ambulance and nonambulance transportation.

19 B. Beginning on October 1, 2002, circumcision of newborn males is not
20 a covered health and medical service.

21 C. The system shall pay noncontracting providers only for health and
22 medical services as prescribed in subsection A of this section and as
23 prescribed by rule.

24 D. The director shall adopt rules necessary to limit, to the extent
25 possible, the scope, duration and amount of services, including maximum
26 limitations for inpatient services that are consistent with federal
27 regulations under title XIX of the social security act (P.L. 89-97; 79 Stat.
28 344; 42 United States Code section 1396 (1980)). To the extent possible and
29 practicable, these rules shall provide for the prior approval of medically
30 necessary services provided pursuant to this chapter.

31 E. The director shall make available home health services in lieu of
32 hospitalization pursuant to contracts awarded under this article. For the
33 purposes of this subsection, "home health services" means the provision of
34 nursing services, home health aide services or medical supplies, equipment
35 and appliances, which are provided on a part-time or intermittent basis by a
36 licensed home health agency within a member's residence based on the orders
37 of a physician or a primary care practitioner. Home health agencies shall
38 comply with the federal bonding requirements in a manner prescribed by the
39 administration.

40 F. The director shall adopt rules for the coverage of behavioral
41 health services for persons who are eligible under section 36-2901, paragraph
42 6, subdivision (a). The administration shall contract with the department of
43 health services for the delivery of all medically necessary behavioral health
44 services to persons who are eligible under rules adopted pursuant to this
45 subsection. The division of behavioral health in the department of health

1 services shall establish a diagnostic and evaluation program to which other
2 state agencies shall refer children who are not already enrolled pursuant to
3 this chapter and who may be in need of behavioral health services. In
4 addition to an evaluation, the division of behavioral health shall also
5 identify children who may be eligible under section 36-2901, paragraph 6,
6 subdivision (a) or section 36-2931, paragraph 5 and shall refer the children
7 to the appropriate agency responsible for making the final eligibility
8 determination.

9 G. The director shall adopt rules for the provision of transportation
10 services and rules providing for copayment by members for transportation for
11 other than emergency purposes. Prior authorization is not required for
12 medically necessary ambulance transportation services rendered to members or
13 eligible persons initiated by dialing telephone number 911 or other
14 designated emergency response systems.

15 H. The director may adopt rules to allow the administration, at the
16 director's discretion, to use a second opinion procedure under which surgery
17 may not be eligible for coverage pursuant to this chapter without
18 documentation as to need by at least two physicians or primary care
19 practitioners.

20 I. If the director does not receive bids within the amounts budgeted
21 or if at any time the amount remaining in the Arizona health care cost
22 containment system fund is insufficient to pay for full contract services for
23 the remainder of the contract term, the administration, on notification to
24 system contractors at least thirty days in advance, may modify the list of
25 services required under subsection A of this section for persons defined as
26 eligible other than those persons defined pursuant to section 36-2901,
27 paragraph 6, subdivision (a). The director may also suspend services or may
28 limit categories of expense for services defined as optional pursuant to
29 title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United
30 States Code section 1396 (1980)) for persons defined pursuant to section
31 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not
32 apply to the continuity of care for persons already receiving these services.

33 J. Additional, reduced or modified hospitalization and medical care
34 benefits may be provided under the system to enrolled members who are
35 eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d)
36 or (e).

37 K. All health and medical services provided under this article shall
38 be provided in the geographic service area of the member, except:

39 1. Emergency services and specialty services provided pursuant to
40 section 36-2908.

41 2. That the director may permit the delivery of health and medical
42 services in other than the geographic service area in this state or in an
43 adjoining state if the director determines that medical practice patterns
44 justify the delivery of services or a net reduction in transportation costs
45 can reasonably be expected. Notwithstanding the definition of physician as

1 prescribed in section 36-2901, if services are procured from a physician or
2 primary care practitioner in an adjoining state, the physician or primary
3 care practitioner shall be licensed to practice in that state pursuant to
4 licensing statutes in that state similar to title 32, chapter 13, 15, 17 or
5 25 and shall complete a provider agreement for this state.

6 L. Covered outpatient services shall be subcontracted by a primary
7 care physician or primary care practitioner to other licensed health care
8 providers to the extent practicable for purposes including, but not limited
9 to, making health care services available to underserved areas, reducing
10 costs of providing medical care and reducing transportation costs.
11 **OUTPATIENT SERVICES DO NOT INCLUDE PHYSICAL THERAPY, OCCUPATIONAL THERAPY OR**
12 **SPEECH THERAPY.**

13 M. The director shall adopt rules that prescribe the coordination of
14 medical care for persons who are eligible for system services. The rules
15 shall include provisions for the transfer of patients, the transfer of
16 medical records and the initiation of medical care.

17 N. **THE ADMINISTRATION SHALL NOT SPEND MONIES ON OR AUTHORIZE A**
18 **CONTRACTOR TO PROVIDE THE FOLLOWING SERVICES:**

19 1. **PHYSICAL THERAPY, OCCUPATIONAL THERAPY OR SPEECH THERAPY.**

20 2. **HOSPICE CARE FOR PERSONS WHO ARE NOT ELIGIBLE UNDER ARTICLE 2 OF**
21 **THIS CHAPTER.**

22 Sec. 4. Title 36, chapter 29, article 1, Arizona Revised Statutes, is
23 amended by adding section 36-2907.02, to read:

24 **36-2907.02. Benefit plan; health and medical services**

25 A. **THE ADMINISTRATION SHALL DESIGN AND REVISE THE HEALTH BENEFIT PLAN**
26 **OFFERED TO THE FOLLOWING POPULATIONS TO BE CONSISTENT WITH THE SERVICES**
27 **PROVIDED IN THE STATE EMPLOYEE HEALTH BENEFIT PLAN AUTHORIZED IN TITLE 38,**
28 **CHAPTER 4, ARTICLE 4:**

29 1. **CHILDREN WHO ARE ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 6,**
30 **SUBDIVISION (a), ITEM (ii).**

31 2. **PERSONS WHO ARE EIGHTEEN YEARS OF AGE OR OLDER, WHO ARE ELIGIBLE**
32 **UNDER SECTION 36-2901 AND WHO DO NOT HAVE CHILDREN.**

33 B. **IN ADDITION TO THE BENEFITS PROVIDED PURSUANT TO SUBSECTION A OF**
34 **THIS SECTION, THE HEALTH BENEFIT PLAN MAY BE MODIFIED TO MEET FEDERAL**
35 **REQUIREMENTS.**

36 C. **INDIVIDUALS WHO ARE ELIGIBLE UNDER SECTION 36-2901 MAY ENROLL IN**
37 **EITHER A HEALTH PLAN AUTHORIZED UNDER THIS ARTICLE OR THE HEALTH BENEFIT PLAN**
38 **AUTHORIZED BY THIS SECTION.**

39 D. **THIS SECTION SHALL BE IMPLEMENTED TO EXTENT PERMITTED UNDER THE**
40 **FEDERAL DEFICIT REDUCTION ACT OF 2005 AND OTHER FEDERAL LAWS, SUBJECT TO THE**
41 **APPROVAL OF FEDERAL WAIVER AUTHORITY AND TO THE EXTENT THAT ANY CHANGES IN**
42 **THE HEALTH BENEFITS OFFERED UNDER THIS SECTION WOULD PERMIT THIS STATE TO**
43 **RECEIVE ANY ENHANCED FEDERAL MATCHING RATE.**

1 Sec. 5. Transplants: repeal
2 Sections 36-2907.10, 36-2907.11 and 36-2907.12, Arizona Revised
3 Statutes, are repealed.

4 Sec. 6. Repeal
5 Title 46, chapter 2, article 2, Arizona Revised Statutes, is repealed.

6 Sec. 7. Section 46-292, Arizona Revised Statutes, is amended to read:
7 46-292. Eligibility for assistance

8 A. Cash assistance may be given under this title to any dependent
9 child:

10 1. Who has established residence in Arizona at the time of application
11 and is either:

12 (a) A citizen by birth or naturalization.

13 (b) A qualified alien who entered the United States on or before
14 August 21, 1996.

15 (c) A qualified alien who entered the United States as a member of one
16 of the exception groups under Public Law 104-193, section 412, in which case
17 the person shall be determined eligible in accordance with Public Law
18 104-193.

19 (d) Defined as a qualified alien by the attorney general of the United
20 States under the authority of Public Law 104-208, section 501.

21 For the purposes of subdivisions (b) and (c) of this paragraph, "qualified
22 alien" means a person who is defined as a qualified alien under Public Law
23 104-193, section 431.

24 2. Whose parent or parents or person or persons acting in the parents'
25 place, if employable, do not refuse to accept available employment and any
26 employable child in the family does not refuse to accept available
27 employment. The department shall assess the applicant's employability at the
28 time of initial application for assistance to establish a self-sufficiency
29 diversion option, if appropriate, before benefit issuance. The determination
30 of employability and the conditions under which employment shall be required
31 shall be determined by the state department, except that claimed
32 unemployability because of physical or mental incapacity shall be determined
33 by the state department in accordance with this title.

34 3. Whose parent or parents or other relatives who are applying for or
35 receiving assistance on behalf of the child have not, within one year prior
36 to application, or while a recipient, transferred or assigned real or
37 personal property with the intent to evade federal or state eligibility
38 requirements. Transfer of property with retention of a life estate for the
39 purpose of qualifying for assistance is prohibited. Where fair consideration
40 for the property was received, no inquiry into motive is necessary. A person
41 found ineligible under this section shall be ineligible for such time as the
42 state department determines.

43 B. Qualified aliens entering the United States after August 21, 1996
44 are ineligible for benefits for a period of five years beginning on their
45 date of entry, except for Cuban and Haitian entrants as defined in section

1 501(e)(2) of the refugee education assistance act of 1980 and exceptions
2 provided under Public Law 104-193 (personal responsibility and work
3 opportunity reconciliation act of 1996) and Public Law 105-32 (balanced
4 budget act of 1997).

5 C. A parent or any other relative who applies for or receives cash
6 assistance under this title on behalf of a child shall cooperate with the
7 department by taking the following actions:

8 1. Providing information regarding the identity of the child's father
9 and mother and other pertinent information including their names, social
10 security numbers and current addresses or a sworn statement that attests to
11 the lack of this information and that is accompanied by facts supporting the
12 asserted lack of information.

13 2. Appearing at interviews, hearings and legal proceedings.

14 3. Submitting and having the child submit to genetic testing.

15 4. Signing authorizations for third parties to release information
16 concerning the applicant or the child, or both.

17 5. In cases in which parentage has not been established, providing a
18 sworn statement alleging paternity and setting forth facts establishing a
19 reasonable possibility of the requisite sexual contact between the parties.

20 6. Supplying additional information the department requires.

21 D. The department shall sanction a recipient who fails, without good
22 cause as prescribed in subsection E of this section, to cooperate with child
23 support enforcement efforts according to the sanction provisions of section
24 46-300.

25 E. One or more of the following circumstances constitute good cause
26 for failure to cooperate with child support enforcement efforts:

27 1. Cooperation may result in physical or emotional harm to the parent,
28 child for whom support is sought or caretaker relative with whom the child is
29 living.

30 2. Legal proceedings for adoption of the child for whom support is
31 sought are pending before a court.

32 3. The participant has been working, for less than ninety days, with a
33 public or licensed private social agency on the issue of whether to allow the
34 child for whom support is sought to be adopted.

35 4. The child for whom support is sought was conceived as a result of
36 sexual assault pursuant to section 13-1406 or incest.

37 F. A person claiming good cause has twenty days from the date the good
38 cause claim is provided to the agency to supply evidence supporting the
39 claim. When determining whether the parent or relative is cooperating with
40 the agency as provided in subsection C of this section, the agency shall
41 require:

42 1. If the good cause exception in subsection E, paragraph 1 of this
43 section is claimed, law enforcement, court, medical, criminal, psychological,
44 social service or governmental records or sworn statements from persons with
45 personal knowledge of the circumstances that indicate that the alleged parent

1 or obligor might inflict physical harm on the parent, child or caretaker
2 relative.

3 2. If the good cause exception in subsection E, paragraph 2 of this
4 section is claimed, court documents that indicate that legal proceedings for
5 adoption are pending before a court of competent jurisdiction.

6 3. If the good cause exception in subsection E, paragraph 3 of this
7 section is claimed, records from a public or licensed private social services
8 agency showing that placing the child for whom support is sought is under
9 consideration.

10 4. If the good cause exception in subsection E, paragraph 4 of this
11 section is claimed, law enforcement, court, medical, criminal, psychological,
12 social service or governmental records or sworn statements from persons with
13 personal knowledge of the circumstances surrounding the conception of the
14 child that indicate the child was conceived as a result of sexual assault
15 pursuant to section 13-1406 or incest.

16 G. Notwithstanding subsection A of this section and except as provided
17 in subsection H of this section, a dependent child or children who are born
18 during one of the following time periods are not eligible for assistance
19 under this title:

20 1. The period in which the parent or other relative is receiving
21 assistance benefits.

22 2. The temporary period in which the parent or other relative is
23 ineligible pursuant to a penalty imposed by the department for failure to
24 comply with benefit eligibility requirements, after which the parent or other
25 relative is eligible for a continuation of benefits.

26 3. Any period after November 1, 1995 that is less than sixty months
27 between a voluntary withdrawal from program benefits or a period of
28 ineligibility for program benefits which immediately followed a period during
29 which program benefits were received and a subsequent reapplication and
30 eligibility approval for benefits.

31 H. The following exceptions apply to subsection G of this section:

32 1. The department shall allow an increase in cash assistance under the
33 program for a dependent child or children born as a result of an act of
34 sexual assault as prescribed in section 13-1406 or incest. The department
35 shall ensure that the proper law enforcement authorities are notified of
36 allegations of sexual assault or incest made pursuant to this paragraph. For
37 the purposes of this paragraph, "an act of sexual assault" includes sexual
38 assault of a spouse if the offense was committed before ~~the effective date of~~
39 ~~this amendment to this section~~ **AUGUST 12, 2005.**

40 2. For those parents or other relatives who are currently authorized
41 for cash assistance the department shall allow an increase in cash assistance
42 under the program as a result of the birth of a child or children to the
43 parent or other relative only if the birth occurred within ten months of the
44 initial eligible month. The department may use only the additional child or

1 children who are born from the pregnancies covered in this subsection in
2 computing the additional benefit.

3 3. The department shall allow an increase in cash assistance for any
4 dependent child born to a parent who has not received cash assistance under
5 this title for at least twelve consecutive months if the child is born within
6 the period beginning ten months after the twelve consecutive month period and
7 ending ten months after the parent resumes receiving cash assistance.

8 4. A dependent child or children who were born during a period in
9 which the custodial parent received cash assistance through the Arizona works
10 program shall be eligible to receive assistance under this title.

11 5. A dependent child or children who were born within ten months after
12 the custodial parent received cash assistance through the Arizona works
13 program shall be eligible to receive assistance under this title.

14 I. The department shall calculate the sixty-month time period
15 referenced in subsection G, paragraph 3 of this section in the following
16 manner:

17 1. For persons who are receiving cash assistance on November 1, 1995,
18 the sixty-month time period begins on November 1, 1995. A subsequent
19 sixty-month time period begins immediately after the previous period ends if
20 the person is receiving cash assistance through two sixty-month periods. If
21 the individual is not receiving cash assistance at the end of the previous
22 sixty-month period, any subsequent sixty-month time period begins on the date
23 when cash assistance became effective again, regardless of when the person
24 received an actual payment.

25 2. For persons who begin receiving cash assistance after November 1,
26 1995, the sixty-month time period begins on the date cash assistance becomes
27 effective, regardless of when the person received an actual payment. A
28 subsequent sixty-month period begins as provided in paragraph 1 of this
29 subsection.

30 J. In calculating a parent's or any other relative's benefit increase
31 that arises from any general increase that has been approved for all program
32 recipients, the department shall not consider a child or children born under
33 the time periods listed in subsection G of this section.

34 K. For the parents or other relatives who have additional children for
35 whom they receive no cash assistance payment under subsection G of this
36 section, the department shall make any necessary program amendments or
37 request any necessary federal waivers to allow the parents or other relatives
38 to earn income in an amount equal to the disallowed cash assistance payment
39 without affecting their eligibility for assistance.

40 L. The director shall adopt rules:

41 1. To implement this section including rules to define the
42 investigatory steps which must be taken to confirm that an act of sexual
43 assault or incest led to the birth of a dependent child or children.

44 2. That require the department to inform both verbally and in writing
45 the parents and other relatives who are receiving assistance under this

1 article of the specific family planning services that are available to them
2 while they are enrolled as eligible persons in the Arizona health care cost
3 containment system.

4 M. Nothing in this section shall be construed to prevent an otherwise
5 eligible child who is not included in the family's calculation of benefits
6 under this article from being eligible for coverage under title 36, chapter
7 29 or for any services that are directly linked to eligibility for the
8 temporary assistance for needy families program.

9 N. Assistance shall not be denied or terminated under this article
10 because the principal wage earner works one hundred or more hours per month.

11 O. The department shall include all income from every source available
12 to the person requesting cash assistance, except income that is required to
13 be disregarded by this subsection and as determined by the department in
14 rules. For the amount of income that is received from employment, each month
15 every employed person is entitled to receive an earned income disregard of
16 ninety dollars plus an additional thirty per cent of the remaining earned
17 income. A household that includes an employed person is entitled to an
18 earned income disregard equal to the actual amount billed to the household
19 for the care of an adult or child dependent household member, up to two
20 hundred dollars a month for a child under two years of age and up to one
21 hundred seventy-five dollars a month for each other dependent. This
22 dependent care disregard is allowed only if the expense is necessary to allow
23 the household member to become or remain employed or to attend postsecondary
24 training or education that is preparatory to employment.

25 P. Any parent or other relative who applies for or receives cash
26 assistance under this article on behalf of a dependent child who is between
27 six and sixteen years of age shall ensure that the child is enrolled in and
28 attending school. An initial applicant is ineligible for benefits until the
29 applicant's dependent children are verified to be enrolled in and attending
30 an educational program. The department of education shall assist the
31 department of economic security in obtaining verification of school
32 enrollment and attendance. The director of the department of economic
33 security may adopt rules for granting good cause exceptions from this
34 subsection. The department of economic security shall sanction a recipient
35 who fails, without good cause, to ensure school enrollment and attendance
36 according to section 46-300.

37 Q. Any parent or other relative who applies for or receives cash
38 assistance under this section on behalf of a dependent child shall ensure
39 that the child is immunized in accordance with the schedule of immunizations
40 pursuant to section 36-672. The director of the department of economic
41 security may adopt rules for granting good cause exceptions from this
42 subsection. The department of economic security shall sanction a recipient,
43 in accordance with section 46-300, who fails, without good cause, to obtain
44 the required immunizations for a dependent child unless the recipient submits

1 to the department of economic security the documentation described in section
2 15-873.

3 R. ELIGIBILITY FOR ASSISTANCE UNDER THIS SECTION IS CONTINGENT ON THE
4 RECIPIENT ANNUALLY SUBMITTING TO AND PASSING A DRUG-SCREENING TEST AS
5 ADMINISTERED BY THE DEPARTMENT AT THE DEPARTMENT'S EXPENSE.

6 Sec. 8. Laws 2008, chapter 288, section 10 is amended to read:

7 Sec. 10. County transfers; fiscal year 2008-2009; county
8 expenditure limitations

9 A. Notwithstanding any other law, in fiscal year 2008-2009, counties
10 with a population of two million or more persons shall transfer \$24,168,400
11 and counties with a population of more than eight hundred thousand persons
12 but less than two million persons shall transfer \$3,794,400 to the Arizona
13 health care cost containment system administration for deposit in the ~~budget~~
14 ~~neutrality compliance~~ STATE GENERAL fund ~~established by section 36-2928,~~
15 ~~Arizona Revised Statutes.~~

16 B. Notwithstanding any other law, a county may meet any statutory
17 funding requirements of this section from any source of county revenue
18 designated by the county, including funds of any county wide special taxing
19 district in which the board of supervisors serves as the board of directors.

20 C. Contributions made pursuant to this section are excluded from the
21 county expenditure limitations.

22 Sec. 9. Laws 2008, chapter 288, section 11 is amended to read:

23 Sec. 11. AHCCCS; transfers

24 Notwithstanding any other law, in fiscal year 2008-2009, the Arizona
25 health care cost containment system administration shall not transfer
26 \$17,830,500 to counties for refunds of county Arizona long-term care system
27 costs for fiscal year 2006-2007 and fiscal year 2007-2008 and shall instead
28 deposit the \$17,830,500 in the ~~budget neutrality compliance~~ STATE GENERAL
29 fund ~~established by section 36-2928, Arizona Revised Statutes.~~

30 Sec. 10. Laws 2008, chapter 288, section 13 is amended to read:

31 Sec. 13. AHCCCS; disproportionate share payments

32 Disproportionate share payments for fiscal year 2008-2009 made pursuant
33 to section 36-2903.01, subsection P, Arizona Revised Statutes, include:

34 1. \$89,877,700 for a qualifying nonstate operated public hospital.
35 The Maricopa county special health care district shall provide a certified
36 public expense form for the amount of qualifying disproportionate share
37 hospital expenditures made on behalf of this state to the administration on
38 or before May 1, 2009 for all state plan years as required by the Arizona
39 health care cost containment system 1115 waiver standard terms and
40 conditions. The administration shall assist the district in determining the
41 amount of qualifying disproportionate share hospital expenditures. Once the
42 administration files a claim with the federal government and receives federal
43 funds participation based on the amount certified by the Maricopa county
44 special health care district, ~~THE ADMINISTRATION SHALL DEPOSIT THE MONIES IN~~
45 ~~THE STATE GENERAL FUND. if the certification is equal to or greater than~~

1 ~~\$89,877,700, the administration shall distribute \$4,202,300 to the Maricopa~~
 2 ~~county special health care district and deposit the balance of the federal~~
 3 ~~funds participation in the state general fund. If the certification provided~~
 4 ~~is for an amount less than \$89,877,700, and the administration determines~~
 5 ~~that the revised amount is correct pursuant to the methodology used by the~~
 6 ~~administration pursuant to section 36-2903.01, Arizona Revised Statutes, the~~
 7 ~~administration shall notify the governor, the president of the senate and the~~
 8 ~~speaker of the house of representatives, shall distribute \$4,202,300 to the~~
 9 ~~Maricopa county special health care district and shall deposit the balance of~~
 10 ~~the federal funds participation in the state general fund. If the~~
 11 ~~certification provided is for an amount less than \$89,877,700 and the~~
 12 ~~administration determines that the revised amount is not correct pursuant to~~
 13 ~~the methodology used by the administration pursuant to section 36-2903.01,~~
 14 ~~Arizona Revised Statutes, the administration shall notify the governor, the~~
 15 ~~president of the senate and the speaker of the house of representatives and~~
 16 ~~shall deposit the total amount of the federal funds participation in the~~
 17 ~~state general fund.~~

18 2. \$28,614,300 for the Arizona state hospital. The Arizona state
 19 hospital shall provide a certified public expense form for the amount of
 20 qualifying disproportionate share hospital expenditures made on behalf of the
 21 state to the administration on or before March 31, 2009. The administration
 22 shall assist the Arizona state hospital in determining the amount of
 23 qualifying disproportionate share hospital expenditures. Once the
 24 administration files a claim with the federal government and receives federal
 25 funds participation based on the amount certified by the Arizona state
 26 hospital, the administration shall distribute the entire amount of federal
 27 financial participation to the state general fund. If the certification
 28 provided is for an amount less than \$28,614,300, the administration shall
 29 notify the governor, the president of the senate and the speaker of the house
 30 of representatives and shall distribute the entire amount of federal
 31 financial participation to the state general fund. The certified public
 32 expense form provided by the Arizona state hospital shall contain both the
 33 total amount of qualifying disproportionate share hospital expenditures and
 34 the amount limited by section 1923(g) of the social security act.

35 3. \$26,147,700 for private qualifying disproportionate share
 36 hospitals.

37 Sec. 11. Competency restoration treatment; city and county
 38 reimbursement; fiscal year 2008-2009; deposit; tax
 39 withholding

40 A. Notwithstanding section 13-4512, Arizona Revised Statutes, if this
 41 state pays the costs of a defendant's inpatient competency restoration
 42 treatment pursuant to section 13-4512, Arizona Revised Statutes, the city or
 43 county shall reimburse the department of health services for eighty-six per
 44 cent of these costs for fiscal year 2008-2009, except for those counties with

1 populations of less than eight hundred thousand persons who shall pay fifty
2 per cent of these costs for fiscal year 2008-2009.

3 B. The department of health services shall deposit the reimbursements,
4 pursuant to sections 35-146 and 35-147, Arizona Revised Statutes, in the
5 Arizona state hospital fund established by section 36-545.08, Arizona Revised
6 Statutes.

7 C. Each city and county shall make the reimbursements for these costs
8 as specified in subsection A of this section within thirty days after a
9 request by the department of health services. If the city or county does not
10 make the reimbursement, the superintendent of the Arizona state hospital
11 shall notify the state treasurer of the amount owed and the treasurer shall
12 withhold the amount, including any additional interest as provided in section
13 42-1123, Arizona Revised Statutes, from any transaction privilege tax
14 distributions to the city or county. The treasurer shall deposit the
15 withholdings, pursuant to sections 35-146 and 35-147, Arizona Revised
16 Statutes, in the Arizona state hospital fund established by section
17 36-545.08, Arizona Revised Statutes.

18 Sec. 12. Child care eligibility; report

19 Notwithstanding section 46-803, Arizona Revised Statutes, for fiscal
20 year 2008-2009, the department of economic security may reduce maximum income
21 eligibility levels for child care assistance in order to manage within
22 appropriated and available monies. The department of economic security shall
23 notify the joint legislative budget committee of any change in maximum income
24 eligibility levels for child care within fifteen days after implementing that
25 change.

26 Sec. 13. Arizona health care cost containment system: optional
27 services: expenditure prohibition

28 Notwithstanding Laws 2008, chapter 285, section 3, the Arizona health
29 care cost containment system shall not spend monies on the following optional
30 services:

- 31 1. Hospice services for non-ALTCS members.
- 32 2. Therapy services.
- 33 3. Optometrist service following cataract surgery.
- 34 4. Screening, diagnostics, rehabilitation and preventive services.
- 35 5. Other practitioner services.

36 Sec. 14. Disproportionate share payments

37 Notwithstanding Laws 2008, chapter 285, section 3, the sum of
38 \$8,922,200 appropriated for disproportionate share payments reverts to the
39 state general fund on the effective date of this act.

40 Sec. 15. Conforming legislation

41 The legislative council staff shall prepare proposed legislation
42 conforming the Arizona Revised Statutes to the provisions of this act for
43 consideration in the forty-ninth legislature, first regular session.