

COMMITTEE ON APPROPRIATIONS  
HOUSE OF REPRESENTATIVES AMENDMENTS TO S.B. 1619  
(Reference to Senate engrossed bill)

1 Strike everything after the enacting clause and insert:

2 "Section 1. Title 36, chapter 2, article 3, Arizona Revised Statutes,  
3 is amended by adding section 36-260, to read:

4 36-260. Definitions

5 IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

6 1. "ADMINISTRATION" MEANS THE ARIZONA HEALTH CARE COST CONTAINMENT  
7 SYSTEM ADMINISTRATION.

8 2. "CHRONICALLY ILL OR PHYSICALLY DISABLED CHILDREN" MEANS CHILDREN  
9 WHO ARE UNDER TWENTY-ONE YEARS OF AGE AND WHOSE PRIMARY DIAGNOSIS IS A SEVERE  
10 PHYSICAL CONDITION THAT MAY REQUIRE ONGOING, MEDICAL OR SURGICAL  
11 INTERVENTION.

12 3. "DIRECTOR" MEANS THE DIRECTOR OF THE ARIZONA HEALTH CARE COST  
13 CONTAINMENT SYSTEM ADMINISTRATION.

14 Sec. 2. Section 36-261, Arizona Revised Statutes, is amended to read:

15 36-261. Powers and duties; expenditure limitation

16 A. The ~~department of health services~~ ARIZONA HEALTH CARE COST  
17 CONTAINMENT SYSTEM ADMINISTRATION shall:

18 1. Employ a full-time or part-time medical director and a full-time or  
19 part-time administrator for children's rehabilitative services who shall have  
20 such titles and duties as shall be fixed by the director. Compensation of  
21 the medical director and the administrator shall be as determined pursuant to  
22 section 38-611.

23 2. Supervise, control and establish policies for children's  
24 rehabilitative services.

25 3. Adopt all rules and policies for the operation of a children's  
26 rehabilitative services program.

27 4. Employ ~~such~~ NECESSARY medical and other staff ~~as may be needed~~,  
28 including resident physicians, whose compensation shall be as determined  
29 pursuant to section 38-611.

30 5. Establish and administer a program of service for children who are  
31 ~~crippled~~ CHRONICALLY ILL OR PHYSICALLY DISABLED or who are suffering from  
32 conditions ~~which~~ THAT lead to ~~crippling~~ A CHRONIC ILLNESS OR PHYSICAL  
33 DISABILITIES. The program shall provide for:

34 (a) Development, extension and improvement of services for locating  
35 ~~such~~ THESE children.

36 (b) Furnishing of medical, surgical, corrective and other services and  
37 care.

38 (c) Furnishing of facilities for diagnosis, hospitalization and  
39 aftercare.

40 (d) Supervision of the administration of services in the program ~~which~~  
41 THAT are not administered directly by the ~~department~~ ADMINISTRATION.

42 (e) The extension and improvement of any services included in the  
43 program of services for chronically ill or physically disabled children as  
44 required by this section.

1 (f) Cooperation with medical, health, nursing and welfare groups and  
2 organizations and with any agency of the state charged with administration of  
3 laws providing for vocational rehabilitation of physically ~~handicapped~~  
4 **DISABLED** children.

5 (g) Cooperation with the federal government through its appropriate  
6 agency or instrumentality in developing, extending and improving services for  
7 chronically ill or physically disabled children.

8 (h) Receipt and expenditure of funds made available to the ~~department~~  
9 **ADMINISTRATION** for services to chronically ill or physically disabled  
10 children by the federal government, ~~the~~ **THIS** state or its political  
11 subdivisions or from other sources excluding monies received from parents or  
12 guardians for the care of children.

13 (i) Carrying on research and compiling statistics.

14 (j) Making necessary expenditures in connection with the duties  
15 provided in this section.

16 (k) Establishing and maintaining safeguards relating to the  
17 confidential aspect of medical records.

18 (l) Acceptance and use of federal funds for children's rehabilitative  
19 services at the discretion of the ~~department~~ **ADMINISTRATION** and subject to  
20 any limitations imposed by the annual state appropriation bill.

21 (m) Such other duties ~~and responsibilities~~ found necessary for the  
22 effective operation of a program for chronically ill or physically disabled  
23 children.

24 6. Establish a statewide computerized information and referral service  
25 for chronically ill or physically disabled children to link those children  
26 and their families with local service providers.

27 7. Deposit in the state general fund all monies received from parents  
28 or guardians for the care of children.

29 8. Deposit in the state general fund all monies received from adults,  
30 other responsible persons, agencies or third party payors for care provided  
31 pursuant to section 36-797.44.

32 B. In order to carry out the provisions of subsection A of this  
33 section, the director may operate outpatient treatment facilities for  
34 chronically ill or physically disabled children and shall contract on the  
35 basis of competitive sealed bids for the care and treatment of chronically  
36 ill or physically disabled children ~~in accordance with~~ **PURSUANT TO** subsection  
37 C of this section.

38 C. The director shall prepare and issue a public request for proposal  
39 including a proposed contract format, at least once every four years, to  
40 contract for the care and treatment of chronically ill or physically disabled  
41 children subject to the following authorizations and limitations:

42 1. The scope of the contracted services shall include inpatient  
43 treatment services, physician services and other care and treatment services  
44 and outpatient treatment services which shall not be mandated at a single  
45 location.

46 2. Bids may be accepted from hospital and medical service  
47 corporations, health care services organizations, hospitals, physicians and  
48 any other qualified public or private persons.

1           3. A bidder's direct costs, as defined in the request for proposal,  
2 shall be disclosed in and be the basis of the bid submitted. Direct costs  
3 shall not include depreciable real or personal property with an original cost  
4 of over one thousand dollars. For bid evaluation purposes only, the director  
5 shall specify a uniform assumed collection rate applicable to all  
6 bidders. If the director executes fee-for-services health care contracts,  
7 the contracts shall provide the maximum payment to be made for specific  
8 procedures and services.

9           4. The ~~department~~ ADMINISTRATION may award a contract at an amount  
10 less than the amount bid, by use of any procedure authorized by the  
11 procurement code.

12           5. If the director receives an insufficient number of bids for a  
13 category of services or in a medical emergency, the director may contract  
14 directly for ~~such~~ THESE services.

15           6. An invitation for bids, a request for proposals or ANY other  
16 solicitation may be cancelled or any or all bids or proposals may be rejected  
17 in whole or in part as may be specified in the solicitation if it is in the  
18 best interests of this state. The reasons for the cancellation or rejection  
19 shall be made part of the contract file. If the amount appropriated for  
20 services provided pursuant to this section is insufficient to pay for the  
21 scope of services as bid, the director may reduce the scope of services to  
22 reflect the amount appropriated or may cancel any invitation for bids,  
23 requests for proposals or other solicitation and contract directly for ~~such~~  
24 THESE services. ~~Such~~ Reductions or suspensions ~~shall~~ DO not apply to the  
25 continuity of care for persons already receiving ~~such~~ THE services. Any  
26 decision to reduce services shall be made independently from any other  
27 modification of services.

28           7. The provisions of title 41, chapter 23 shall apply to the  
29 procurement process ~~set forth~~ PRESCRIBED in this section to the extent that  
30 they are not inconsistent with the provisions of this section. The director  
31 may vary the bid format and the terms of the request for proposal each bid  
32 term.

33           D. In awarding contracts for inpatient and outpatient treatment  
34 services under this section, the ~~department~~ ADMINISTRATION shall use the  
35 following criteria in addition to other consistent criteria:

36           1. Cost to this state.

37           2. The treatment facility's demonstrated experience in and  
38 qualifications for providing pediatric services.

39           E. If the provision of any services ~~under~~ PURSUANT TO this section  
40 requires compliance with chapter 4, article 2 of this title, the contractor  
41 shall comply ~~prior to~~ BEFORE commencement of services ~~under~~ PURSUANT TO this  
42 section.

43           F. SUBJECT TO THE AVAILABILITY OF APPROPRIATIONS, the ~~department~~  
44 ADMINISTRATION may, ~~subject to appropriation therefor,~~ provide or arrange for  
45 the provision of health services and supervisory care for child patients of  
46 other state agencies.

1 G. The ~~department may~~ ADMINISTRATION, through the children's  
2 rehabilitative services division, MAY establish and administer a program for  
3 children with sickle cell anemia, as provided for in section 36-797.43.

4 H. The ~~department may~~ ADMINISTRATION, through the children's  
5 rehabilitative services division, MAY establish and administer a program for  
6 adults with sickle cell anemia, as provided for in section 36-797.44.

7 I. The director may provide for the education of inpatients at any  
8 facility ~~which~~ THAT contracts with the director to provide care and treatment  
9 of chronically ill or physically disabled children. The director shall  
10 include in ~~his~~ THE DIRECTOR'S annual proposed budget a request for sufficient  
11 monies to finance the education of inpatients as authorized in this  
12 subsection.

13 J. The total amount of state monies that may be spent in any fiscal  
14 year by the ~~department of health services~~ ADMINISTRATION for children's  
15 rehabilitative services shall not exceed the amount appropriated or  
16 authorized by section 35-173 for that purpose. This section ~~shall~~ DOES  
17 ~~not be construed to~~ impose a duty on an officer, agent or employee of this state  
18 to discharge a responsibility or to create any right in a person or group if  
19 the discharge or right would require an expenditure of state monies in excess  
20 of the expenditure authorized by legislative appropriation for that specific  
21 purpose.

22 Sec. 3. Section 36-262, Arizona Revised Statutes, is amended to read:

23 36-262. Central statewide information and referral service for  
24 chronically ill or physically disabled children

25 ~~A. For the purposes of this section, "chronically ill or physically~~  
26 ~~disabled children" means children who are under twenty-one years of age and~~  
27 ~~whose primary diagnosis is a severe physical condition which may require~~  
28 ~~ongoing, medical or surgical intervention.~~

29 ~~B.~~ A. The purposes of the information and referral service for  
30 chronically ill or physically disabled children AS PRESCRIBED PURSUANT TO  
31 THIS ARTICLE are to:

32 1. Establish a roster of agencies providing medical, educational,  
33 financial, social and transportation services to chronically ill or  
34 physically disabled children.

35 2. Develop or use an existing statewide, computerized information and  
36 referral service that provides information on services for chronically ill or  
37 physically disabled children.

38 ~~C.~~ B. ~~Nothing in~~ This section ~~shall~~ DOES NOT require any person or  
39 public or private agency or other entity to participate in the information  
40 and referral service.

41 Sec. 4. Section 36-263, Arizona Revised Statutes, is amended to read:

42 36-263. Eligibility for children's rehabilitative services

43 A. Any chronically ill or physically disabled person or the person's  
44 parent or legal guardian who applies for children's rehabilitative services  
45 is subject to a preliminary financial screening process developed by the  
46 ~~department in coordination with the Arizona health care cost containment~~  
47 ~~system~~ administration ~~to be administered~~ at the initial intake level. If the  
48 results of a screening indicate that a child may be title XIX eligible, in

1 order to continue to receive services pursuant to this article the applicant  
2 must then submit a complete application within ten working days to the  
3 department of economic security, or the ~~Arizona health care cost containment~~  
4 ~~system~~ administration, which shall determine the applicant's eligibility  
5 pursuant to section 36-2901, paragraph 6, subdivision (a) or section 36-2931,  
6 paragraph 5 for health and medical or long-term care services. If the person  
7 is in need of emergency services provided pursuant to this article, the  
8 person may begin to receive these services immediately, provided that within  
9 five days from the date of service a financial screen is initiated.

10 B. Applicants who refuse to cooperate in the financial screen and  
11 eligibility process are not eligible for services pursuant to this  
12 article. A form explaining loss of benefits due to refusal to cooperate  
13 shall be signed by the applicant. Refusal to cooperate shall not be  
14 construed to mean the applicant's inability to obtain documentation required  
15 for eligibility determination.

16 C. The department of economic security ~~shall~~, in coordination with the  
17 ~~department of health services~~ ADMINISTRATION, SHALL provide on-site  
18 eligibility determination at appropriate program locations subject to  
19 legislative appropriation.

20 D. This section only applies to persons who receive services that are  
21 provided pursuant to this section and that are paid for in whole or in part  
22 with state funds.

23 E. Notwithstanding any other law, ~~beginning on July 1, 2000~~, the  
24 ~~department of health services~~ ADMINISTRATION shall not provide services in  
25 the children's rehabilitative services non-title XIX program to persons who  
26 are not citizens of the United States or who do not meet the alienage  
27 requirements that are established pursuant to title XIX of the social  
28 security act. This subsection does not apply to persons who are receiving  
29 services before August 6, 1999.

30 Sec. 5. Section 36-264, Arizona Revised Statutes, is amended to read:

31 36-264. Coordination of benefits; third party payments;  
32 definition

33 A. The ~~department of health services~~ ADMINISTRATION shall establish a  
34 benefit recovery program for state funded services to persons who receive  
35 services pursuant to this article ~~which~~ THAT are covered in whole or in part  
36 by a first party health insurance medical benefit. The ~~department of health~~  
37 ~~services~~ ADMINISTRATION shall coordinate benefits provided ~~under~~ PURSUANT TO  
38 this article so that any costs for services payable by the ~~department~~  
39 ADMINISTRATION are costs avoided or recovered from any available provider of  
40 first party health insurance medical benefits, subject to the specific scope  
41 of benefits of the provider of first party medical insurance benefits. The  
42 ~~department~~ ADMINISTRATION may require that health care service providers are  
43 responsible for the coordination of benefits provided pursuant to this  
44 article. The ~~department~~ ADMINISTRATION shall act as a payor of last resort  
45 unless this is specifically prohibited by federal law.

46 B. The director ~~of the department of health services~~ shall require  
47 each parent or legal guardian of a child receiving services ~~under~~ PURSUANT TO  
48 this article to assign to the ~~department~~ ADMINISTRATION rights that the

1 ~~individual~~ PERSON or ~~his~~ THE PERSON'S parents or guardian has to first party  
2 health insurance medical benefits to which the ~~individual~~ PERSON is entitled  
3 and ~~which~~ THAT relate to the specific services ~~which~~ THAT the person has  
4 received or will receive pursuant to this program. This state has a right to  
5 subrogation against a provider of first party health insurance medical  
6 benefits to enforce the assignment of first party health insurance medical  
7 benefits for services provided ~~under the provisions of~~ PURSUANT TO this  
8 article.

9 C. The provisions of this section are controlling over the provisions  
10 of a first party health insurance medical benefits policy issued after the  
11 ~~effective date of this section~~ SEPTEMBER 30, 1992. If the policy provisions  
12 exclude or limit coverage on the basis of a child's eligibility for services  
13 under this article, the ~~department~~ ADMINISTRATION shall monitor payments from  
14 providers of first party health insurance medical benefits ~~which~~ THAT are  
15 collected by providers of medical care.

16 D. ~~The provisions of~~ This section shall apply APPLIES to a health care  
17 services organization subject to ~~the provisions of~~ title 20, chapter 4,  
18 article 9 in which a child is enrolled and who is receiving services pursuant  
19 to this article. If a ~~health care services organization's enrolled~~ child  
20 ENROLLED IN A HEALTH CARE SERVICES ORGANIZATION requires services under this  
21 article and if the benefits for the services are contractually available  
22 through the health care services organization, the health care services  
23 organization may require the enrolled child to receive the services through  
24 the health care services organization's contracted provider network up to the  
25 coverage limits set forth in the health care services organization's evidence  
26 of coverage. If the health care services organization elects not to provide  
27 the covered services either directly or through its contracted provider  
28 network or is unable to provide the covered services directly or through its  
29 contracted provider network and the services are covered benefits as set  
30 forth in the health care services organization's evidence of coverage, then  
31 the health care services organization shall reimburse the ~~department~~  
32 ADMINISTRATION for the services provided through the ~~department~~  
33 ADMINISTRATION for the enrolled child. The health care services organization  
34 shall IS not be required to reimburse the ~~department~~ ADMINISTRATION for  
35 services beyond the coverage limits set forth in the health care services  
36 organization's evidence of coverage for the enrolled child. The amount of  
37 reimbursement paid by a health care services organization to the ~~department~~  
38 ADMINISTRATION shall not be greater than the level of compensation the health  
39 care services organization pays to its contracted provider network. A health  
40 care services organization may impose prior authorization, referral and other  
41 utilization review requirements in providing or paying for services to an  
42 enrolled child under this section.

43 E. For THE purposes of this section, "first party health insurance  
44 medical benefits" ~~include~~ INCLUDES benefits payable from a hospital, medical,  
45 dental and optometric service corporation subject to ~~the provisions of~~ title  
46 20, chapter 4, article 3, a health care services organization subject to ~~the~~  
47 ~~provisions of~~ title 20, chapter 4, article 9, an insurer providing disability  
48 insurance subject to ~~the provisions of~~ title 20, chapter 6, article 4, an

1 insurer providing group disability insurance subject to ~~the provisions of~~  
2 title 20, chapter 6, article 5, and any other available first party health  
3 insurance medical benefits, but does not include monies available under a  
4 social services block grant or an optional state supplemental payment program  
5 if federal monies are available.

6 Sec. 6. Repeal

7 Section ~~36-265~~, Arizona Revised Statutes, is repealed.

8 Sec. 7. Section 36-341, Arizona Revised Statutes, is amended to read:

9 36-341. Fees received by state and local registrars

10 A. The ~~state registrar~~ DIRECTOR OF THE DEPARTMENT shall establish ~~by~~  
11 ~~rule~~ the fees, ~~if any~~, to be charged for searches, copies of registered  
12 certificates, certified copies of registered certificates, amending  
13 registered certificates and correcting certificates that are processed by the  
14 department. THE DIRECTOR MAY ESTABLISH A SURCHARGE TO BE ASSESSED ON ANY  
15 LOCAL REGISTRAR WHO OBTAINS ACCESS TO THE DEPARTMENT'S VITAL RECORDS  
16 AUTOMATION SYSTEM. A local registrar may establish the local registrar's own  
17 fees to be charged for searches, copies of registered certificates, certified  
18 copies of registered certificates, amending registered certificates and  
19 correcting certificates as determined necessary by the local entity.

20 B. In addition to fees collected pursuant to subsection A of this  
21 section, the state registrar shall assess an additional one dollar surcharge  
22 on fees for all certified copies of registered birth certificates. The state  
23 registrar shall deposit, pursuant to sections 35-146 and 35-147, all monies  
24 received from the surcharge in the confidential intermediary and fiduciary  
25 fund established by section 8-135.

26 C. The state registrar shall keep a true and accurate account of all  
27 fees collected by the state registrar under this chapter and shall deposit,  
28 pursuant to sections 35-146 and 35-147: ~~;~~

29 1. EIGHTY-FIVE PER CENT OF THE FIRST FOUR MILLION DOLLARS COLLECTED  
30 EACH FISCAL YEAR IN THE VITAL RECORDS ELECTRONIC SYSTEMS FUND ESTABLISHED BY  
31 SECTION 36-341.01 AND THE REMAINING FIFTEEN PER CENT OF THE FIRST FOUR  
32 MILLION DOLLARS COLLECTED EACH FISCAL YEAR IN THE STATE GENERAL FUND.

33 2. Forty per cent of ~~these monies~~ THE AMOUNT COLLECTED IN EXCESS OF  
34 FOUR MILLION DOLLARS EACH FISCAL YEAR in the vital records electronic systems  
35 fund established by section 36-341.01 and the remaining sixty per cent in the  
36 state general fund.

37 D. A local registrar shall keep a true and accurate account of all  
38 fees collected by the local registrar under this chapter and shall deposit  
39 them with the county treasurer to be credited to a special registration and  
40 statistical revenue account of the health department fund.

41 E. In addition to fees collected pursuant to subsection A of this  
42 section, the department shall assess an additional one dollar surcharge on  
43 fees for all certified copies of registered death certificates. The  
44 department shall deposit, pursuant to sections 35-146 and 35-147, monies  
45 received from the surcharge in the child fatality review fund established by  
46 section 36-3504.

1 F. The state and local registrars may exempt an agency as defined in  
2 section 41-1001 from any fee required by this section, section 8-135 or  
3 section 36-3504.

4 Sec. 8. Section 36-797.43, Arizona Revised Statutes, is amended to  
5 read:

6 36-797.43. Care and treatment of children with sickle cell  
7 anemia; reimbursement

8 A. The ~~department may~~ ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM  
9 ADMINISTRATION, through the children's rehabilitative services, MAY develop  
10 and operate, either directly or by contracting with public or private  
11 providers, programs for the diagnosis, care and treatment of children  
12 suffering from sickle cell anemia.

13 B. The programs developed and operated pursuant to this section are  
14 part of the children's rehabilitative services provided by the ~~department~~  
15 ADMINISTRATION pursuant to section 36-261.

16 C. The parent or other responsible person, agency or third party payor  
17 shall reimburse the ~~department~~ ADMINISTRATION for part or all of the costs of  
18 services rendered to a child pursuant to this section according to a scale of  
19 rates and charges established by the ~~department~~ ADMINISTRATION and based on  
20 the cost of services provided and the ability of the parent or responsible  
21 person to pay for ~~such~~ THESE services.

22 Sec. 9. Section 36-797.44, Arizona Revised Statutes, is amended to  
23 read:

24 36-797.44. Care and treatment of adults with sickle cell  
25 anemia; reimbursement

26 A. The ~~department may~~ ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM  
27 ADMINISTRATION, through the children's rehabilitative services, MAY develop  
28 and operate, either directly or by contracting with public or private  
29 providers, programs for the diagnosis, care and treatment of adults suffering  
30 from sickle cell anemia.

31 B. The adult or other responsible person, agency or third party payor  
32 shall reimburse the ~~department~~ ADMINISTRATION for part or all of the costs of  
33 services rendered to an adult pursuant to this section according to a scale  
34 of rates and charges established by the ~~department~~ ADMINISTRATION and based  
35 on the cost of services provided and the ability of the adult or other  
36 responsible person to pay for ~~such~~ THESE services.

37 Sec. 10. Section 36-2901.03, Arizona Revised Statutes, is amended to  
38 read:

39 36-2901.03. Federal poverty program; eligibility

40 A. The administration shall adopt rules for a streamlined eligibility  
41 determination process for any person who applies to be an eligible person as  
42 defined in section 36-2901, paragraph 6, subdivision (a), item (iv). The  
43 administration shall adopt these rules in accordance with state and federal  
44 requirements and the section 1115 waiver.

45 B. The administration must base eligibility on an adjusted gross  
46 income that does not exceed one hundred per cent of the federal poverty  
47 guidelines.

1 C. For persons who the administration determines are eligible pursuant  
2 to this section, the date of eligibility is the first day of the month of  
3 application.

4 D. Except as provided in subsection E of this section, the  
5 administration shall determine an eligible person's continued eligibility ~~on~~  
6 ~~an annual basis~~ AT LEAST ANNUALLY.

7 E. Every six months the administration shall determine the continued  
8 eligibility of any adult who is at least twenty-one years of age and who is  
9 subject to redetermination of eligibility for temporary assistance for needy  
10 families cash benefits by the department. Acute care redeterminations  
11 pursuant to this subsection shall occur simultaneously with redeterminations  
12 of eligibility for temporary assistance for needy families cash benefits.

13 Sec. 11. Section 36-2903.01, Arizona Revised Statutes, is amended to  
14 read:

15 36-2903.01. Additional powers and duties: report

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

22 B. The director shall:

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

29 2. Enter into an interagency agreement with the department to  
30 establish a streamlined eligibility process to determine the eligibility of  
31 all persons defined pursuant to section 36-2901, paragraph 6,  
32 subdivision (a). At the administration's option, the interagency agreement  
33 may allow the administration to determine the eligibility of certain persons,  
34 including those defined pursuant to section 36-2901, paragraph 6,  
35 subdivision (a).

36 3. Enter into an intergovernmental agreement with the department to:

37 (a) Establish an expedited eligibility and enrollment process for all  
38 persons who are hospitalized at the time of application.

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

40 (c) Establish the process for management evaluation reviews that the  
41 administration shall perform to evaluate the eligibility determination  
42 functions performed by the department.

43 (d) Establish eligibility quality control reviews by the  
44 administration.

45 (e) Require the department to adopt rules, consistent with the rules  
46 adopted by the administration for a hearing process, that applicants or  
47 members may use for appeals of eligibility determinations or  
48 redeterminations.

1 (f) Establish the department's responsibility to place sufficient  
2 eligibility workers at federally qualified health centers to screen for  
3 eligibility and at hospital sites and level one trauma centers to ensure that  
4 persons seeking hospital services are screened on a timely basis for  
5 eligibility for the system, including a process to ensure that applications  
6 for the system can be accepted on a twenty-four hour basis, seven days a  
7 week.

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

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

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

42 5. Apply for and accept federal funds available under title XIX of the  
43 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section  
44 1396 (1980)) in support of the system. The application made by the director  
45 pursuant to this paragraph shall be designed to qualify for federal funding  
46 primarily on a prepaid capitated basis. Such funds may be used only for the  
47 support of persons defined as eligible pursuant to title XIX of the social  
48 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 the 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), section 36-2931 and section  
42 36-2981, paragraph 6 to be financially responsible for any cost sharing  
43 requirements established in a state plan or a section 1115 waiver and  
44 approved by the centers for medicare and medicaid services. Cost sharing  
45 requirements may include copayments, coinsurance, deductibles, enrollment  
46 fees and monthly premiums for enrolled members, including households with  
47 children enrolled in the Arizona long-term care system.

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

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

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

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

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

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

21           (c) The schedule of rates and charges for a hospital that became  
22 effective after May 31, 1984 but before July 2, 1984, limited to five per  
23 cent over the hospital's previous rate schedule, and if the hospital's  
24 previous rate schedule became effective on or after April 30, 1983 but before  
25 October 1, 1983.

26 For the purposes of this paragraph, "constant" means equal to or lower than.

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

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

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

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

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

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

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

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

12           1. For inpatient hospital stays, the administration shall use a  
13 prospective tiered per diem methodology, using hospital peer groups if  
14 analysis shows that cost differences can be attributed to independently  
15 definable features that hospitals within a peer group share. In peer  
16 grouping the administration may consider such factors as length of stay  
17 differences and labor market variations. If there are no cost differences,  
18 the administration shall implement a stop loss-stop gain or similar  
19 mechanism. Any stop loss-stop gain or similar mechanism shall ensure that  
20 the tiered per diem rates assigned to a hospital do not represent less than  
21 ninety per cent of its 1990 base year costs or more than one hundred ten per  
22 cent of its 1990 base year costs, adjusted by an audit factor, during the  
23 period of March 1, 1993 through September 30, 1994. The tiered per diem  
24 rates set for hospitals shall represent no less than eighty-seven and  
25 one-half per cent or more than one hundred twelve and one-half per cent of  
26 its 1990 base year costs, adjusted by an audit factor, from October 1, 1994  
27 through September 30, 1995 and no less than eighty-five per cent or more than  
28 one hundred fifteen per cent of its 1990 base year costs, adjusted by an  
29 audit factor, from October 1, 1995 through September 30, 1996. For the  
30 periods after September 30, 1996 no stop loss-stop gain or similar mechanisms  
31 shall be in effect. An adjustment in the stop loss-stop gain percentage may  
32 be made to ensure that total payments do not increase as a result of this  
33 provision. If peer groups are used the administration shall establish  
34 initial peer group designations for each hospital before implementation of  
35 the per diem system. The administration may also use a negotiated rate  
36 methodology. The tiered per diem methodology may include separate  
37 consideration for specialty hospitals that limit their provision of services  
38 to specific patient populations, such as rehabilitative patients or children.  
39 The initial per diem rates shall be based on hospital claims and encounter  
40 data for dates of service November 1, 1990 through October 31, 1991 and  
41 processed through May of 1992.

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

1           3. Through June 30, 2004, for outpatient hospital services, the  
2 administration shall reimburse a hospital by applying a hospital specific  
3 outpatient cost-to-charge ratio to the covered charges. Beginning on July 1,  
4 2004 through June 30, 2005, the administration shall reimburse a hospital by  
5 applying a hospital specific outpatient cost-to-charge ratio to covered  
6 charges. If the hospital increases its charges for outpatient services filed  
7 with the Arizona department of health services pursuant to chapter 4, article  
8 3 of this title, by more than 4.7 per cent for dates of service effective on  
9 or after July 1, 2004, the hospital specific cost-to-charge ratio will be  
10 reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7  
11 per cent, the effective date of the increased charges will be the effective  
12 date of the adjusted Arizona health care cost containment system  
13 cost-to-charge ratio. The administration shall develop the methodology for a  
14 capped fee-for-service schedule and a statewide cost-to-charge ratio. Any  
15 covered outpatient service not included in the capped fee-for-service  
16 schedule shall be reimbursed by applying the statewide cost-to-charge ratio  
17 that is based on the services not included in the capped fee-for-service  
18 schedule. Beginning on July 1, 2005, the administration shall reimburse  
19 clean claims with dates of service on or after July 1, 2005, based on the  
20 capped fee-for-service schedule or the statewide cost-to-charge ratio  
21 established pursuant to this paragraph. The administration may make  
22 additional adjustments to the outpatient hospital rates established pursuant  
23 to this section based on other factors, including the number of beds in the  
24 hospital, specialty services available to patients and the geographic  
25 location of the hospital.

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

- 30           (a) An admission face sheet.
- 31           (b) An itemized statement.
- 32           (c) An admission history and physical.
- 33           (d) A discharge summary or an interim summary if the claim is split.
- 34           (e) An emergency record, if admission was through the emergency room.
- 35           (f) Operative reports, if applicable.
- 36           (g) A labor and delivery room report, if applicable.

37           Payment received by a hospital from the administration pursuant to this  
38 subsection or from a contractor either by contract or pursuant to section  
39 36-2904, subsection I is considered payment by the administration or the  
40 contractor of the administration's or contractor's liability for the hospital  
41 bill. A hospital may collect any unpaid portion of its bill from other third  
42 party payors or in situations covered by title 33, chapter 7, article 3.

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

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

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

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

9 6. In developing the reimbursement methodology, if a review of the  
10 reports filed by a hospital pursuant to section 36-125.04 indicates that  
11 further investigation is considered necessary to verify the accuracy of the  
12 information in the reports, the administration may examine the hospital's  
13 records and accounts related to the reporting requirements of section  
14 36-125.04. The administration shall bear the cost incurred in connection  
15 with this examination unless the administration finds that the records  
16 examined are significantly deficient or incorrect, in which case the  
17 administration may charge the cost of the investigation to the hospital  
18 examined.

19 7. Except for privileged medical information, the administration shall  
20 make available for public inspection the cost and charge data and the  
21 calculations used by the administration to determine payments under the  
22 tiered per diem system, provided that individual hospitals are not identified  
23 by name. The administration shall make the data and calculations available  
24 for public inspection during regular business hours and shall provide copies  
25 of the data and calculations to individuals requesting such copies within  
26 thirty days of receipt of a written request. The administration may charge a  
27 reasonable fee for the provision of the data or information.

28 8. The prospective tiered per diem payment methodology for inpatient  
29 hospital services shall include a mechanism for the prospective payment of  
30 inpatient hospital capital related costs. The capital payment shall include  
31 hospital specific and statewide average amounts. For tiered per diem rates  
32 beginning on October 1, 1999, the capital related cost component is frozen at  
33 the blended rate of forty per cent of the hospital specific capital cost and  
34 sixty per cent of the statewide average capital cost in effect as of  
35 January 1, 1999 and as further adjusted by the calculation of tier rates for  
36 maternity and nursery as prescribed by law. The administration shall adjust  
37 the capital related cost component by the data resources incorporated market  
38 basket index for prospective payment system hospitals.

39 9. For graduate medical education programs:

40 (a) Beginning September 30, 1997, the administration shall establish a  
41 separate graduate medical education program to reimburse hospitals that had  
42 graduate medical education programs that were approved by the administration  
43 as of October 1, 1999. The administration shall separately account for  
44 monies for the graduate medical education program based on the total  
45 reimbursement for graduate medical education reimbursed to hospitals by the  
46 system in federal fiscal year 1995-1996 pursuant to the tiered per diem  
47 methodology specified in this section. The graduate medical education  
48 program reimbursement shall be adjusted annually by the increase or decrease

1 in the index published by the global insight hospital market basket index for  
2 prospective hospital reimbursement. Subject to legislative appropriation, on  
3 an annual basis, each qualified hospital shall receive a single payment from  
4 the graduate medical education program that is equal to the same percentage  
5 of graduate medical education reimbursement that was paid by the system in  
6 federal fiscal year 1995-1996. Any reimbursement for graduate medical  
7 education made by the administration shall not be subject to future  
8 settlements or appeals by the hospitals to the administration. The monies  
9 available under this subdivision shall not exceed the fiscal year 2005-2006  
10 appropriation adjusted annually by the increase or decrease in the index  
11 published by the global insight hospital market basket index for prospective  
12 hospital reimbursement, except for monies distributed for expansions pursuant  
13 to subdivision (b) of this paragraph.

14 (b) The monies available for graduate medical education programs  
15 pursuant to this subdivision shall not exceed the fiscal year 2006-2007  
16 appropriation adjusted annually by the increase or decrease in the index  
17 published by the global insight hospital market basket index for prospective  
18 hospital reimbursement. Graduate medical education programs eligible for  
19 such reimbursement are not precluded from receiving reimbursement for funding  
20 under subdivision (c) of this paragraph. Beginning July 1, 2006, the  
21 administration shall distribute any monies appropriated for graduate medical  
22 education above the amount prescribed in subdivision (a) of this paragraph in  
23 the following order or priority:

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

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

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

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

37 (ii) For a portion of additional indirect graduate medical education  
38 costs for programs that are located in a county with a population of less  
39 than five hundred thousand persons at the time the residency position was  
40 created or for a residency position that includes a rotation in a county with  
41 a population of less than five hundred thousand persons at the time the  
42 residency position was established. These programs must be approved by the  
43 administration.

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

46 (e) Each graduate medical education program that receives funding  
47 pursuant to subdivision (b) or (c) of this paragraph shall identify and  
48 report to the administration the number of new residency positions created by

1 the funding provided in this paragraph, including positions in rural areas.  
2 The program shall also report information related to the number of funded  
3 residency positions that resulted in physicians locating their practice in  
4 this state. The administration shall report to the joint legislative budget  
5 committee by February 1 of each year on the number of new residency positions  
6 as reported by the graduate medical education programs.

7 (f) Local, county and tribal governments and any university under the  
8 jurisdiction of the Arizona board of regents may provide monies in addition  
9 to any state general fund monies appropriated for graduate medical education  
10 in order to qualify for additional matching federal monies for providers,  
11 programs or positions in a specific locality and costs incurred pursuant to a  
12 specific contract between the administration and providers or other entities  
13 to provide graduate medical education services as an administrative  
14 activity. Payments by the administration pursuant to this subdivision may be  
15 limited to those providers designated by the funding entity and may be based  
16 on any methodology deemed appropriate by the administration, including  
17 replacing any payments that might otherwise have been paid pursuant to  
18 subdivision (a), (b) or (c) of this paragraph had sufficient state general  
19 fund monies or other monies been appropriated to fully fund those payments.  
20 These programs, positions, payment methodologies and administrative graduate  
21 medical education services must be approved by the administration and the  
22 centers for medicare and medicaid services. The administration shall report  
23 to the president of the senate, the speaker of the house of representatives  
24 and the director of the joint legislative budget committee on or before July  
25 1 of each year on the amount of money contributed and number of residency  
26 positions funded by local, county and tribal governments, including the  
27 amount of federal matching monies used.

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

32 10. The prospective tiered per diem payment methodology for inpatient  
33 hospital services shall include a mechanism for the payment of claims with  
34 extraordinary operating costs per day. For tiered per diem rates effective  
35 beginning on October 1, 1999, outlier cost thresholds are frozen at the  
36 levels in effect on January 1, 1999 and adjusted annually by the  
37 administration by the global insight hospital market basket index for  
38 prospective payment system hospitals. Beginning with dates of service on or  
39 after October 1, 2007, the administration shall phase in the use of the most  
40 recent statewide urban and statewide rural average medicare cost-to-charge  
41 ratios or centers for medicare and medicaid services approved cost-to-charge  
42 ratios to qualify and pay extraordinary operating costs. Cost-to-charge  
43 ratios shall be updated annually. Routine maternity charges are not eligible  
44 for outlier reimbursement. The administration shall complete full  
45 implementation of the phase-in on or before October 1, 2009. FOR DATES OF  
46 SERVICE ON AND AFTER OCTOBER 1, 2011 AND FOR EACH SUBSEQUENT CONTRACT YEAR,  
47 THE ADMINISTRATION SHALL USE NINETY-FIVE PER CENT OF THE STATEWIDE URBAN AND  
48 STATEWIDE RURAL AVERAGE MEDICARE COST-TO-CHARGE RATIOS IN EFFECT ON THE

1 PRECEDING JULY 1 OR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES APPROVED  
2 COST-TO-CHARGE RATIOS TO QUALIFY AND PAY EXTRAORDINARY OPERATING COSTS.

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

6 12. FOR INPATIENT HOSPITAL SERVICES RENDERED ON OR AFTER OCTOBER 1,  
7 2011, THE PROSPECTIVE TIERED PER DIEM PAYMENT RATES ARE PERMANENTLY RESET TO  
8 THE AMOUNTS PAYABLE FOR THOSE SERVICES AS OF SEPTEMBER 30, 2011 PURSUANT TO  
9 THIS SUBSECTION.

10 I. The director may adopt rules that specify enrollment procedures,  
11 including notice to contractors of enrollment. The rules may provide for  
12 varying time limits for enrollment in different situations. The  
13 administration shall specify in contract when a person who has been  
14 determined eligible will be enrolled with that contractor and the date on  
15 which the contractor will be financially responsible for health and medical  
16 services to the person.

17 J. The administration may make direct payments to hospitals for  
18 hospitalization and medical care provided to a member in accordance with this  
19 article and rules. The director may adopt rules to establish the procedures  
20 by which the administration shall pay hospitals pursuant to this subsection  
21 if a contractor fails to make timely payment to a hospital. Such payment  
22 shall be at a level determined pursuant to section 36-2904, subsection H  
23 or I. The director may withhold payment due to a contractor in the amount of  
24 any payment made directly to a hospital by the administration on behalf of a  
25 contractor pursuant to this subsection.

26 K. The director shall establish a special unit within the  
27 administration for the purpose of monitoring the third party payment  
28 collections required by contractors and noncontracting providers pursuant to  
29 section 36-2903, subsection B, paragraph 10 and subsection F and section  
30 36-2915, subsection E. The director shall determine by rule:

31 1. The type of third party payments to be monitored pursuant to this  
32 subsection.

33 2. The percentage of third party payments that is collected by a  
34 contractor or noncontracting provider and that the contractor or  
35 noncontracting provider may keep and the percentage of such payments that the  
36 contractor or noncontracting provider may be required to pay to the  
37 administration. Contractors and noncontracting providers must pay to the  
38 administration one hundred per cent of all third party payments that are  
39 collected and that duplicate administration fee-for-service payments. A  
40 contractor that contracts with the administration pursuant to section  
41 36-2904, subsection A may be entitled to retain a percentage of third party  
42 payments if the payments collected and retained by a contractor are reflected  
43 in reduced capitation rates. A contractor may be required to pay the  
44 administration a percentage of third party payments that are collected by a  
45 contractor and that are not reflected in reduced capitation rates.

46 L. The administration shall establish procedures to apply to the  
47 following if a provider that has a contract with a contractor or  
48 noncontracting provider seeks to collect from an individual or financially

1 responsible relative or representative a claim that exceeds the amount that  
2 is reimbursed or should be reimbursed by the system:

3 1. On written notice from the administration or oral or written notice  
4 from a member that a claim for covered services may be in violation of this  
5 section, the provider that has a contract with a contractor or noncontracting  
6 provider shall investigate the inquiry and verify whether the person was  
7 eligible for services at the time that covered services were provided. If  
8 the claim was paid or should have been paid by the system, the provider that  
9 has a contract with a contractor or noncontracting provider shall not  
10 continue billing the member.

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

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

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

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

23 3. If the administration determines that a provider that has a  
24 contract with a contractor or noncontracting provider has billed a member for  
25 charges that were paid or should have been paid by the administration, the  
26 administration shall send written notification by certified mail or other  
27 service with proof of delivery to the provider that has a contract with a  
28 contractor or noncontracting provider stating that this billing is in  
29 violation of federal and state law. If, twenty-one days or more after  
30 receiving the notification, a provider that has a contract with a contractor  
31 or noncontracting provider knowingly continues billing a member for charges  
32 that were paid or should have been paid by the system, the administration may  
33 assess a civil penalty in an amount equal to three times the amount of the  
34 billing and reduce payment to the provider that has a contract with a  
35 contractor or noncontracting provider accordingly. Receipt of delivery  
36 signed by the addressee or the addressee's employee is prima facie evidence  
37 of knowledge. Civil penalties collected pursuant to this subsection shall be  
38 deposited in the state general fund. Section 36-2918, subsections C, D and  
39 F, relating to the imposition, collection and enforcement of civil penalties,  
40 apply to civil penalties imposed pursuant to this paragraph.

41 M. The administration may conduct postpayment review of all claims  
42 paid by the administration and may recoup any monies erroneously paid. The  
43 director may adopt rules that specify procedures for conducting postpayment  
44 review. A contractor may conduct a postpayment review of all claims paid by  
45 the contractor and may recoup monies that are erroneously paid.

46 N. The director or the director's designee may employ and supervise  
47 personnel necessary to assist the director in performing the functions of the  
48 administration.

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

4           P. Notwithstanding any other law, on federal approval the  
5 administration may make disproportionate share payments to private hospitals,  
6 county operated hospitals, including hospitals owned or leased by a special  
7 health care district, and state operated institutions for mental disease  
8 beginning October 1, 1991 in accordance with federal law and subject to  
9 legislative appropriation. If at any time the administration receives  
10 written notification from federal authorities of any change or difference in  
11 the actual or estimated amount of federal funds available for  
12 disproportionate share payments from the amount reflected in the legislative  
13 appropriation for such purposes, the administration shall provide written  
14 notification of such change or difference to the president and the minority  
15 leader of the senate, the speaker and the minority leader of the house of  
16 representatives, the director of the joint legislative budget committee, the  
17 legislative committee of reference and any hospital trade association within  
18 this state, within three working days not including weekends after receipt of  
19 the notice of the change or difference. In calculating disproportionate  
20 share payments as prescribed in this section, the administration may use  
21 either a methodology based on claims and encounter data that is submitted to  
22 the administration from contractors or a methodology based on data that is  
23 reported to the administration by private hospitals and state operated  
24 institutions for mental disease. The selected methodology applies to all  
25 private hospitals and state operated institutions for mental disease  
26 qualifying for disproportionate share payments. For the purposes of this  
27 subsection, "disproportionate share payment" means a payment to a hospital  
28 that serves a disproportionate share of low-income patients as described by  
29 42 United States Code section 1396r-4.

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

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

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

40           T. IN ADDITION TO ANY REQUIREMENTS ADOPTED PURSUANT TO SUBSECTION D,  
41 PARAGRAPH 4 OF THIS SECTION, NOTWITHSTANDING ANY OTHER LAW, SUBJECT TO  
42 APPROVAL BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, BEGINNING JULY 1,  
43 2011, MEMBERS ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 6, SUBDIVISION  
44 (a), SECTION 36-2931 AND SECTION 36-2981, PARAGRAPH 6 SHALL PAY THE  
45 FOLLOWING:

- 46           1. A MONTHLY PREMIUM OF FIFTEEN DOLLARS, EXCEPT THAT THE TOTAL MONTHLY  
47 PREMIUM FOR AN ENTIRE HOUSEHOLD SHALL NOT EXCEED SIXTY DOLLARS.
- 48           2. A COPAYMENT OF FIVE DOLLARS FOR EACH PHYSICIAN OFFICE VISIT.



1 person whose care is covered by reinsurance. The rules shall provide that if  
2 a contractor does not follow specified guidelines for care or services and if  
3 the care or services could be provided pursuant to the guidelines at a lower  
4 cost the contractor is entitled to reimbursement as if the care or services  
5 specified in the guidelines had been provided.

6 7. For the awarding of contracts to contractors with qualified  
7 proposals determined to be the most advantageous to the state for each of the  
8 counties in this state. A contract may be awarded that provides services  
9 only to persons defined as eligible pursuant to section 36-2901, paragraph 6,  
10 subdivision (b), (c), (d) or (e). The director may provide by rule a second  
11 round competitive proposal procedure for the director to request voluntary  
12 price reduction of proposals from only those that have been tentatively  
13 selected for award, before the final award or rejection of proposals.

14 8. For the requirement that any proposal in a geographic service area  
15 provide for the full range of system covered services.

16 9. For the option of the administration to waive the requirement in  
17 any request for proposal or in any contract awarded pursuant to a request for  
18 proposal for a subcontract with a hospital for good cause in a county or area  
19 including but not limited to situations when such hospital is the only  
20 hospital in the health service area. In any situation where the subcontract  
21 requirement is waived, no hospital may refuse to treat members of the system  
22 admitted by primary care physicians or primary care practitioners with  
23 hospital privileges in that hospital. In the absence of a subcontract, the  
24 reimbursement level shall be at the levels specified in section 36-2904,  
25 subsection H or I.

26 D. Reinsurance may be obtained against expenses in excess of a  
27 specified amount on behalf of any individual for system covered emergency or  
28 inpatient services either through the purchase of a reinsurance policy or  
29 through a system self-insurance program as determined by the director.  
30 Reinsurance ~~may~~, subject to the approval of the director, **MAY** be obtained  
31 against expenses in excess of a specified amount on behalf of any individual  
32 for outpatient services either through the purchase of a reinsurance policy  
33 or through a system self-insurance program as determined by the director.

34 E. Notwithstanding the other provisions of this section, the ~~system~~  
35 **ADMINISTRATION** may procure, provide or coordinate system covered services by  
36 interagency agreement with authorized agencies of this state or with a  
37 federal agency for distinct groups of eligible persons, including persons  
38 eligible for children's rehabilitative services ~~through the department of~~  
39 ~~health services~~ and persons eligible for comprehensive medical and dental  
40 program services through the department **OF ECONOMIC SECURITY**.

41 F. Contracts shall be awarded as otherwise provided by law, except  
42 that in no event may a contract be awarded to any respondent that will cause  
43 the system to lose any federal monies to which it is otherwise entitled.

44 G. After contracts are awarded pursuant to this section, the director  
45 may negotiate with any successful proposal respondent for the expansion or  
46 contraction of services or service areas if there are unnecessary gaps or  
47 duplications in services or service areas.



1           9. Podiatry services ordered by a primary care physician or primary  
2 care practitioner.

3           10. Nonexperimental transplants approved for title XIX reimbursement.

4           11. Ambulance and nonambulance transportation, except as provided in  
5 subsection G of this section.

6           B. The limitations and exclusions for health and medical services  
7 provided under this section are as follows:

8           1. ~~Beginning on October 1, 2002,~~ Circumcision of newborn males is not  
9 a covered health and medical service.

10           2. For eligible persons who are at least twenty-one years of age:

11           (a) Outpatient health services do not include occupational therapy or  
12 speech therapy.

13           (b) Prosthetic devices do not include hearing aids, dentures, bone  
14 anchored hearing aids or cochlear implants. Prosthetic devices, except  
15 prosthetic implants, may be limited to twelve thousand ~~five-hundred~~ FIVE  
16 HUNDRED dollars per contract year.

17           (c) Insulin pumps, percussive vests and orthotics are not covered  
18 health and medical services.

19           (d) Durable medical equipment is limited to items covered by medicare.

20           (e) Podiatry services do not include services performed by a  
21 podiatrist.

22           (f) Nonexperimental transplants do not include the following:

23           (i) Pancreas only transplants.

24           (ii) Pancreas after kidney transplants.

25           (iii) Lung transplants.

26           (iv) Hemopoetic cell allogenic unrelated transplants.

27           (v) Heart transplants for non-ischemic cardiomyopathy.

28           (vi) Liver transplants for diagnosis of hepatitis C.

29           (g) Beginning October 1, 2011, bariatric surgery procedures, including  
30 laparoscopic and open gastric bypass and restrictive procedures, are not  
31 covered health and medical services.

32           (h) Well exams are not a covered health and medical service, except  
33 mammograms, pap smears and colonoscopies.

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

37           D. The director shall adopt rules necessary to limit, to the extent  
38 possible, the scope, duration and amount of services, including maximum  
39 limitations for inpatient services that are consistent with federal  
40 regulations under title XIX of the social security act (P.L. 89-97; 79 Stat.  
41 344; 42 United States Code section 1396 (1980)). To the extent possible and  
42 practicable, these rules shall provide for the prior approval of medically  
43 necessary services provided pursuant to this chapter.

44           E. The director shall make available home health services in lieu of  
45 hospitalization pursuant to contracts awarded under this article. For the  
46 purposes of this subsection, "home health services" means the provision of  
47 nursing services, home health aide services or medical supplies, equipment  
48 and appliances, which are provided on a part-time or intermittent basis by a

1 licensed home health agency within a member's residence based on the orders  
2 of a physician or a primary care practitioner. Home health agencies shall  
3 comply with the federal bonding requirements in a manner prescribed by the  
4 administration.

5 F. The director shall adopt rules for the coverage of behavioral  
6 health services for persons who are eligible under section 36-2901, paragraph  
7 6, subdivision (a). The administration shall contract with the department of  
8 health services for the delivery of all medically necessary behavioral health  
9 services to persons who are eligible under rules adopted pursuant to this  
10 subsection. The division of behavioral health in the department of health  
11 services shall establish a diagnostic and evaluation program to which other  
12 state agencies shall refer children who are not already enrolled pursuant to  
13 this chapter and who may be in need of behavioral health services. In  
14 addition to an evaluation, the division of behavioral health shall also  
15 identify children who may be eligible under section 36-2901, paragraph 6,  
16 subdivision (a) or section 36-2931, paragraph 5 and shall refer the children  
17 to the appropriate agency responsible for making the final eligibility  
18 determination.

19 G. The director shall adopt rules for the provision of transportation  
20 services and rules providing for copayment by members for transportation for  
21 other than emergency purposes. Subject to approval by the centers for  
22 medicare and medicaid services, nonemergency medical transportation shall not  
23 be provided ~~to persons who are eligible pursuant to sections 36-2901.01 and~~  
24 ~~36-2901.04 and who reside in a county with a population of more than five~~  
25 ~~hundred thousand persons~~ EXCEPT WHEN TRANSPORTING MEMBERS FROM ONE HEALTH  
26 CARE FACILITY OR OFFICE TO ANOTHER. Prior authorization is not required for  
27 medically necessary ambulance transportation services rendered to members or  
28 eligible persons initiated by dialing telephone number 911 or other  
29 designated emergency response systems.

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

35 I. If the director does not receive bids within the amounts budgeted  
36 or if at any time the amount remaining in the Arizona health care cost  
37 containment system fund is insufficient to pay for full contract services for  
38 the remainder of the contract term, the administration, on notification to  
39 system contractors at least thirty days in advance, may modify the list of  
40 services required under subsection A of this section for persons defined as  
41 eligible other than those persons defined pursuant to section 36-2901,  
42 paragraph 6, subdivision (a). The director may also suspend services or may  
43 limit categories of expense for services defined as optional pursuant to  
44 title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United  
45 States Code section 1396 (1980)) for persons defined pursuant to section  
46 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not  
47 apply to the continuity of care for persons already receiving these services.

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

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

7 1. Emergency services and specialty services provided pursuant to  
8 section 36-2908.

9 2. That the director may permit the delivery of health and medical  
10 services in other than the geographic service area in this state or in an  
11 adjoining state if the director determines that medical practice patterns  
12 justify the delivery of services or a net reduction in transportation costs  
13 can reasonably be expected. Notwithstanding the definition of physician as  
14 prescribed in section 36-2901, if services are procured from a physician or  
15 primary care practitioner in an adjoining state, the physician or primary  
16 care practitioner shall be licensed to practice in that state pursuant to  
17 licensing statutes in that state similar to title 32, chapter 13, 15, 17 or  
18 25 and shall complete a provider agreement for this state.

19 L. Covered outpatient services shall be subcontracted by a primary  
20 care physician or primary care practitioner to other licensed health care  
21 providers to the extent practicable for purposes including, but not limited  
22 to, making health care services available to underserved areas, reducing  
23 costs of providing medical care and reducing transportation costs.

24 M. The director shall adopt rules that prescribe the coordination of  
25 medical care for persons who are eligible for system services. The rules  
26 shall include provisions for the transfer of patients, the transfer of  
27 medical records and the initiation of medical care.

28 N. For the purposes of this section, "ambulance" has the same meaning  
29 prescribed in section 36-2201.

30 Sec. 14. Title 36, chapter 29, article 1, Arizona Revised Statutes, is  
31 amended by adding section 36-2930, to read:

32 36-2930. Prescription drug rebate fund; exemption; definition

33 A. THE PRESCRIPTION DRUG REBATE FUND IS ESTABLISHED CONSISTING OF  
34 PRESCRIPTION DRUG REBATE COLLECTIONS, INTEREST FROM PRESCRIPTION DRUG REBATE  
35 LATE PAYMENTS AND FEDERAL MONIES MADE AVAILABLE TO THIS STATE FOR THE  
36 OPERATION OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PRESCRIPTION  
37 DRUG REBATE PROGRAM. THE ADMINISTRATION SHALL ADMINISTER THE FUND.  
38 NONFEDERAL MONIES IN THE FUND ARE SUBJECT TO ANNUAL LEGISLATIVE  
39 APPROPRIATION. FEDERAL MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED AND  
40 ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190 RELATING TO THE LAPSING OF  
41 APPROPRIATIONS.

42 B. MONIES IN THE FUND SHALL BE USED TO RETURN THE FEDERAL SHARE OF  
43 PRESCRIPTION DRUG REBATE COLLECTIONS AND INTEREST FROM LATE PAYMENTS TO THE  
44 CENTERS FOR MEDICARE AND MEDICAID SERVICES BY OFFSETTING FUTURE FEDERAL  
45 DRAWS, TO PAY FOR THE ADMINISTRATIVE COSTS OF THE PRESCRIPTION DRUG REBATE  
46 PROGRAM AND AS THE NONFEDERAL SHARE FOR PAYMENTS TO CONTRACTORS OR PROVIDERS  
47 IN THE ADMINISTRATION'S MEDICAL SERVICES PROGRAMS. THE NONFEDERAL SHARE OF  
48 PRESCRIPTION DRUG REBATE COLLECTIONS AND INTEREST FROM LATE PAYMENTS INCLUDE

1 REBATES RELATING TO PROGRAMS ADMINISTERED BY THE DEPARTMENT OF ECONOMIC  
2 SECURITY, THE DEPARTMENT OF HEALTH SERVICES AND OTHER GOVERNMENTAL ENTITIES  
3 THAT CONTRIBUTE TO THE NONFEDERAL SHARE FOR PRESCRIPTION DRUGS.

4 C. FOR THE PURPOSES OF THIS SECTION, "ADMINISTRATIVE COSTS OF THE  
5 PRESCRIPTION DRUG REBATE PROGRAM" INCLUDES:

6 1. PAYMENTS TO THE PRESCRIPTION DRUG REBATE VENDOR.

7 2. ADMINISTRATIVE COSTS OF THE ADMINISTRATION IN SUPPORT OF THE  
8 PRESCRIPTION DRUG REBATE PROGRAM.

9 Sec. 15. Section 36-2988, Arizona Revised Statutes, is amended to  
10 read:

11 36-2988. Delivery of services; health plans; requirements

12 A. To the extent possible, the administration shall use contractors  
13 that have a contract with the administration pursuant to article 1 of this  
14 chapter or qualifying plans to provide services to members who qualify for  
15 the program.

16 B. The administration has full authority to amend existing contracts  
17 awarded pursuant to article 1 of this chapter.

18 C. As determined by the director, reinsurance may be provided against  
19 expenses in excess of a specified amount on behalf of any member for covered  
20 emergency services, inpatient services or outpatient services in the same  
21 manner as reinsurance provided under article 1 of this chapter. Subject to  
22 the approval of the director, reinsurance may be obtained against expenses in  
23 excess of a specified amount on behalf of any member.

24 D. Notwithstanding any other law, the administration may procure,  
25 provide or coordinate covered services by interagency agreement with  
26 authorized agencies of this state for distinct groups of members, including  
27 persons eligible for children's rehabilitative services ~~through the~~  
28 ~~department of health services~~ and members eligible for comprehensive medical  
29 and dental benefits through the department of economic security.

30 E. After contracts are awarded pursuant to this section, the director  
31 may negotiate with any successful bidder for the expansion or contraction of  
32 services or service areas.

33 F. Payments to contractors shall be made monthly and may be subject to  
34 contract provisions requiring the retention of a specified percentage of the  
35 payment by the director, a reserve fund or any other contract provisions by  
36 which adjustments to the payments are made based on utilization efficiency,  
37 including incentives for maintaining quality care and minimizing unnecessary  
38 inpatient services. Reserve monies withheld from contractors shall be  
39 distributed to providers who meet performance standards established by the  
40 director. Any reserve fund established pursuant to this subsection shall be  
41 established as a separate account within the Arizona health care cost  
42 containment system.

43 G. The director may negotiate at any time with a hospital on behalf of  
44 a contractor for inpatient hospital services and outpatient hospital services  
45 provided pursuant to the requirements specified in section 36-2904.

46 H. A contractor may require that subcontracting providers or  
47 noncontracting providers be paid for covered services, other than hospital

1 services, according to the capped fee-for-service schedule adopted by the  
2 administration or at lower rates as may be negotiated by the contractor.

3 I. A school district may perform outreach and information activities  
4 that relate to this article, with permission of the school principal and  
5 school district. The administration and contractors may collaborate with  
6 entities such as community based organizations, faith based organizations,  
7 schools and school districts for outreach and information activities related  
8 to this article. Outreach and information activities shall not include  
9 delivery of services, screening activities, eligibility determination or  
10 enrollment related to this article. Outreach and information activities  
11 include promotion of health care coverage, participation in school events and  
12 distribution of applications and materials to pupils and their families.  
13 Outreach and information activities performed by the administration,  
14 contractors or a school district shall not reduce or interfere with classroom  
15 instruction time.

16 J. The administration is exempt from the procurement code pursuant to  
17 section 41-2501.

18 Sec. 16. Section 38-654, Arizona Revised Statutes, is amended to read:  
19 38-654. Special employee health insurance trust fund; purpose;  
20 investment of monies; use of monies; exemption from  
21 lapsing; annual report

22 A. There is established a special employee health insurance trust fund  
23 for the purpose of administering the state employee health insurance benefit  
24 plans. The fund shall consist of legislative appropriations, monies  
25 collected from the employer and employees for the health insurance benefit  
26 plans and investment earnings on monies collected from employees. The fund  
27 shall be administered by the director of the department of administration.  
28 Monies in the fund that are determined by the legislature to be for  
29 administrative expenses of the department of administration, including monies  
30 authorized by subsection ~~D~~ C, paragraph 4 of this section, are subject to  
31 legislative appropriation.

32 B. On notice from the department of administration, the state  
33 treasurer shall invest and divest monies in the fund as provided by section  
34 35-313, and monies earned from investment shall be credited to the fund.  
35 There shall be a separate accounting of monies contributed by the employer,  
36 monies collected from state employees and investment earnings on monies  
37 collected from employees. Monies collected from state employees for health  
38 insurance benefit plans shall be expended ~~prior to~~ BEFORE expenditure of  
39 monies contributed by the employer.

40 ~~C. The director of the department of administration may authorize the~~  
41 ~~employer health insurance contributions by fund to be payable in advance~~  
42 ~~whether the budget unit is funded in whole or in part by state monies. By~~  
43 ~~July 15 each year, the joint legislative budget committee staff shall~~  
44 ~~determine the amount appropriated for employer health insurance~~  
45 ~~contributions. The department of administration may transfer to the special~~  
46 ~~employee health insurance trust fund in whole or in part the amount~~  
47 ~~appropriated to budget units for employer health insurance contributions as~~  
48 ~~deemed necessary.~~

1           ~~D.~~ C. Monies in the fund shall be used by the department of  
2 administration for the following purposes for the benefit of officers and  
3 employees who participate in a health insurance benefit plan pursuant to this  
4 article:

5           1. To administer a health insurance benefit program for state officers  
6 and employees.

7           2. To pay health insurance premiums, claims costs and related  
8 administrative expenses.

9           3. To apply against future premiums, claims costs and related  
10 administrative expenses.

11           4. To apply the equivalent of not more than one dollar fifty cents for  
12 each employee for each month to administer applicable federal and state laws  
13 relating to health insurance benefit programs and to design, implement and  
14 administer improvements to the employee health insurance or benefit program.

15           ~~E.~~ D. Subsection ~~D.~~ C of this section shall not be construed to  
16 require that all monies in the special employee health insurance trust fund  
17 shall be used within any one or more fiscal years. Any person who is no  
18 longer a state employee or an employee who is no longer a participant in a  
19 health insurance plan under contract with the department of administration  
20 shall have no claim ~~upon~~ ON monies in the fund.

21           ~~F.~~ E. Monies deposited in or credited to the fund are exempt from the  
22 provisions of section 35-190 relating to lapsing of appropriations.

23           ~~G.~~ F. Claims for services rendered ~~prior to~~ BEFORE July 1, 1989 shall  
24 not be paid from the special employee health insurance trust fund.

25           ~~H.~~ G. The department of administration shall submit an annual report  
26 on the financial status of the special employee insurance trust fund to the  
27 governor, the president of the senate, the speaker of the house of  
28 representatives, the chairpersons of the house and senate appropriations  
29 committees and the joint legislative budget committee staff by March 1. The  
30 report shall include:

31           1. The actuarial assumptions and a description of the methodology used  
32 to set premiums and reserve balance targets for the health insurance benefit  
33 program for the current plan year.

34           2. An analysis of the actuarial soundness of the health insurance  
35 benefit program for the previous plan year.

36           3. An analysis of the actuarial soundness of the health insurance  
37 benefit program for the current plan year, based on both year-to-date  
38 experience and total expected experience.

39           4. A preliminary estimate of the premiums and reserve balance targets  
40 for the next plan year, including the actuarial assumptions and a description  
41 of the methodology used.

42           ~~I.~~ H. The department shall submit a report to the joint legislative  
43 budget committee detailing any changes to the type of benefits offered under  
44 the plan and associated costs at least forty-five days before making the  
45 change. The report shall include:

46           1. An estimate of the cost or saving associated with the change.

47           2. An explanation of why the change was implemented before the next  
48 plan year.

1           Sec. 17. Section 43-1088, Arizona Revised Statutes, is amended to  
2 read:

3           43-1088. Credit for contribution to qualifying charitable  
4           organizations; definitions

5           A. A credit is allowed against the taxes imposed by this title for  
6 voluntary cash contributions by the taxpayer or on the taxpayer's behalf  
7 pursuant to section 43-401, subsection ~~H~~ I during the taxable year to a  
8 qualifying charitable organization not to exceed:

9           1. Two hundred dollars in any taxable year for a single individual or  
10 a head of household.

11           2. Four hundred dollars in any taxable year for a married couple  
12 filing a joint return.

13           B. A husband and wife who file separate returns for a taxable year in  
14 which they could have filed a joint return may each claim only one-half of  
15 the tax credit that would have been allowed for a joint return.

16           C. If the allowable tax credit exceeds the taxes otherwise due under  
17 this title on the claimant's income, or if there are no taxes due under this  
18 title, the taxpayer may carry forward the amount of the claim not used to  
19 offset the taxes under this title for not more than five consecutive taxable  
20 years' income tax liability.

21           D. The credit allowed by this section:

22           1. Is allowed only if the taxpayer itemizes deductions pursuant to  
23 section 43-1042 for the taxable year.

24           2. Is in lieu of a deduction pursuant to section 170 of the internal  
25 revenue code and taken for state tax purposes.

26           E. Taxpayers taking a credit authorized by this section shall provide  
27 the name of the qualifying charitable organization and the amount of the  
28 contribution to the department of revenue on forms provided by the  
29 department.

30           F. A qualifying charitable organization shall provide the department  
31 of revenue with a written certification that it meets all criteria to be  
32 considered a qualifying charitable organization. The organization shall also  
33 notify the department of any changes that may affect the qualifications under  
34 this section.

35           G. The charitable organization's written certification must be signed  
36 by an officer of the organization under penalty of perjury. The written  
37 certification must include the following:

38           1. Verification of the organization's status under section 501(c)(3)  
39 of the internal revenue code or verification that the organization is a  
40 designated community action agency that receives community services block  
41 grant program monies pursuant to 42 United States Code section 9901.

42           2. Financial data indicating the organization's budget for the  
43 organization's prior operating year and the amount of that budget spent on  
44 services to residents of this state who either:

45           (a) Receive temporary assistance for needy families benefits.

46           (b) Are low income residents of this state.

47           (c) Are chronically ill or physically disabled children.

1           3. A statement that the organization plans to continue spending at  
2 least fifty per cent of its budget on services to residents of this state who  
3 receive temporary assistance for needy families benefits, who are low income  
4 residents of this state or who are chronically ill or physically disabled  
5 children.

6           H. The department shall review each written certification and  
7 determine whether the organization meets all the criteria to be considered a  
8 qualifying charitable organization and notify the organization of its  
9 determination. The department may also periodically request recertification  
10 from the organization. The department shall compile and make available to  
11 the public a list of the qualifying charitable organizations.

12           I. For the purposes of this section:

13           1. "Chronically ill or physically disabled children" has the same  
14 meaning prescribed in section ~~36-262~~ 36-260.

15           2. "Low income residents" means persons whose household income is less  
16 than one hundred fifty per cent of the federal poverty level.

17           3. "Qualifying charitable organization" means a charitable  
18 organization that is exempt from federal income taxation under section  
19 501(c)(3) of the internal revenue code or is a designated community action  
20 agency that receives community services block grant program monies pursuant  
21 to 42 United States Code section 9901. The organization must spend at least  
22 fifty per cent of its budget on services to residents of this state who  
23 receive temporary assistance for needy families benefits or low income  
24 residents of this state and their households or to chronically ill or  
25 physically disabled children who are residents of this state. Taxpayers  
26 choosing to make donations through an umbrella charitable organization that  
27 collects donations on behalf of member charities shall designate that the  
28 donation be directed to a member charitable organization that would qualify  
29 under this section on a stand-alone basis.

30           4. "Services" means cash assistance, medical care, child care, food,  
31 clothing, shelter, job placement and job training services or any other  
32 assistance that is reasonably necessary to meet immediate basic needs and  
33 that is provided and used in this state.

34           Sec. 18. Laws 2010, chapter 232, section 13 is amended to read:

35           Sec. 13. ALTCS: county contributions: fiscal year 2010-2011

36           A. If the federal government extends the enhanced federal match rate  
37 through June 30, 2011, notwithstanding Laws 2010, seventh special session,  
38 chapter 10, section 15 and section 11-292, Arizona Revised Statutes, county  
39 contributions for the Arizona long-term care system for fiscal year 2010-2011  
40 are as follows:

- |                          |                         |
|--------------------------|-------------------------|
| 41           1. Apache   | <del>\$ 469,400</del>   |
| 42                       | \$ 485,000              |
| 43           2. Cochise  | <del>\$ 4,023,400</del> |
| 44                       | \$ 4,140,300            |
| 45           3. Coconino | <del>\$ 1,408,800</del> |
| 46                       | \$ 1,455,400            |
| 47           4. Gila     | <del>\$ 1,623,600</del> |
| 48                       | \$ 1,670,700            |

1	5. Graham	<del>\$ 1,072,900</del>
2		\$ 1,098,000
3	6. Greenlee	<del>\$ 122,200</del>
4		\$ 124,600
5	7. La Paz	<del>\$ 619,700</del>
6		\$ 636,800
7	8. Maricopa	<del>\$115,295,400</del>
8		\$118,573,200
9	9. Mohave	<del>\$ 5,479,700</del>
10		\$ 5,629,100
11	10. Navajo	<del>\$ 1,942,400</del>
12		\$ 2,006,700
13	11. Pima	<del>\$ 29,839,700</del>
14		\$ 30,705,400
15	12. Pinal	<del>\$ 11,132,800</del>
16		\$ 11,455,700
17	13. Santa Cruz	<del>\$ 1,434,600</del>
18		\$ 1,476,300
19	14. Yavapai	<del>\$ 7,024,400</del>
20		\$ 7,228,300
21	15. Yuma	<del>\$ 6,018,000</del>
22		\$ 6,192,500

23 B. The amounts specified in subsection A of this section reflect  
 24 ~~\$76,014,400~~ \$57,757,000 in decreases in county contributions for the Arizona  
 25 long-term care system.

26 C. The amounts specified in subsection A of this section reflect  
 27 ~~\$4,390,700~~ \$3,629,200 in decreases in county contributions for the Arizona  
 28 long-term care system for medicare clawback savings.

29 D. The county contributions for the Arizona long-term care system  
 30 would have otherwise totaled ~~\$267,912,100~~ \$250,635,000 in fiscal year  
 31 2010-2011.

32 E. IF THE OVERALL COST FOR THE ARIZONA LONG-TERM CARE SERVICES PROGRAM  
 33 EXCEEDS \$1,242,309,200 FOR FISCAL YEAR 2010-2011, THE STATE TREASURER SHALL  
 34 COLLECT FROM THE COUNTIES THE DIFFERENCE BETWEEN THE AMOUNT SPECIFIED IN  
 35 SUBSECTION A OF THIS SECTION AND THE COUNTIES' SHARE OF THE STATE'S ACTUAL  
 36 CONTRIBUTION. THE COUNTIES' SHARE OF THE STATE'S CONTRIBUTION SHALL NOT  
 37 EXCEED 59.3%. THE DIRECTOR OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM  
 38 ADMINISTRATION SHALL NOTIFY THE STATE TREASURER OF THE COUNTIES' SHARE OF THE  
 39 STATE'S CONTRIBUTION AND REPORT THE AMOUNT TO THE DIRECTOR OF JOINT  
 40 LEGISLATIVE BUDGET COMMITTEE. THE STATE TREASURER SHALL WITHHOLD FROM ANY  
 41 OTHER MONIES PAYABLE TO THAT COUNTY FROM WHATEVER STATE FUNDING SOURCE IS  
 42 AVAILABLE AN AMOUNT NECESSARY TO FULFILL THAT COUNTY'S REQUIREMENT SPECIFIED  
 43 IN THIS SUBSECTION. THE STATE TREASURER SHALL NOT WITHHOLD DISTRIBUTIONS FROM  
 44 THE HIGHWAY USER REVENUE FUND PURSUANT TO TITLE 28, CHAPTER 18, ARTICLE 2,  
 45 ARIZONA REVISED STATUTES. THE STATE TREASURER SHALL DEPOSIT THE AMOUNTS  
 46 WITHHELD PURSUANT TO THIS SUBSECTION AND AMOUNTS PAID PURSUANT TO SUBSECTION  
 47 A OF THIS SECTION IN THE LONG-TERM CARE SYSTEM FUND ESTABLISHED BY SECTION  
 48 36-2913, ARIZONA REVISED STATUTES.

1           Sec. 19. ALTCS; county contributions; fiscal year 2011-2012

2           A. Notwithstanding section 11-292, Arizona Revised Statutes, county  
3 contributions for the Arizona long-term care system for fiscal year 2011-2012  
4 are as follows:

5	1. Apache	\$ 631,800
6	2. Cochise	\$ 5,309,100
7	3. Coconino	\$ 1,896,300
8	4. Gila	\$ 2,113,600
9	5. Graham	\$ 1,430,800
10	6. Greenlee	\$ 162,300
11	7. La Paz	\$ 827,500
12	8. Maricopa	\$154,518,900
13	9. Mohave	\$ 7,335,500
14	10. Navajo	\$ 2,614,500
15	11. Pima	\$ 39,653,400
16	12. Pinal	\$ 15,702,000
17	13. Santa Cruz	\$ 1,933,300
18	14. Yavapai	\$ 9,586,200
19	15. Yuma	\$ 8,017,700

20           B. If the overall cost for the Arizona long-term care services line  
21 item exceeds the amount specified in the general appropriations act for  
22 fiscal year 2011-2012, the state treasurer shall collect from the counties  
23 the difference between the amount specified in subsection A of this section  
24 and the counties' share of the state's actual contribution. The counties  
25 share of the state contribution shall be in compliance with any federal  
26 maintenance of effort requirements. The director of the Arizona health care  
27 cost containment system administration shall notify the state treasurer of  
28 the counties' share of the state's contribution and report the amount to the  
29 director of the joint legislative budget committee. The state treasurer shall  
30 withhold from any other monies payable to that county from whatever state  
31 funding source is available an amount necessary to fulfill that county's  
32 requirement specified in this subsection. The state treasurer shall not  
33 withhold distributions from the highway user revenue fund pursuant to title  
34 28, chapter 18, article 2, Arizona Revised Statutes. The state treasurer  
35 shall deposit the amounts withheld pursuant to this subsection and amounts  
36 paid pursuant to subsection A of this section in the long-term care system  
37 fund established by section 36-2913, Arizona Revised Statutes.

38           Sec. 20. Sexually violent persons; county reimbursement; fiscal  
39 year 2011-2012; deposit; tax withholding

40           A. Notwithstanding any other law, if this state pays the costs of a  
41 commitment of an individual determined to be sexually violent by the court,  
42 the county shall reimburse the department of health services for fifty per  
43 cent of these costs for fiscal year 2011-2012.

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

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

11 D. Notwithstanding any other law, a county may meet any statutory  
12 funding requirements of this section from any source of county revenue  
13 designated by the county, including funds of any countywide special taxing  
14 district in which the board of supervisors serves as the board of directors.

15 E. County contributions made pursuant to this section are excluded  
16 from the county expenditure limitations.

17 Sec. 21. Competency restoration treatment; city and county  
18 reimbursement; fiscal year 2011-2012; deposit; tax  
19 withholding

20 A. Notwithstanding section 13-4512, Arizona Revised Statutes, if this  
21 state pays the costs of a defendant's inpatient competency restoration  
22 treatment pursuant to section 13-4512, Arizona Revised Statutes, the city or  
23 county shall reimburse the department of health services for one hundred per  
24 cent of these costs for fiscal year 2011-2012.

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

29 C. Each city and county shall make the reimbursements for these costs  
30 as specified in subsection A of this section within thirty days after a  
31 request by the department of health services. If the city or county does not  
32 make the reimbursement, the superintendent of the Arizona state hospital  
33 shall notify the state treasurer of the amount owed and the treasurer shall  
34 withhold the amount, including any additional interest as provided in section  
35 42-1123, Arizona Revised Statutes, from any transaction privilege tax  
36 distributions to the city or county. The treasurer shall deposit the  
37 withholdings, pursuant to sections 35-146 and 35-147, Arizona Revised  
38 Statutes, in the Arizona state hospital fund established by section  
39 36-545.08, Arizona Revised Statutes.

40 D. Notwithstanding any other law, a county may meet any statutory  
41 funding requirements of this section from any source of county revenue  
42 designated by the county, including funds of any countywide special taxing  
43 district in which the board of supervisors serves as the board of directors.

44 E. County contributions made pursuant to this section are excluded  
45 from the county expenditure limitations.

46 Sec. 22. State employee health benefits

47 For fiscal year 2011-2012, the department of administration shall not  
48 implement a differentiated health insurance premium based on the integrated

1 or nonintegrated status of a health insurance provider available through the  
2 state employee health insurance program.

3 Sec. 23. AHCCCS; disproportionate share payments

4 A. Disproportionate share payments for fiscal year 2011-2012 made  
5 pursuant to section 36-2903.01, subsection P, Arizona Revised Statutes,  
6 include:

7 1. \$55,507,900 for a qualifying nonstate operated public hospital.  
8 The Maricopa county special health care district shall provide a certified  
9 public expense form for the amount of qualifying disproportionate share  
10 hospital expenditures made on behalf of this state to the administration on  
11 or before May 1, 2012 for all state plan years as required by the Arizona  
12 health care cost containment system 1115 waiver standard terms and  
13 conditions. The administration shall assist the district in determining the  
14 amount of qualifying disproportionate share hospital expenditures. Once the  
15 administration files a claim with the federal government and receives federal  
16 funds participation based on the amount certified by the Maricopa county  
17 special health care district, if the certification is equal to or greater  
18 than \$55,507,900, the administration shall distribute \$4,202,300 to the  
19 Maricopa county special health care district and deposit the balance of the  
20 federal funds participation in the state general fund. If the certification  
21 provided is for an amount less than \$55,507,900, and the administration  
22 determines that the revised amount is correct pursuant to the methodology  
23 used by the administration pursuant to section 36-2903.01, Arizona Revised  
24 Statutes, the administration shall notify the governor, the president of the  
25 senate and the speaker of the house of representatives, shall distribute  
26 \$4,202,300 to the Maricopa county special health care district and shall  
27 deposit the balance of the federal funds participation in the state general  
28 fund. If the certification provided is for an amount less than \$55,507,900  
29 and the administration determines that the revised amount is not correct  
30 pursuant to the methodology used by the administration pursuant to section  
31 36-2903.01, Arizona Revised Statutes, the administration shall notify the  
32 governor, the president of the senate and the speaker of the house of  
33 representatives and shall deposit the total amount of the federal funds  
34 participation in the state general fund.

35 2. \$28,474,900 for the Arizona state hospital. The Arizona state  
36 hospital shall provide a certified public expense form for the amount of  
37 qualifying disproportionate share hospital expenditures made on behalf of the  
38 state to the administration on or before March 31, 2012. The administration  
39 shall assist the Arizona state hospital in determining the amount of  
40 qualifying disproportionate share hospital expenditures. Once the  
41 administration files a claim with the federal government and receives federal  
42 funds participation based on the amount certified by the Arizona state  
43 hospital, the administration shall distribute the entire amount of federal  
44 financial participation to the state general fund. If the certification  
45 provided is for an amount less than \$28,474,900, the administration shall  
46 notify the governor, the president of the senate and the speaker of the house  
47 of representatives and shall distribute the entire amount of federal  
48 financial participation to the state general fund. The certified public

1 expense form provided by the Arizona state hospital shall contain both the  
2 total amount of qualifying disproportionate share hospital expenditures and  
3 the amount limited by section 1923(g) of the social security act.

4 3. \$9,284,800 for private qualifying disproportionate share hospitals.  
5 The Arizona health care cost containment system administration shall make  
6 payments to hospitals consistent with this appropriation and the terms of the  
7 section 1115 waiver, however, payments shall be limited to those hospitals  
8 that either:

9 (a) Meet the mandatory definition of disproportionate share qualifying  
10 hospitals under section 1923 of the social security act.

11 (b) Are located in Yuma county and contain at least three hundred  
12 beds.

13 B. Disproportionate share payments in fiscal years 2010-2011 and  
14 2011-2012 made pursuant to section 36-2903.01, subsection D, Arizona Revised  
15 Statutes, include amounts for disproportionate share hospitals designated by  
16 political subdivisions of this state, tribal governments and any university  
17 under the jurisdiction of the Arizona board of regents. Contingent on  
18 approval by the administration and the centers for medicare and Medicaid  
19 services any amount of federal funding allotted to this state pursuant to  
20 section 1923(f) of the social security act and not otherwise expended under  
21 subsection A, paragraph 1, 2 or 3 of this section shall be made available for  
22 distribution pursuant to this subsection. Political subdivisions of this  
23 state, tribal governments and any university under the jurisdiction of the  
24 Arizona board of regents may designate hospitals eligible to receive  
25 disproportionate share funds in an amount up to the limit prescribed in  
26 section 1923(g) of the social security act if those political subdivisions,  
27 tribal governments or universities provide sufficient monies to qualify for  
28 the matching federal monies for the disproportionate share payments.

29 Sec. 24. AHCCCS transfer; counties; federal monies

30 On or before December 31, 2012, notwithstanding any other law, for  
31 fiscal year 2011-2012 the Arizona health care cost containment system  
32 administration shall transfer to the counties such portion, if any, as may be  
33 necessary to comply with section 10201(c)(6) of the patient protection and  
34 affordable care act (P.L. 111-148), regarding the counties' proportional  
35 share of the state's contribution.

36 Sec. 25. AHCCCS; fraudulent payments; verification

37 A. The Arizona health care cost containment system administration  
38 shall issue a request for information on or before August 1, 2011 for  
39 mechanisms to reduce erroneous and fraudulent payments in the Arizona health  
40 care cost containment system, which may include mechanisms that verify the  
41 identity of individual recipients and that verify the services provided to  
42 individual recipients. The responses to the request for information may  
43 address either reducing incorrect payments due to actions of the individual  
44 recipient or the health care provider. Based on information received under  
45 this subsection, the Arizona health care cost containment system  
46 administration shall issue a request for proposals no later than October 1,  
47 2011. The request for proposals shall be reviewed by the joint legislative  
48 budget committee before it is issued.

1 B. The Arizona health care cost containment system administration shall  
2 award a contract under this section no later than January 1, 2012.

3 Sec. 26. County acute care contribution; fiscal year 2011-2012

4 A. Notwithstanding section 11-292, Arizona Revised Statutes, for  
5 fiscal year 2011-2012 for the provision of hospitalization and medical care,  
6 the counties shall contribute the following amounts:

7	1. Apache	\$ 268,800
8	2. Cochise	\$ 2,214,800
9	3. Coconino	\$ 742,900
10	4. Gila	\$ 1,413,200
11	5. Graham	\$ 536,200
12	6. Greenlee	\$ 190,700
13	7. La Paz	\$ 212,100
14	8. Maricopa	\$20,575,000
15	9. Mohave	\$ 1,237,700
16	10. Navajo	\$ 310,800
17	11. Pima	\$14,951,800
18	12. Pinal	\$ 2,715,600
19	13. Santa Cruz	\$ 482,800
20	14. Yavapai	\$ 1,427,800
21	15. Yuma	\$ 1,325,100

22 B. If a county does not provide funding as specified in subsection A  
23 of this section, the state treasurer shall subtract the amount owed by the  
24 county to the Arizona health care cost containment system fund and the  
25 long-term care system fund established by section 36-2913, Arizona Revised  
26 Statutes, from any payments required to be made by the state treasurer to  
27 that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona  
28 Revised Statutes, plus interest on that amount pursuant to section 44-1201,  
29 Arizona Revised Statutes, retroactive to the first day the funding was due.  
30 If the monies the state treasurer withholds are insufficient to meet that  
31 county's funding requirements as specified in subsection A of this section,  
32 the state treasurer shall withhold from any other monies payable to that  
33 county from whatever state funding source is available an amount necessary to  
34 fulfill that county's requirement. The state treasurer shall not withhold  
35 distributions from the highway user revenue fund pursuant to title 28,  
36 chapter 18, article 2, Arizona Revised Statutes.

37 C. Payment of an amount equal to one-twelfth of the total amount  
38 determined pursuant to subsection A of this section shall be made to the  
39 state treasurer on or before the fifth day of each month. On request from  
40 the director of the Arizona health care cost containment system  
41 administration, the state treasurer shall require that up to three months'  
42 payments be made in advance, if necessary.

43 D. The state treasurer shall deposit the amounts paid pursuant to  
44 subsection C of this section and amounts withheld pursuant to subsection B of  
45 this section in the Arizona health care cost containment system fund and the  
46 long-term care system fund established by section 36-2913, Arizona Revised  
47 Statutes.

1 E. If payments made pursuant to subsection C of this section exceed  
2 the amount required to meet the costs incurred by the Arizona health care  
3 cost containment system for the hospitalization and medical care of those  
4 persons defined as an eligible person pursuant to section 36-2901, paragraph  
5 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of  
6 the Arizona health care cost containment system administration may instruct  
7 the state treasurer either to reduce remaining payments to be paid pursuant  
8 to this section by a specified amount or to provide to the counties specified  
9 amounts from the Arizona health care cost containment system fund and the  
10 long-term care system fund.

11 F. It is the intent of the legislature that the Maricopa county  
12 contribution pursuant to subsection A of this section be reduced in each  
13 subsequent year according to the changes in the GDP price deflator. For the  
14 purposes of this subsection, "GDP price deflator" has the same meaning  
15 prescribed in section 41-563, Arizona Revised Statutes.

16 Sec. 27. Hospitalization and medical care contribution: fiscal  
17 year 2011-2012

18 A. Notwithstanding any other law, for fiscal year 2011-2012, beginning  
19 with the second monthly distribution of transaction privilege tax revenues,  
20 the state treasurer shall withhold one-eleventh of the following amounts from  
21 state transaction privilege tax revenues otherwise distributable, after any  
22 amounts withheld for the county long-term care contribution or the county  
23 administration contribution pursuant to section 11-292, subsection 0, Arizona  
24 Revised Statutes, for deposit in the Arizona health care cost containment  
25 system fund established by section 36-2913, Arizona Revised Statutes, for the  
26 provision of hospitalization and medical care:

27	1. Apache	\$ 87,300
28	2. Cochise	\$ 162,700
29	3. Coconino	\$ 160,500
30	4. Gila	\$ 65,900
31	5. Graham	\$ 46,800
32	6. Greenlee	\$ 12,000
33	7. La Paz	\$ 24,900
34	8. Mohave	\$ 187,400
35	9. Navajo	\$ 122,800
36	10. Pima	\$1,115,900
37	11. Pinal	\$ 218,300
38	12. Santa Cruz	\$ 51,600
39	13. Yavapai	\$ 206,200
40	14. Yuma	\$ 183,900

41 B. If the monies the state treasurer withholds are insufficient to  
42 meet that county's funding requirement as specified in subsection A of this  
43 section, the state treasurer shall withhold from any other monies payable to  
44 that county from whatever state funding source is available an amount  
45 necessary to fulfill that county's requirement. The state treasurer shall  
46 not withhold distributions from the highway user revenue fund pursuant to  
47 title 28, chapter 18, article 2, Arizona Revised Statutes.

1 C. On request from the director of the Arizona health care cost  
2 containment system administration, the state treasurer shall require that up  
3 to three months' payments be made in advance.

4 D. In fiscal year 2011-2012, the sum of \$2,646,200 withheld pursuant  
5 to subsection A of this section is allocated for the county acute care  
6 contribution for the provision of hospitalization and medical care services  
7 administered by the Arizona health care cost containment system  
8 administration.

9 E. County contributions made pursuant to this section are excluded  
10 from the county expenditure limitations.

11 Sec. 28. Proposition 204 administration; county expenditure  
12 limitation

13 County contributions for the administrative costs of implementing  
14 sections 36-2901.01 and 36-2901.04, Arizona Revised Statutes, that are made  
15 pursuant to section 11-292, subsection 0, Arizona Revised Statutes, are  
16 excluded from the county expenditure limitations.

17 Sec. 29. AHCCCS; ambulance services; reimbursement;  
18 retroactivity

19 A. Notwithstanding Laws 2010, chapter 86, section 7, subsection A and  
20 section 36-2239, subsection H, Arizona Revised Statutes, for dates of service  
21 on and after April 1, 2011 through September 30, 2011, the Arizona health  
22 care cost containment system administration and its contractors shall  
23 reimburse ambulance service providers in an amount equal to 72.2 per cent of  
24 the amounts prescribed by the department of health services.

25 B. Notwithstanding Laws 2010, chapter 86, section 7, subsection A and  
26 section 36-2239, subsection H, Arizona Revised Statutes, the Arizona health  
27 care cost containment system administration shall not include any rate  
28 increases approved by the department of health services between July 2, 2011  
29 and September 30, 2011 in the administration's reimbursement rates. The  
30 Arizona health care cost containment system administration shall make annual  
31 adjustments to its fee schedule on October 1, 2011 as otherwise provided in  
32 section 36-2239, subsection H, Arizona Revised Statutes, and shall reimburse  
33 ambulance providers consistent with subsection A of this section.

34 C. For dates of service beginning October 1, 2011 through September  
35 30, 2012, remuneration for ambulance services may be reduced by up to an  
36 additional five per cent of the amounts otherwise provided in this section.

37 D. This section is effective retroactively to from and after June 30,  
38 2011.

39 Sec. 30. AHCCCS; risk contingency rate setting

40 Notwithstanding any other law, for the contract year beginning  
41 October 1, 2011 and ending September 30, 2012, the Arizona health care cost  
42 containment system administration may continue the risk contingency rate  
43 setting for all managed care organizations and the funding for all managed  
44 care organizations administrative funding levels that was imposed for the  
45 contract year beginning October 1, 2010 and ending September 30, 2011.

46 Sec. 31. AHCCCS; hospital reimbursement inflation adjustment  
47 freeze

48 For the contract year beginning October 1, 2011:

1           1. Notwithstanding section 36-2903.01, subsection H, paragraph 2,  
2 Arizona Revised Statutes, and any rules adopted to implement that provision,  
3 the Arizona health care cost containment system administration shall not  
4 adjust tiered per diem payments for inpatient hospital care by the 2011 data  
5 resources incorporated market basket index for prospective payment system  
6 hospitals.

7           2. Notwithstanding section 36-2903.01, subsection H, paragraph 3,  
8 Arizona Revised Statutes, and any rules adopted to implement that provision,  
9 the Arizona health care cost containment system administration shall not  
10 adjust outpatient hospital fee schedule rates by any inflation index.

11           3. Notwithstanding section 36-2903.01, subsection H, paragraph 10,  
12 Arizona Revised Statutes, and any rules adopted to implement that provision,  
13 the Arizona health care cost containment system administration shall not  
14 adjust outlier cost thresholds by the global insight hospital market basket  
15 index for prospective payment system hospitals.

16           Sec. 32. AHCCCS; hospital rates; reduction authority

17           Notwithstanding any other law, for rates effective October 1, 2011  
18 through September 30, 2012, the Arizona health care cost containment system  
19 administration may reduce payments for institutional and noninstitutional  
20 services up to five per cent.

21           Sec. 33. Exemption from rule making; Arizona health care cost  
22 containment system

23           A. The Arizona health care cost containment system is exempt from the  
24 rule making requirements of title 41, chapter 6, Arizona Revised Statutes,  
25 for two years after the effective date of this act, to establish and maintain  
26 rules regarding standards, methods and procedures for determining eligibility  
27 necessary to implement a program within the available appropriation. The  
28 agency shall provide public notice and an opportunity for public comment on  
29 proposed rules at least thirty days before rules are adopted or amended  
30 pursuant to this section.

31           B. The Arizona health care cost containment system administration is  
32 exempt from the rule making requirements of title 41, chapter 6, Arizona  
33 Revised Statutes, for one year after the effective date of this act, to  
34 implement the requirements of section 36-2903.01, subsection H, Arizona  
35 Revised Statutes, as amended by this act.

36           Sec. 34. Exemption from rule making; department of health services

37           The department of health services is exempt from the rule making  
38 requirements of title 41, chapter 6, Arizona Revised Statutes, for two years  
39 after the effective date of this act for the purpose of establishing fees  
40 pursuant to section 36-341, Arizona Revised Statutes, as amended by this act.

41           Sec. 35. Intent; false claims act; savings

42           It is the intent of the legislature that the Arizona health care cost  
43 containment system administration comply with the federal false claims act  
44 and maximize savings in, and continue to consider best available technologies  
45 in detecting fraud in, the administration's programs.

46           Sec. 36. Intent; vital records fees

1 It is the intent of the legislature that the fees collected pursuant to  
2 section 36-341, subsection A, Arizona Revised Statutes, as amended by this  
3 act, shall not exceed \$4,539,000 in fiscal year 2011-2012.

4 Sec. 37. Transfer of powers; effect

5 A. The Arizona health care cost containment system administration  
6 succeeds to the powers and duties of the department of health services  
7 relating to children's rehabilitative services prescribed pursuant to title  
8 36, chapter 2, article 3, Arizona Revised Statutes.

9 B. All matters, including contracts, orders and judicial or  
10 quasi-judicial actions, whether completed or pending, of the department of  
11 health services relating to children's rehabilitative services are  
12 transferred on the effective date of this act, and maintain the same status  
13 with the Arizona health care cost containment system administration.

14 C. Rules adopted by the department of health services relating to  
15 children's rehabilitative services are effective until superseded by rules  
16 adopted by the Arizona health care cost containment system administration.

17 D. All personnel, property and records, all data and investigative  
18 findings and all appropriated monies remaining unspent and unencumbered of  
19 the department of health services relating to children's rehabilitative  
20 services are transferred to the Arizona health care cost containment system  
21 administration and may be used for the purposes prescribed in title 36,  
22 chapter 2, article 3, Arizona Revised Statutes.

23 Sec. 38. Retroactivity

24 A. Section 36-2930, Arizona Revised Statutes, as added by this act, is  
25 effective retroactively to March 1, 2011.

26 B. Section 36-260, Arizona Revised Statutes, as added by this act, is  
27 effective, and sections 36-261, 36-262, 36-263, 36-264, 36-797.43, 36-797.44,  
28 36-2903.01, 36-2988 and 43-1088, Arizona Revised Statutes, as amended by this  
29 act, apply, retroactively to from and after June 30, 2011.

30 C. Laws 2010, chapter 232, section 13, as amended by this act, applies  
31 retroactively to from and after June 29, 2011."

32 Amend title to conform

and, as so amended, it do pass

JOHN KAVANAGH  
Chairman

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