

PROPOSED

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:

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

3 (b) Furnishing of medical, surgical, corrective and other services and  
4 care.

5 (c) Furnishing of facilities for diagnosis, hospitalization and  
6 aftercare.

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

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

12 (f) Cooperation with medical, health, nursing and welfare groups and  
13 organizations and with any agency of the state charged with administration of  
14 laws providing for vocational rehabilitation of physically ~~handicapped~~  
15 DISABLED children.

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

19 (h) Receipt and expenditure of funds made available to the ~~department~~  
20 ADMINISTRATION for services to chronically ill or physically disabled  
21 children by the federal government, ~~the~~ THIS state or its political  
22 subdivisions or from other sources excluding monies received from parents or  
23 guardians for the care of children.

24 (i) Carrying on research and compiling statistics.

25 (j) Making necessary expenditures in connection with the duties  
26 provided in this section.

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

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

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

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

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

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

6           B. In order to carry out the provisions of subsection A of this  
7 section, the director may operate outpatient treatment facilities for  
8 chronically ill or physically disabled children and shall contract on the  
9 basis of competitive sealed bids for the care and treatment of chronically  
10 ill or physically disabled children ~~in accordance with~~ PURSUANT TO subsection  
11 C of this section.

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

16           1. The scope of the contracted services shall include inpatient  
17 treatment services, physician services and other care and treatment services  
18 and outpatient treatment services which shall not be mandated at a single  
19 location.

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

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

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

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

1           6. An invitation for bids, a request for proposals or ANY other  
2 solicitation may be cancelled or any or all bids or proposals may be rejected  
3 in whole or in part as may be specified in the solicitation if it is in the  
4 best interests of this state. The reasons for the cancellation or rejection  
5 shall be made part of the contract file. If the amount appropriated for  
6 services provided pursuant to this section is insufficient to pay for the  
7 scope of services as bid, the director may reduce the scope of services to  
8 reflect the amount appropriated or may cancel any invitation for bids,  
9 requests for proposals or other solicitation and contract directly for ~~such~~  
10 THESE services. ~~Such~~ Reductions or suspensions ~~shall~~ DO not apply to the  
11 continuity of care for persons already receiving ~~such~~ THE services. Any  
12 decision to reduce services shall be made independently from any other  
13 modification of services.

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

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

22           1. Cost to this state.

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

25           E. If the provision of any services ~~under~~ PURSUANT TO this section  
26 requires compliance with chapter 4, article 2 of this title, the contractor  
27 shall comply ~~prior to~~ BEFORE commencement of services ~~under~~ PURSUANT TO this  
28 section.

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

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

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

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

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

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

20 36-262. Central statewide information and referral service for  
21 chronically ill or physically disabled children

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

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

29 1. Establish a roster of agencies providing medical, educational,  
30 financial, social and transportation services to chronically ill or  
31 physically disabled children.

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

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

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

2           36-263. Eligibility for children's rehabilitative services

3           A. Any chronically ill or physically disabled person or the person's  
4 parent or legal guardian who applies for children's rehabilitative services  
5 is subject to a preliminary financial screening process developed by the  
6 ~~department in coordination with the Arizona health care cost containment~~  
7 ~~system~~ administration ~~to be administered~~ at the initial intake level. If the  
8 results of a screening indicate that a child may be title XIX eligible, in  
9 order to continue to receive services pursuant to this article the applicant  
10 must then submit a complete application within ten working days to the  
11 department of economic security, or the ~~Arizona health care cost containment~~  
12 ~~system~~ administration, which shall determine the applicant's eligibility  
13 pursuant to section 36-2901, paragraph 6, subdivision (a) or section 36-2931,  
14 paragraph 5 for health and medical or long-term care services. If the person  
15 is in need of emergency services provided pursuant to this article, the  
16 person may begin to receive these services immediately, provided that within  
17 five days from the date of service a financial screen is initiated.

18           B. Applicants who refuse to cooperate in the financial screen and  
19 eligibility process are not eligible for services pursuant to this  
20 article. A form explaining loss of benefits due to refusal to cooperate  
21 shall be signed by the applicant. Refusal to cooperate shall not be  
22 construed to mean the applicant's inability to obtain documentation required  
23 for eligibility determination.

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

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

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

1           Sec. 5. Section 36-264, Arizona Revised Statutes, is amended to read:  
2           36-264. Coordination of benefits; third party payments;  
3                                   definition

4           A. The ~~department of health services~~ ADMINISTRATION shall establish a  
5 benefit recovery program for state funded services to persons who receive  
6 services pursuant to this article ~~which~~ THAT are covered in whole or in part  
7 by a first party health insurance medical benefit. The ~~department of health~~  
8 ~~services~~ ADMINISTRATION shall coordinate benefits provided ~~under~~ PURSUANT TO  
9 this article so that any costs for services payable by the ~~department~~  
10 ADMINISTRATION are costs avoided or recovered from any available provider of  
11 first party health insurance medical benefits, subject to the specific scope  
12 of benefits of the provider of first party medical insurance benefits. The  
13 ~~department~~ ADMINISTRATION may require that health care service providers are  
14 responsible for the coordination of benefits provided pursuant to this  
15 article. The ~~department~~ ADMINISTRATION shall act as a payor of last resort  
16 unless this is specifically prohibited by federal law.

17           B. The director ~~of the department of health services~~ shall require  
18 each parent or legal guardian of a child receiving services ~~under~~ PURSUANT TO  
19 this article to assign to the ~~department~~ ADMINISTRATION rights that the  
20 ~~individual~~ PERSON or ~~his~~ THE PERSON'S parents or guardian has to first party  
21 health insurance medical benefits to which the ~~individual~~ PERSON is entitled  
22 and ~~which~~ THAT relate to the specific services ~~which~~ THAT the person has  
23 received or will receive pursuant to this program. This state has a right to  
24 subrogation against a provider of first party health insurance medical  
25 benefits to enforce the assignment of first party health insurance medical  
26 benefits for services provided ~~under the provisions of~~ PURSUANT TO this  
27 article.

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

35           D. ~~The provisions of~~ This section ~~shall apply~~ APPLIES to a health care  
36 services organization subject to ~~the provisions of~~ title 20, chapter 4,  
37 article 9 in which a child is enrolled and who is receiving services pursuant

1 to this article. If a ~~health care services organization's enrolled~~ child  
2 ENROLLED IN A HEALTH CARE SERVICES ORGANIZATION requires services under this  
3 article and if the benefits for the services are contractually available  
4 through the health care services organization, the health care services  
5 organization may require the enrolled child to receive the services through  
6 the health care services organization's contracted provider network up to the  
7 coverage limits set forth in the health care services organization's evidence  
8 of coverage. If the health care services organization elects not to provide  
9 the covered services either directly or through its contracted provider  
10 network or is unable to provide the covered services directly or through its  
11 contracted provider network and the services are covered benefits as set  
12 forth in the health care services organization's evidence of coverage, then  
13 the health care services organization shall reimburse the ~~department~~  
14 ADMINISTRATION for the services provided through the ~~department~~  
15 ADMINISTRATION for the enrolled child. The health care services organization  
16 ~~shall~~ IS not ~~be~~ required to reimburse the ~~department~~ ADMINISTRATION for  
17 services beyond the coverage limits set forth in the health care services  
18 organization's evidence of coverage for the enrolled child. The amount of  
19 reimbursement paid by a health care services organization to the ~~department~~  
20 ADMINISTRATION shall not be greater than the level of compensation the health  
21 care services organization pays to its contracted provider network. A health  
22 care services organization may impose prior authorization, referral and other  
23 utilization review requirements in providing or paying for services to an  
24 enrolled child under this section.

25 E. For THE purposes of this section, "first party health insurance  
26 medical benefits" ~~include~~ INCLUDES benefits payable from a hospital, medical,  
27 dental and optometric service corporation subject to ~~the provisions of~~ title  
28 20, chapter 4, article 3, a health care services organization subject to ~~the~~  
29 ~~provisions of~~ title 20, chapter 4, article 9, an insurer providing disability  
30 insurance subject to ~~the provisions of~~ title 20, chapter 6, article 4, an  
31 insurer providing group disability insurance subject to ~~the provisions of~~  
32 title 20, chapter 6, article 5, and any other available first party health  
33 insurance medical benefits, but does not include monies available under a  
34 social services block grant or an optional state supplemental payment program  
35 if federal monies are available.

36 Sec. 6. Repeal

37 Section 36-265, Arizona Revised Statutes, is repealed.

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

2           36-341. Fees received by state and local registrars

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

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

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

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

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

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

34           E. In addition to fees collected pursuant to subsection A of this  
35 section, the department shall assess an additional one dollar surcharge on  
36 fees for all certified copies of registered death certificates. The  
37 department shall deposit, pursuant to sections 35-146 and 35-147, monies

1 received from the surcharge in the child fatality review fund established by  
2 section 36-3504.

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

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

8 36-797.43. Care and treatment of children with sickle cell  
9 anemia; reimbursement

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

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

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

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

26 36-797.44. Care and treatment of adults with sickle cell  
27 anemia; reimbursement

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

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

1 on the cost of services provided and the ability of the adult or other  
2 responsible person to pay for ~~such~~ THESE services.

3 Sec. 10. Section 36-2903.01, Arizona Revised Statutes, is amended to  
4 read:

5 36-2903.01. Additional powers and duties; report

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

12 B. The director shall:

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

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

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

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

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

30 (c) Establish the process for management evaluation reviews that the  
31 administration shall perform to evaluate the eligibility determination  
32 functions performed by the department.

33 (d) Establish eligibility quality control reviews by the  
34 administration.

35 (e) Require the department to adopt rules, consistent with the rules  
36 adopted by the administration for a hearing process, that applicants or

1 members may use for appeals of eligibility determinations or  
2 redeterminations.

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

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

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

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

1 conference if it is not a real party in interest. In any proceeding before  
2 the administration, including a grievance or hearing, persons may represent  
3 themselves or be represented by a duly authorized agent who is not charging a  
4 fee. A legal entity may be represented by an officer, partner or employee  
5 who is specifically authorized by the legal entity to represent it in the  
6 particular proceeding.

7 5. Apply for and accept federal funds available under title XIX of the  
8 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section  
9 1396 (1980)) in support of the system. The application made by the director  
10 pursuant to this paragraph shall be designed to qualify for federal funding  
11 primarily on a prepaid capitated basis. Such funds may be used only for the  
12 support of persons defined as eligible pursuant to title XIX of the social  
13 security act or the approved section 1115 waiver.

14 6. At least thirty days before the implementation of a policy or a  
15 change to an existing policy relating to reimbursement, provide notice to  
16 interested parties. Parties interested in receiving notification of policy  
17 changes shall submit a written request for notification to the  
18 administration.

19 7. In addition to the cost sharing requirements specified in  
20 subsection D, paragraph 4 of this section:

21 (a) Charge monthly premiums up to the maximum amount allowed by  
22 federal law to all populations of eligible persons who may be charged.

23 (b) Implement this paragraph to the extent permitted under the federal  
24 deficit reduction act of 2005 and other federal laws, subject to the approval  
25 of federal waiver authority and to the extent that any changes in the cost  
26 sharing requirements under this paragraph would permit this state to receive  
27 any enhanced federal matching rate.

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

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

34 1. Authorize advance payments based on estimated liability to a  
35 contractor or a noncontracting provider after the contractor or  
36 noncontracting provider has submitted a claim for services and before the  
37 claim is ultimately resolved. The rules shall specify that any advance

1 payment shall be conditioned on the execution before payment of a contract  
2 with the contractor or noncontracting provider that requires the  
3 administration to retain a specified percentage, which shall be at least  
4 twenty per cent, of the claimed amount as security and that requires  
5 repayment to the administration if the administration makes any overpayment.

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

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

16 4. Notwithstanding any other law, require persons eligible pursuant to  
17 section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section  
18 36-2981, paragraph 6 to be financially responsible for any cost sharing  
19 requirements established in a state plan or a section 1115 waiver and  
20 approved by the centers for medicare and medicaid services. Cost sharing  
21 requirements may include copayments, coinsurance, deductibles, enrollment  
22 fees and monthly premiums for enrolled members, including households with  
23 children enrolled in the Arizona long-term care system.

24 E. The director shall adopt rules that further specify the medical  
25 care and hospital services that are covered by the system pursuant to section  
26 36-2907.

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

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

35 1. The director shall adopt rules that, for services rendered from and  
36 after September 30, 1985 until October 1, 1986, define "adjusted billed

1 charges" as that reimbursement level that has the effect of holding constant  
2 whichever of the following is applicable:

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

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

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

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

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

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

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

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

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

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

35 5. The director shall define by rule the method of determining when a  
36 hospital bill will be considered received and when a hospital's billed  
37 charges will be considered paid. Payment received by a hospital from the

1 administration pursuant to this subsection or from a contractor either by  
2 contract or pursuant to section 36-2904, subsection I shall be considered  
3 payment of the hospital bill in full, except that a hospital may collect any  
4 unpaid portion of its bill from other third party payors or in situations  
5 covered by title 33, chapter 7, article 3.

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

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

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

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

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

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

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

8 Payment received by a hospital from the administration pursuant to this  
9 subsection or from a contractor either by contract or pursuant to section  
10 36-2904, subsection I is considered payment by the administration or the  
11 contractor of the administration's or contractor's liability for the hospital  
12 bill. A hospital may collect any unpaid portion of its bill from other third  
13 party payors or in situations covered by title 33, chapter 7, article 3.

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

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

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

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

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

1           7. Except for privileged medical information, the administration shall  
2 make available for public inspection the cost and charge data and the  
3 calculations used by the administration to determine payments under the  
4 tiered per diem system, provided that individual hospitals are not identified  
5 by name. The administration shall make the data and calculations available  
6 for public inspection during regular business hours and shall provide copies  
7 of the data and calculations to individuals requesting such copies within  
8 thirty days of receipt of a written request. The administration may charge a  
9 reasonable fee for the provision of the data or information.

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

21           9. For graduate medical education programs:

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

1 settlements or appeals by the hospitals to the administration. The monies  
2 available under this subdivision shall not exceed the fiscal year 2005-2006  
3 appropriation adjusted annually by the increase or decrease in the index  
4 published by the global insight hospital market basket index for prospective  
5 hospital reimbursement, except for monies distributed for expansions pursuant  
6 to subdivision (b) of this paragraph.

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

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

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

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

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

30 (ii) For a portion of additional indirect graduate medical education  
31 costs for programs that are located in a county with a population of less  
32 than five hundred thousand persons at the time the residency position was  
33 created or for a residency position that includes a rotation in a county with  
34 a population of less than five hundred thousand persons at the time the  
35 residency position was established. These programs must be approved by the  
36 administration.

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

3           (e) Each graduate medical education program that receives funding  
4 pursuant to subdivision (b) or (c) of this paragraph shall identify and  
5 report to the administration the number of new residency positions created by  
6 the funding provided in this paragraph, including positions in rural areas.  
7 The program shall also report information related to the number of funded  
8 residency positions that resulted in physicians locating their practice in  
9 this state. The administration shall report to the joint legislative budget  
10 committee by February 1 of each year on the number of new residency positions  
11 as reported by the graduate medical education programs.

12           (f) Local, county and tribal governments and any university under the  
13 jurisdiction of the Arizona board of regents may provide monies in addition  
14 to any state general fund monies appropriated for graduate medical education  
15 in order to qualify for additional matching federal monies for providers,  
16 programs or positions in a specific locality and costs incurred pursuant to a  
17 specific contract between the administration and providers or other entities  
18 to provide graduate medical education services as an administrative  
19 activity. Payments by the administration pursuant to this subdivision may be  
20 limited to those providers designated by the funding entity and may be based  
21 on any methodology deemed appropriate by the administration, including  
22 replacing any payments that might otherwise have been paid pursuant to  
23 subdivision (a), (b) or (c) of this paragraph had sufficient state general  
24 fund monies or other monies been appropriated to fully fund those payments.  
25 These programs, positions, payment methodologies and administrative graduate  
26 medical education services must be approved by the administration and the  
27 centers for medicare and medicaid services. The administration shall report  
28 to the president of the senate, the speaker of the house of representatives  
29 and the director of the joint legislative budget committee on or before July  
30 1 of each year on the amount of money contributed and number of residency  
31 positions funded by local, county and tribal governments, including the  
32 amount of federal matching monies used.

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

1           10. The prospective tiered per diem payment methodology for inpatient  
2 hospital services shall include a mechanism for the payment of claims with  
3 extraordinary operating costs per day. For tiered per diem rates effective  
4 beginning on October 1, 1999, outlier cost thresholds are frozen at the  
5 levels in effect on January 1, 1999 and adjusted annually by the  
6 administration by the global insight hospital market basket index for  
7 prospective payment system hospitals. Beginning with dates of service on or  
8 after October 1, 2007, the administration shall phase in the use of the most  
9 recent statewide urban and statewide rural average medicare cost-to-charge  
10 ratios or centers for medicare and medicaid services approved cost-to-charge  
11 ratios to qualify and pay extraordinary operating costs. Cost-to-charge  
12 ratios shall be updated annually. Routine maternity charges are not eligible  
13 for outlier reimbursement. The administration shall complete full  
14 implementation of the phase-in on or before October 1, 2009. FOR DATES OF  
15 SERVICE ON AND AFTER OCTOBER 1, 2011 AND FOR EACH SUBSEQUENT CONTRACT YEAR,  
16 THE ADMINISTRATION SHALL USE NINETY-FIVE PER CENT OF THE STATEWIDE URBAN AND  
17 STATEWIDE RURAL AVERAGE MEDICARE COST-TO-CHARGE RATIOS IN EFFECT ON THE  
18 PRECEDING JULY 1 OR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES APPROVED  
19 COST-TO-CHARGE RATIOS TO QUALIFY AND PAY EXTRAORDINARY OPERATING COSTS.

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

23           12. FOR INPATIENT HOSPITAL SERVICES RENDERED ON OR AFTER OCTOBER 1,  
24 2011, THE PROSPECTIVE TIERED PER DIEM PAYMENT RATES ARE PERMANENTLY RESET TO  
25 THE AMOUNTS PAYABLE FOR THOSE SERVICES AS OF SEPTEMBER 30, 2011 PURSUANT TO  
26 THIS SUBSECTION.

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

34           J. The administration may make direct payments to hospitals for  
35 hospitalization and medical care provided to a member in accordance with this  
36 article and rules. The director may adopt rules to establish the procedures  
37 by which the administration shall pay hospitals pursuant to this subsection

1 if a contractor fails to make timely payment to a hospital. Such payment  
2 shall be at a level determined pursuant to section 36-2904, subsection H  
3 or I. The director may withhold payment due to a contractor in the amount of  
4 any payment made directly to a hospital by the administration on behalf of a  
5 contractor pursuant to this subsection.

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

11 1. The type of third party payments to be monitored pursuant to this  
12 subsection.

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

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

31 1. On written notice from the administration or oral or written notice  
32 from a member that a claim for covered services may be in violation of this  
33 section, the provider that has a contract with a contractor or noncontracting  
34 provider shall investigate the inquiry and verify whether the person was  
35 eligible for services at the time that covered services were provided. If  
36 the claim was paid or should have been paid by the system, the provider that

1 has a contract with a contractor or noncontracting provider shall not  
2 continue billing the member.

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

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

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

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

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

33 M. The administration may conduct postpayment review of all claims  
34 paid by the administration and may recoup any monies erroneously paid. The  
35 director may adopt rules that specify procedures for conducting postpayment  
36 review. A contractor may conduct a postpayment review of all claims paid by  
37 the contractor and may recoup monies that are erroneously paid.

1           N. The director or the director's designee may employ and supervise  
2 personnel necessary to assist the director in performing the functions of the  
3 administration.

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

7           P. Notwithstanding any other law, on federal approval the  
8 administration may make disproportionate share payments to private hospitals,  
9 county operated hospitals, including hospitals owned or leased by a special  
10 health care district, and state operated institutions for mental disease  
11 beginning October 1, 1991 in accordance with federal law and subject to  
12 legislative appropriation. If at any time the administration receives  
13 written notification from federal authorities of any change or difference in  
14 the actual or estimated amount of federal funds available for  
15 disproportionate share payments from the amount reflected in the legislative  
16 appropriation for such purposes, the administration shall provide written  
17 notification of such change or difference to the president and the minority  
18 leader of the senate, the speaker and the minority leader of the house of  
19 representatives, the director of the joint legislative budget committee, the  
20 legislative committee of reference and any hospital trade association within  
21 this state, within three working days not including weekends after receipt of  
22 the notice of the change or difference. In calculating disproportionate  
23 share payments as prescribed in this section, the administration may use  
24 either a methodology based on claims and encounter data that is submitted to  
25 the administration from contractors or a methodology based on data that is  
26 reported to the administration by private hospitals and state operated  
27 institutions for mental disease. The selected methodology applies to all  
28 private hospitals and state operated institutions for mental disease  
29 qualifying for disproportionate share payments. For the purposes of this  
30 subsection, "disproportionate share payment" means a payment to a hospital  
31 that serves a disproportionate share of low-income patients as described by  
32 42 United States Code section 1396r-4.

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

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

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

8 T. IN ADDITION TO ANY REQUIREMENTS ADOPTED PURSUANT TO SUBSECTION D,  
9 PARAGRAPH 4 OF THIS SECTION, NOTWITHSTANDING ANY OTHER LAW, SUBJECT TO  
10 APPROVAL BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, BEGINNING JULY 1,  
11 2011, MEMBERS ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 6, SUBDIVISION  
12 (a), SECTION 36-2931 AND SECTION 36-2981, PARAGRAPH 6 SHALL PAY THE  
13 FOLLOWING:

14 1. A MONTHLY PREMIUM OF FIFTEEN DOLLARS, EXCEPT THAT THE TOTAL MONTHLY  
15 PREMIUM FOR AN ENTIRE HOUSEHOLD SHALL NOT EXCEED SIXTY DOLLARS.

16 2. A COPAYMENT OF FIVE DOLLARS FOR EACH PHYSICIAN OFFICE VISIT.

17 3. A COPAYMENT OF TEN DOLLARS FOR EACH URGENT CARE VISIT.

18 4. A COPAYMENT OF THIRTY DOLLARS FOR EACH EMERGENCY DEPARTMENT VISIT.

19 Sec. 11. Section 36-2906, Arizona Revised Statutes, is amended to  
20 read:

21 36-2906. Qualified plan health services contracts; proposals;  
22 administration

23 A. The administration shall:

24 1. Supervise the administrator.

25 2. Review the proposals.

26 3. Award contracts.

27 B. The director shall prepare and issue a request for proposal,  
28 including a proposed contract format, in each of the counties of this state,  
29 at least once every five years, to qualified group disability insurers,  
30 hospital and medical service corporations, health care services organizations  
31 and any other qualified public or private persons, including county-owned and  
32 operated health care facilities. The contracts shall specify the  
33 administrative requirements, the delivery of medically necessary services and  
34 the subcontracting requirements.

35 C. The director shall adopt rules regarding the request for proposal  
36 process that provide:

1           1. For definition of proposals in the following categories subject to  
2 the following conditions:

3           (a) Inpatient hospital services.

4           (b) Outpatient services, including emergency dental care, and early  
5 and periodic health screening and diagnostic services for children.

6           (c) Pharmacy services.

7           (d) Laboratory, x-ray and related diagnostic medical services and  
8 appliances.

9           2. Allowance for the adjustment of such categories by expansion,  
10 deletion, segregation or combination in order to secure the most financially  
11 advantageous proposals for the system.

12           3. An allowance for limitations on the number of high risk persons  
13 that must be included in any proposal.

14           4. For analysis of the proposals for each geographic service area as  
15 defined by the director to ensure the provision of health and medical  
16 services that are required to be provided throughout the geographic service  
17 area pursuant to section 36-2907.

18           5. For the submittal of proposals by a group disability insurer,  
19 hospital and medical service corporation, health care services organization  
20 or any other qualified public or private person intending to submit a  
21 proposal pursuant to this section. Each qualified proposal shall be entered  
22 with separate categories for the distinct groups of persons to be covered by  
23 the proposed contracts, as set forth in the request for proposal.

24           6. For the procurement of reinsurance for expenses incurred by any  
25 contractor or member or the system in providing services in excess of amounts  
26 specified by the director in any contract year. The director shall adopt  
27 rules to provide that the administrator may specify guidelines on a case by  
28 case basis for the types of care and services that may be provided to a  
29 person whose care is covered by reinsurance. The rules shall provide that if  
30 a contractor does not follow specified guidelines for care or services and if  
31 the care or services could be provided pursuant to the guidelines at a lower  
32 cost the contractor is entitled to reimbursement as if the care or services  
33 specified in the guidelines had been provided.

34           7. For the awarding of contracts to contractors with qualified  
35 proposals determined to be the most advantageous to the state for each of the  
36 counties in this state. A contract may be awarded that provides services  
37 only to persons defined as eligible pursuant to section 36-2901, paragraph 6,

1 subdivision (b), (c), (d) or (e). The director may provide by rule a second  
2 round competitive proposal procedure for the director to request voluntary  
3 price reduction of proposals from only those that have been tentatively  
4 selected for award, before the final award or rejection of proposals.

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

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

17 D. Reinsurance may be obtained against expenses in excess of a  
18 specified amount on behalf of any individual for system covered emergency or  
19 inpatient services either through the purchase of a reinsurance policy or  
20 through a system self-insurance program as determined by the director.  
21 Reinsurance ~~may~~, subject to the approval of the director, **MAY** be obtained  
22 against expenses in excess of a specified amount on behalf of any individual  
23 for outpatient services either through the purchase of a reinsurance policy  
24 or through a system self-insurance program as determined by the director.

25 E. Notwithstanding the other provisions of this section, the ~~system~~  
26 **ADMINISTRATION** may procure, provide or coordinate system covered services by  
27 interagency agreement with authorized agencies of this state or with a  
28 federal agency for distinct groups of eligible persons, including persons  
29 eligible for children's rehabilitative services ~~through the department of~~  
30 ~~health services~~ and persons eligible for comprehensive medical and dental  
31 program services through the department **OF ECONOMIC SECURITY**.

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

35 G. After contracts are awarded pursuant to this section, the director  
36 may negotiate with any successful proposal respondent for the expansion or

1 contraction of services or service areas if there are unnecessary gaps or  
2 duplications in services or service areas.

3 Sec. 12. Section 36-2907, Arizona Revised Statutes, is amended to  
4 read:

5 36-2907. Covered health and medical services; modifications;  
6 related delivery of service requirements; definition

7 A. Subject to the limitations and exclusions specified in this  
8 section, contractors shall provide the following medically necessary health  
9 and medical services:

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

16 2. Outpatient health services that are ordinarily provided in  
17 hospitals, clinics, offices and other health care facilities by licensed  
18 health care providers. Outpatient health services include services provided  
19 by or under the direction of a physician or a primary care practitioner.

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

22 4. Medications that are ordered on prescription by a physician or a  
23 dentist licensed pursuant to title 32, chapter 11. ~~Beginning January 1,~~  
24 ~~2006,~~ Persons who are dually eligible for title XVIII and title XIX services  
25 must obtain available medications through a medicare licensed or certified  
26 medicare advantage prescription drug plan, a medicare prescription drug plan  
27 or any other entity authorized by medicare to provide a medicare part D  
28 prescription drug benefit.

29 5. Medical supplies, durable medical equipment and prosthetic devices  
30 ordered by a physician or a primary care practitioner. Suppliers of durable  
31 medical equipment shall provide the administration with complete information  
32 about the identity of each person who has an ownership or controlling  
33 interest in their business and shall comply with federal bonding requirements  
34 in a manner prescribed by the administration.

35 6. For persons who are at least twenty-one years of age, treatment of  
36 medical conditions of the eye, excluding eye examinations for prescriptive  
37 lenses and the provision of prescriptive lenses.

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

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

12           9. Podiatry services ordered by a primary care physician or primary  
13 care practitioner.

14           10. Nonexperimental transplants approved for title XIX reimbursement.

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

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

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

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

22           (a) Outpatient health services do not include occupational therapy or  
23 speech therapy.

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

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

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

31           (e) Podiatry services do not include services performed by a  
32 podiatrist.

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

34           (i) Pancreas only transplants.

35           (ii) Pancreas after kidney transplants.

36           (iii) Lung transplants.

37           (iv) Hemopoetic cell allogenic unrelated transplants.

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

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

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

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

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

11 D. The director shall adopt rules necessary to limit, to the extent  
12 possible, the scope, duration and amount of services, including maximum  
13 limitations for inpatient services that are consistent with federal  
14 regulations under title XIX of the social security act (P.L. 89-97; 79 Stat.  
15 344; 42 United States Code section 1396 (1980)). To the extent possible and  
16 practicable, these rules shall provide for the prior approval of medically  
17 necessary services provided pursuant to this chapter.

18 E. The director shall make available home health services in lieu of  
19 hospitalization pursuant to contracts awarded under this article. For the  
20 purposes of this subsection, "home health services" means the provision of  
21 nursing services, home health aide services or medical supplies, equipment  
22 and appliances, which are provided on a part-time or intermittent basis by a  
23 licensed home health agency within a member's residence based on the orders  
24 of a physician or a primary care practitioner. Home health agencies shall  
25 comply with the federal bonding requirements in a manner prescribed by the  
26 administration.

27 F. The director shall adopt rules for the coverage of behavioral  
28 health services for persons who are eligible under section 36-2901, paragraph  
29 6, subdivision (a). The administration shall contract with the department of  
30 health services for the delivery of all medically necessary behavioral health  
31 services to persons who are eligible under rules adopted pursuant to this  
32 subsection. The division of behavioral health in the department of health  
33 services shall establish a diagnostic and evaluation program to which other  
34 state agencies shall refer children who are not already enrolled pursuant to  
35 this chapter and who may be in need of behavioral health services. In  
36 addition to an evaluation, the division of behavioral health shall also  
37 identify children who may be eligible under section 36-2901, paragraph 6,

1 subdivision (a) or section 36-2931, paragraph 5 and shall refer the children  
2 to the appropriate agency responsible for making the final eligibility  
3 determination.

4 G. The director shall adopt rules for the provision of transportation  
5 services and rules providing for copayment by members for transportation for  
6 other than emergency purposes. Subject to approval by the centers for  
7 medicare and medicaid services, nonemergency medical transportation shall not  
8 be provided ~~to persons who are eligible pursuant to sections 36-2901.01 and~~  
9 ~~36-2901.04 and who reside in a county with a population of more than five~~  
10 ~~hundred thousand persons~~ EXCEPT WHEN TRANSPORTING MEMBERS FROM ONE HEALTH  
11 CARE FACILITY OR OFFICE TO ANOTHER. Prior authorization is not required for  
12 medically necessary ambulance transportation services rendered to members or  
13 eligible persons initiated by dialing telephone number 911 or other  
14 designated emergency response systems.

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

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

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

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

3 1. Emergency services and specialty services provided pursuant to  
4 section 36-2908.

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

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

20 M. The director shall adopt rules that prescribe the coordination of  
21 medical care for persons who are eligible for system services. The rules  
22 shall include provisions for the transfer of patients, the transfer of  
23 medical records and the initiation of medical care.

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

26 Sec. 13. Title 36, chapter 29, article 1, Arizona Revised Statutes, is  
27 amended by adding section 36-2930, to read:

28 36-2930. Prescription drug rebate fund; exemption; definition

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

1           B. MONIES IN THE FUND SHALL BE USED TO RETURN THE FEDERAL SHARE OF  
2 PRESCRIPTION DRUG REBATE COLLECTIONS AND INTEREST FROM LATE PAYMENTS TO THE  
3 CENTERS FOR MEDICARE AND MEDICAID SERVICES BY OFFSETTING FUTURE FEDERAL  
4 DRAWS, TO PAY FOR THE ADMINISTRATIVE COSTS OF THE PRESCRIPTION DRUG REBATE  
5 PROGRAM AND AS THE NONFEDERAL SHARE FOR PAYMENTS TO CONTRACTORS OR PROVIDERS  
6 IN THE ADMINISTRATION'S MEDICAL SERVICES PROGRAMS. THE NONFEDERAL SHARE OF  
7 PRESCRIPTION DRUG REBATE COLLECTIONS AND INTEREST FROM LATE PAYMENTS INCLUDE  
8 REBATES RELATING TO PROGRAMS ADMINISTERED BY THE DEPARTMENT OF ECONOMIC  
9 SECURITY, THE DEPARTMENT OF HEALTH SERVICES AND OTHER GOVERNMENTAL ENTITIES  
10 THAT CONTRIBUTE TO THE NONFEDERAL SHARE FOR PRESCRIPTION DRUGS.

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

- 13           1. PAYMENTS TO THE PRESCRIPTION DRUG REBATE VENDOR.
- 14           2. ADMINISTRATIVE COSTS OF THE ADMINISTRATION IN SUPPORT OF THE  
15 PRESCRIPTION DRUG REBATE PROGRAM.

16           Sec. 14. Section 36-2988, Arizona Revised Statutes, is amended to  
17 read:

18           36-2988. Delivery of services; health plans; requirements

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

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

25           C. As determined by the director, reinsurance may be provided against  
26 expenses in excess of a specified amount on behalf of any member for covered  
27 emergency services, inpatient services or outpatient services in the same  
28 manner as reinsurance provided under article 1 of this chapter. Subject to  
29 the approval of the director, reinsurance may be obtained against expenses in  
30 excess of a specified amount on behalf of any member.

31           D. Notwithstanding any other law, the administration may procure,  
32 provide or coordinate covered services by interagency agreement with  
33 authorized agencies of this state for distinct groups of members, including  
34 persons eligible for children's rehabilitative services ~~through the~~  
35 ~~department of health services~~ and members eligible for comprehensive medical  
36 and dental benefits through the department of economic security.

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

4           F. Payments to contractors shall be made monthly and may be subject to  
5 contract provisions requiring the retention of a specified percentage of the  
6 payment by the director, a reserve fund or any other contract provisions by  
7 which adjustments to the payments are made based on utilization efficiency,  
8 including incentives for maintaining quality care and minimizing unnecessary  
9 inpatient services. Reserve monies withheld from contractors shall be  
10 distributed to providers who meet performance standards established by the  
11 director. Any reserve fund established pursuant to this subsection shall be  
12 established as a separate account within the Arizona health care cost  
13 containment system.

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

17           H. A contractor may require that subcontracting providers or  
18 noncontracting providers be paid for covered services, other than hospital  
19 services, according to the capped fee-for-service schedule adopted by the  
20 administration or at lower rates as may be negotiated by the contractor.

21           I. A school district may perform outreach and information activities  
22 that relate to this article, with permission of the school principal and  
23 school district. The administration and contractors may collaborate with  
24 entities such as community based organizations, faith based organizations,  
25 schools and school districts for outreach and information activities related  
26 to this article. Outreach and information activities shall not include  
27 delivery of services, screening activities, eligibility determination or  
28 enrollment related to this article. Outreach and information activities  
29 include promotion of health care coverage, participation in school events and  
30 distribution of applications and materials to pupils and their families.  
31 Outreach and information activities performed by the administration,  
32 contractors or a school district shall not reduce or interfere with classroom  
33 instruction time.

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

1           Sec. 15. Section 38-654, Arizona Revised Statutes, is amended to read:

2           38-654. Special employee health insurance trust fund; purpose;  
3                           investment of monies; use of monies; exemption from  
4                           lapsing; annual report

5           A. There is established a special employee health insurance trust fund  
6           for the purpose of administering the state employee health insurance benefit  
7           plans. The fund shall consist of legislative appropriations, monies  
8           collected from the employer and employees for the health insurance benefit  
9           plans and investment earnings on monies collected from employees. The fund  
10          shall be administered by the director of the department of administration.  
11          Monies in the fund that are determined by the legislature to be for  
12          administrative expenses of the department of administration, including monies  
13          authorized by subsection ~~D~~ C, paragraph 4 of this section, are subject to  
14          legislative appropriation.

15          B. On notice from the department of administration, the state  
16          treasurer shall invest and divest monies in the fund as provided by section  
17          35-313, and monies earned from investment shall be credited to the fund.  
18          There shall be a separate accounting of monies contributed by the employer,  
19          monies collected from state employees and investment earnings on monies  
20          collected from employees. Monies collected from state employees for health  
21          insurance benefit plans shall be expended ~~prior to~~ BEFORE expenditure of  
22          monies contributed by the employer.

23          ~~C. The director of the department of administration may authorize the~~  
24          ~~employer health insurance contributions by fund to be payable in advance~~  
25          ~~whether the budget unit is funded in whole or in part by state monies. By~~  
26          ~~July 15 each year, the joint legislative budget committee staff shall~~  
27          ~~determine the amount appropriated for employer health insurance~~  
28          ~~contributions. The department of administration may transfer to the special~~  
29          ~~employee health insurance trust fund in whole or in part the amount~~  
30          ~~appropriated to budget units for employer health insurance contributions as~~  
31          ~~deemed necessary.~~

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

36                1. To administer a health insurance benefit program for state officers  
37                and employees.

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

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

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

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

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

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

19           ~~H.~~ G. The department of administration shall submit an annual report  
20 on the financial status of the special employee insurance trust fund to the  
21 governor, the president of the senate, the speaker of the house of  
22 representatives, the chairpersons of the house and senate appropriations  
23 committees and the joint legislative budget committee staff by March 1. The  
24 report shall include:

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

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

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

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

36           ~~I.~~ H. The department shall submit a report to the joint legislative  
37 budget committee detailing any changes to the type of benefits offered under

1 the plan and associated costs at least forty-five days before making the  
2 change. The report shall include:

- 3 1. An estimate of the cost or saving associated with the change.
- 4 2. An explanation of why the change was implemented before the next  
5 plan year.

6 Sec. 16. Section 43-1088, Arizona Revised Statutes, is amended to  
7 read:

8 43-1088. Credit for contribution to qualifying charitable  
9 organizations: definitions

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

- 14 1. Two hundred dollars in any taxable year for a single individual or  
15 a head of household.
- 16 2. Four hundred dollars in any taxable year for a married couple  
17 filing a joint return.

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

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

26 D. The credit allowed by this section:

- 27 1. Is allowed only if the taxpayer itemizes deductions pursuant to  
28 section 43-1042 for the taxable year.
- 29 2. Is in lieu of a deduction pursuant to section 170 of the internal  
30 revenue code and taken for state tax purposes.

31 E. Taxpayers taking a credit authorized by this section shall provide  
32 the name of the qualifying charitable organization and the amount of the  
33 contribution to the department of revenue on forms provided by the  
34 department.

35 F. A qualifying charitable organization shall provide the department  
36 of revenue with a written certification that it meets all criteria to be  
37 considered a qualifying charitable organization. The organization shall also

1 notify the department of any changes that may affect the qualifications under  
2 this section.

3 G. The charitable organization's written certification must be signed  
4 by an officer of the organization under penalty of perjury. The written  
5 certification must include the following:

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

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

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

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

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

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

21 H. The department shall review each written certification and  
22 determine whether the organization meets all the criteria to be considered a  
23 qualifying charitable organization and notify the organization of its  
24 determination. The department may also periodically request recertification  
25 from the organization. The department shall compile and make available to  
26 the public a list of the qualifying charitable organizations.

27 I. For the purposes of this section:

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

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

32 3. "Qualifying charitable organization" means a charitable  
33 organization that is exempt from federal income taxation under section  
34 501(c)(3) of the internal revenue code or is a designated community action  
35 agency that receives community services block grant program monies pursuant  
36 to 42 United States Code section 9901. The organization must spend at least  
37 fifty per cent of its budget on services to residents of this state who

1 receive temporary assistance for needy families benefits or low income  
2 residents of this state and their households or to chronically ill or  
3 physically disabled children who are residents of this state. Taxpayers  
4 choosing to make donations through an umbrella charitable organization that  
5 collects donations on behalf of member charities shall designate that the  
6 donation be directed to a member charitable organization that would qualify  
7 under this section on a stand-alone basis.

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

12 Sec. 17. Laws 2010, chapter 232, section 13 is amended to read:

13 Sec. 13. ALTCS; county contributions; fiscal year 2010-2011

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

19	1. Apache	<del>\$ 469,400</del>
20		\$ 485,000
21	2. Cochise	<del>\$ 4,023,400</del>
22		\$ 4,140,300
23	3. Coconino	<del>\$ 1,408,800</del>
24		\$ 1,455,400
25	4. Gila	<del>\$ 1,623,600</del>
26		\$ 1,670,700
27	5. Graham	<del>\$ 1,072,900</del>
28		\$ 1,098,000
29	6. Greenlee	<del>\$ 122,200</del>
30		\$ 124,600
31	7. La Paz	<del>\$ 619,700</del>
32		\$ 636,800
33	8. Maricopa	<del>\$115,295,400</del>
34		\$118,573,200
35	9. Mohave	<del>\$ 5,479,700</del>
36		\$ 5,629,100

1	10. Navajo	<del>\$ 1,942,400</del>
2		\$ 2,006,700
3	11. Pima	<del>\$ 29,839,700</del>
4		\$ 30,705,400
5	12. Pinal	<del>\$ 11,132,800</del>
6		\$ 11,455,700
7	13. Santa Cruz	<del>\$ 1,434,600</del>
8		\$ 1,476,300
9	14. Yavapai	<del>\$ 7,024,400</del>
10		\$ 7,228,300
11	15. Yuma	<del>\$ 6,018,000</del>
12		\$ 6,192,500

13 B. The amounts specified in subsection A of this section reflect  
14 ~~\$76,014,400~~ \$57,757,000 in decreases in county contributions for the Arizona  
15 long-term care system.

16 C. The amounts specified in subsection A of this section reflect  
17 ~~\$4,390,700~~ \$3,629,200 in decreases in county contributions for the Arizona  
18 long-term care system for medicare clawback savings.

19 D. The county contributions for the Arizona long-term care system  
20 would have otherwise totaled ~~\$267,912,100~~ \$250,635,000 in fiscal year  
21 2010-2011.

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

1 A OF THIS SECTION IN THE LONG-TERM CARE SYSTEM FUND ESTABLISHED BY SECTION  
2 36-2913, ARIZONA REVISED STATUTES.

3 Sec. 18. ALTCS: county contributions: fiscal year 2011-2012

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

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

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

1 paid pursuant to subsection A of this section in the long-term care system  
2 fund established by section 36-2913, Arizona Revised Statutes.

3 Sec. 19. Sexually violent persons; county reimbursement; fiscal  
4 year 2011-2012; deposit; tax withholding

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

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

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

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

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

29 Sec. 20. Competency restoration treatment; city and county  
30 reimbursement; fiscal year 2011-2012; deposit; tax  
31 withholding

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

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

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

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

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

22           Sec. 21. State employee health benefits

23           For fiscal year 2011-2012, the department of administration shall not  
24 implement a differentiated health insurance premium based on the integrated  
25 or nonintegrated status of a health insurance provider available through the  
26 state employee health insurance program.

27           Sec. 22. AHCCCS: disproportionate share payments

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

31           1. \$55,507,900 for a qualifying nonstate operated public hospital.  
32 The Maricopa county special health care district shall provide a certified  
33 public expense form for the amount of qualifying disproportionate share  
34 hospital expenditures made on behalf of this state to the administration on  
35 or before May 1, 2012 for all state plan years as required by the Arizona  
36 health care cost containment system 1115 waiver standard terms and  
37 conditions. The administration shall assist the district in determining the

1 amount of qualifying disproportionate share hospital expenditures. Once the  
2 administration files a claim with the federal government and receives federal  
3 funds participation based on the amount certified by the Maricopa county  
4 special health care district, if the certification is equal to or greater  
5 than \$55,507,900, the administration shall distribute \$4,202,300 to the  
6 Maricopa county special health care district and deposit the balance of the  
7 federal funds participation in the state general fund. If the certification  
8 provided is for an amount less than \$55,507,900, and the administration  
9 determines that the revised amount is correct pursuant to the methodology  
10 used by the administration pursuant to section 36-2903.01, Arizona Revised  
11 Statutes, the administration shall notify the governor, the president of the  
12 senate and the speaker of the house of representatives, shall distribute  
13 \$4,202,300 to the Maricopa county special health care district and shall  
14 deposit the balance of the federal funds participation in the state general  
15 fund. If the certification provided is for an amount less than \$55,507,900  
16 and the administration determines that the revised amount is not correct  
17 pursuant to the methodology used by the administration pursuant to section  
18 36-2903.01, Arizona Revised Statutes, the administration shall notify the  
19 governor, the president of the senate and the speaker of the house of  
20 representatives and shall deposit the total amount of the federal funds  
21 participation in the state general fund.

22 2. \$28,474,900 for the Arizona state hospital. The Arizona state  
23 hospital shall provide a certified public expense form for the amount of  
24 qualifying disproportionate share hospital expenditures made on behalf of the  
25 state to the administration on or before March 31, 2012. The administration  
26 shall assist the Arizona state hospital in determining the amount of  
27 qualifying disproportionate share hospital expenditures. Once the  
28 administration files a claim with the federal government and receives federal  
29 funds participation based on the amount certified by the Arizona state  
30 hospital, the administration shall distribute the entire amount of federal  
31 financial participation to the state general fund. If the certification  
32 provided is for an amount less than \$28,474,900, the administration shall  
33 notify the governor, the president of the senate and the speaker of the house  
34 of representatives and shall distribute the entire amount of federal  
35 financial participation to the state general fund. The certified public  
36 expense form provided by the Arizona state hospital shall contain both the

1 total amount of qualifying disproportionate share hospital expenditures and  
2 the amount limited by section 1923(g) of the social security act.

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

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

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

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

28 Sec. 23. AHCCCS transfer; counties; federal monies

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

35 Sec. 24. AHCCCS; fraudulent payments; verification

36 A. The Arizona health care cost containment system administration  
37 shall issue a request for information on or before August 1, 2011 for

1 mechanisms to reduce erroneous and fraudulent payments in the Arizona health  
2 care cost containment system, which may include mechanisms that verify the  
3 identity of individual recipients and that verify the services provided to  
4 individual recipients. The responses to the request for information may  
5 address either reducing incorrect payments due to actions of the individual  
6 recipient or the health care provider. Based on information received under  
7 this subsection, the Arizona health care cost containment system  
8 administration shall issue a request for proposals no later than October 1,  
9 2011. The request for proposals shall be reviewed by the joint legislative  
10 budget committee before it is issued.

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

13 Sec. 25. County acute care contribution: fiscal year 2011-2012

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

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

32 B. If a county does not provide funding as specified in subsection A  
33 of this section, the state treasurer shall subtract the amount owed by the  
34 county to the Arizona health care cost containment system fund and the  
35 long-term care system fund established by section 36-2913, Arizona Revised  
36 Statutes, from any payments required to be made by the state treasurer to  
37 that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona

1 Revised Statutes, plus interest on that amount pursuant to section 44-1201,  
2 Arizona Revised Statutes, retroactive to the first day the funding was due.  
3 If the monies the state treasurer withholds are insufficient to meet that  
4 county's funding requirements as specified in subsection A of this section,  
5 the state treasurer shall withhold from any other monies payable to that  
6 county from whatever state funding source is available an amount necessary to  
7 fulfill that county's requirement. The state treasurer shall not withhold  
8 distributions from the highway user revenue fund pursuant to title 28,  
9 chapter 18, article 2, Arizona Revised Statutes.

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

16 D. The state treasurer shall deposit the amounts paid pursuant to  
17 subsection C of this section and amounts withheld pursuant to subsection B of  
18 this section in the Arizona health care cost containment system fund and the  
19 long-term care system fund established by section 36-2913, Arizona Revised  
20 Statutes.

21 E. If payments made pursuant to subsection C of this section exceed  
22 the amount required to meet the costs incurred by the Arizona health care  
23 cost containment system for the hospitalization and medical care of those  
24 persons defined as an eligible person pursuant to section 36-2901, paragraph  
25 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of  
26 the Arizona health care cost containment system administration may instruct  
27 the state treasurer either to reduce remaining payments to be paid pursuant  
28 to this section by a specified amount or to provide to the counties specified  
29 amounts from the Arizona health care cost containment system fund and the  
30 long-term care system fund.

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



1 contribution for the provision of hospitalization and medical care services  
2 administered by the Arizona health care cost containment system  
3 administration.

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

6 Sec. 27. Proposition 204 administration; county expenditure  
7 limitation

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

12 Sec. 28. AHCCCS; ambulance services; reimbursement;  
13 retroactivity

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

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

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

32 D. This section is effective retroactively to from and after June 30,  
33 2011.

34 Sec. 29. AHCCCS; risk contingency rate setting

35 Notwithstanding any other law, for the contract year beginning  
36 October 1, 2011 and ending September 30, 2012, the Arizona health care cost  
37 containment system administration may continue the risk contingency rate

1 setting for all managed care organizations and the funding for all managed  
2 care organizations administrative funding levels that was imposed for the  
3 contract year beginning October 1, 2010 and ending September 30, 2011.

4 Sec. 30. AHCCCS; hospital reimbursement inflation adjustment  
5 freeze

6 For the contract year beginning October 1, 2011:

7 1. Notwithstanding section 36-2903.01, subsection H, paragraph 2,  
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 tiered per diem payments for inpatient hospital care by the 2011 data  
11 resources incorporated market basket index for prospective payment system  
12 hospitals.

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

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

22 Sec. 31. AHCCCS; hospital rates; reduction authority

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

27 Sec. 32. Exemption from rule making; Arizona health care cost  
28 containment system

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

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

6           Sec. 33. Exemption from rule making; department of health services

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

11           Sec. 34. Intent; false claims act; savings

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

16           Sec. 35. Intent; vital records fees

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

20           Sec. 36. Transfer of powers; effect

21           A. The Arizona health care cost containment system administration  
22 succeeds to the powers and duties of the department of health services  
23 relating to children's rehabilitative services prescribed pursuant to title  
24 36, chapter 2, article 3, Arizona Revised Statutes.

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

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

33           D. All personnel, property and records, all data and investigative  
34 findings and all appropriated monies remaining unspent and unencumbered of  
35 the department of health services relating to children's rehabilitative  
36 services are transferred to the Arizona health care cost containment system

1 administration and may be used for the purposes prescribed in title 36,  
2 chapter 2, article 3, Arizona Revised Statutes.

3 Sec. 37. Retroactivity

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

6 B. Section 36-260, Arizona Revised Statutes, as added by this act, is  
7 effective, and sections 36-261, 36-262, 36-263, 36-264, 36-797.43, 36-797.44,  
8 36-2903.01, 36-2988 and 43-1088, Arizona Revised Statutes, as amended by this  
9 act, apply, retroactively to from and after June 30, 2011.

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

12 Amend title to conform

JOHN KAVANAGH

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