

State of Arizona
Senate
Fiftieth Legislature
First Regular Session
2011

SENATE BILL 1619

AN ACT

AMENDING TITLE 36, CHAPTER 2, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-260; AMENDING SECTIONS 36-261, 36-262, 36-263 AND 36-264, ARIZONA REVISED STATUTES; REPEALING SECTION 36-265, ARIZONA REVISED STATUTES; AMENDING SECTIONS 36-341, 36-797.43, 36-797.44, 36-2901.03, 36-2903.01, 36-2906 AND 36-2907, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-2930; AMENDING SECTIONS 36-2988, 38-654 AND 43-1088, ARIZONA REVISED STATUTES; AMENDING LAWS 2010, CHAPTER 232, SECTION 13; MAKING APPROPRIATIONS AND TRANSFERS; RELATING TO HEALTH BUDGET RECONCILIATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

4 36-260. Definitions

5 IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

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

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

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

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

15 36-261. Powers and duties; expenditure limitation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 (i) Carrying on research and compiling statistics.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39 1. Cost to this state.

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

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

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

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

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

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

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

26 Sec. 3. Section 36-262, Arizona Revised Statutes, is amended to read:
27 ~~36-262.~~ Central statewide information and referral service for
28 chronically ill or physically disabled children

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

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

36 1. Establish a roster of agencies providing medical, educational,
37 financial, social and transportation services to chronically ill or
38 physically disabled children.

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

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

1 this article so that any costs for services payable by the ~~department~~
2 ~~ADMINISTRATION~~ are costs avoided or recovered from any available provider of
3 first party health insurance medical benefits, subject to the specific scope
4 of benefits of the provider of first party medical insurance benefits. The
5 ~~department~~ ~~ADMINISTRATION~~ may require that health care service providers are
6 responsible for the coordination of benefits provided pursuant to this
7 article. The ~~department~~ ~~ADMINISTRATION~~ shall act as a payor of last resort
8 unless this is specifically prohibited by federal law.

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

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

27 D. ~~The provisions of~~ This section ~~shall apply~~ ~~APPLIES~~ to a health care
28 services organization subject to ~~the provisions of~~ title 20, chapter 4,
29 article 9 in which a child is enrolled and who is receiving services pursuant
30 to this article. If a ~~health care services organization's enrolled~~ child
31 ~~ENROLLED IN A HEALTH CARE SERVICES ORGANIZATION~~ requires services under this
32 article and if the benefits for the services are contractually available
33 through the health care services organization, the health care services
34 organization may require the enrolled child to receive the services through
35 the health care services organization's contracted provider network up to the
36 coverage limits set forth in the health care services organization's evidence
37 of coverage. If the health care services organization elects not to provide
38 the covered services either directly or through its contracted provider
39 network or is unable to provide the covered services directly or through its
40 contracted provider network and the services are covered benefits as set
41 forth in the health care services organization's evidence of coverage, then
42 the health care services organization shall reimburse the ~~department~~
43 ~~ADMINISTRATION~~ for the services provided through the ~~department~~
44 ~~ADMINISTRATION~~ for the enrolled child. The health care services organization
45 ~~shall~~ ~~IS~~ not ~~be~~ required to reimburse the ~~department~~ ~~ADMINISTRATION~~ for

1 services beyond the coverage limits set forth in the health care services
2 organization's evidence of coverage for the enrolled child. The amount of
3 reimbursement paid by a health care services organization to the ~~department~~
4 **ADMINISTRATION** shall not be greater than the level of compensation the health
5 care services organization pays to its contracted provider network. A health
6 care services organization may impose prior authorization, referral and other
7 utilization review requirements in providing or paying for services to an
8 enrolled child under this section.

9 E. For **THE** purposes of this section, "first party health insurance
10 medical benefits" ~~include~~ **INCLUDES** benefits payable from a hospital, medical,
11 dental and optometric service corporation subject to ~~the provisions of~~ title
12 20, chapter 4, article 3, a health care services organization subject to ~~the~~
13 ~~provisions of~~ title 20, chapter 4, article 9, an insurer providing disability
14 insurance subject to ~~the provisions of~~ title 20, chapter 6, article 4, an
15 insurer providing group disability insurance subject to ~~the provisions of~~
16 title 20, chapter 6, article 5, and any other available first party health
17 insurance medical benefits, but does not include monies available under a
18 social services block grant or an optional state supplemental payment program
19 if federal monies are available.

20 Sec. 6. Repeal

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

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

23 ~~36-341.~~ Fees received by state and local registrars

24 A. The ~~state registrar~~ **DIRECTOR OF THE DEPARTMENT** shall establish ~~by~~
25 ~~rule~~ the fees, ~~if any~~, to be charged for searches, copies of registered
26 certificates, certified copies of registered certificates, amending
27 registered certificates and correcting certificates that are processed by the
28 department. **THE DIRECTOR MAY ESTABLISH A SURCHARGE TO BE ASSESSED ON ANY**
29 **LOCAL REGISTRAR WHO OBTAINS ACCESS TO THE DEPARTMENT'S VITAL RECORDS**
30 **AUTOMATION SYSTEM.** A local registrar may establish the local registrar's own
31 fees to be charged for searches, copies of registered certificates, certified
32 copies of registered certificates, amending registered certificates and
33 correcting certificates as determined necessary by the local entity.

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

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

1 and operate, either directly or by contracting with public or private
2 providers, programs for the diagnosis, care and treatment of adults suffering
3 from sickle cell anemia.

4 B. The adult or other responsible person, agency or third party payor
5 shall reimburse the ~~department~~ ADMINISTRATION for part or all of the costs of
6 services rendered to an adult pursuant to this section according to a scale
7 of rates and charges established by the ~~department~~ ADMINISTRATION and based
8 on the cost of services provided and the ability of the adult or other
9 responsible person to pay for ~~such~~ THESE services.

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

12 36-2901.03. Federal poverty program; eligibility

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

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

21 C. For persons who the administration determines are eligible pursuant
22 to this section, the date of eligibility is the first day of the month of
23 application.

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

27 E. Every six months the administration shall determine the continued
28 eligibility of any adult who is at least twenty-one years of age and who is
29 subject to redetermination of eligibility for temporary assistance for needy
30 families cash benefits by the department. Acute care redeterminations
31 pursuant to this subsection shall occur simultaneously with redeterminations
32 of eligibility for temporary assistance for needy families cash benefits.

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

35 36-2903.01. Additional powers and duties; report

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

42 B. The director shall:

43 1. Prescribe uniform forms to be used by all contractors. The rules
44 shall require a written and signed application by the applicant or an
45 applicant's authorized representative, or, if the person is incompetent or

1 incapacitated, a family member or a person acting responsibly for the
2 applicant may obtain a signature or a reasonable facsimile and file the
3 application as prescribed by the administration.

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

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

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

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

15 (c) Establish the process for management evaluation reviews that the
16 administration shall perform to evaluate the eligibility determination
17 functions performed by the department.

18 (d) Establish eligibility quality control reviews by the
19 administration.

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

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

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

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

38 4. By rule establish a procedure and time frames for the intake of
39 grievances and requests for hearings, for the continuation of benefits and
40 services during the appeal process and for a grievance process at the
41 contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and
42 41-1092.05, the administration shall develop rules to establish the procedure
43 and time frame for the informal resolution of grievances and appeals. A
44 grievance that is not related to a claim for payment of system covered
45 services shall be filed in writing with and received by the administration or

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

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

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

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

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

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

41 C. The director is authorized to apply for any federal funds available
42 for the support of programs to investigate and prosecute violations arising
43 from the administration and operation of the system. Available state funds
44 appropriated for the administration and operation of the system may be used
45 as matching funds to secure federal funds pursuant to this subsection.

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

2 1. Authorize advance payments based on estimated liability to a
3 contractor or a noncontracting provider after the contractor or
4 noncontracting provider has submitted a claim for services and before the
5 claim is ultimately resolved. The rules shall specify that any advance
6 payment shall be conditioned on the execution before payment of a contract
7 with the contractor or noncontracting provider that requires the
8 administration to retain a specified percentage, which shall be at least
9 twenty per cent, of the claimed amount as security and that requires
10 repayment to the administration if the administration makes any overpayment.

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

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

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

29 E. The director shall adopt rules that further specify the medical
30 care and hospital services that are covered by the system pursuant to section
31 36-2907.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42 1. For inpatient hospital stays, the administration shall use a
43 prospective tiered per diem methodology, using hospital peer groups if
44 analysis shows that cost differences can be attributed to independently
45 definable features that hospitals within a peer group share. In peer

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

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

33 3. Through June 30, 2004, for outpatient hospital services, the
34 administration shall reimburse a hospital by applying a hospital specific
35 outpatient cost-to-charge ratio to the covered charges. Beginning on July 1,
36 2004 through June 30, 2005, the administration shall reimburse a hospital by
37 applying a hospital specific outpatient cost-to-charge ratio to covered
38 charges. If the hospital increases its charges for outpatient services filed
39 with the Arizona department of health services pursuant to chapter 4, article
40 3 of this title, by more than 4.7 per cent for dates of service effective on
41 or after July 1, 2004, the hospital specific cost-to-charge ratio will be
42 reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7
43 per cent, the effective date of the increased charges will be the effective
44 date of the adjusted Arizona health care cost containment system
45 cost-to-charge ratio. The administration shall develop the methodology for a

1 capped fee-for-service schedule and a statewide cost-to-charge ratio. Any
2 covered outpatient service not included in the capped fee-for-service
3 schedule shall be reimbursed by applying the statewide cost-to-charge ratio
4 that is based on the services not included in the capped fee-for-service
5 schedule. Beginning on July 1, 2005, the administration shall reimburse
6 clean claims with dates of service on or after July 1, 2005, based on the
7 capped fee-for-service schedule or the statewide cost-to-charge ratio
8 established pursuant to this paragraph. The administration may make
9 additional adjustments to the outpatient hospital rates established pursuant
10 to this section based on other factors, including the number of beds in the
11 hospital, specialty services available to patients and the geographic
12 location of the hospital.

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

- 17 (a) An admission face sheet.
- 18 (b) An itemized statement.
- 19 (c) An admission history and physical.
- 20 (d) A discharge summary or an interim summary if the claim is split.
- 21 (e) An emergency record, if admission was through the emergency room.
- 22 (f) Operative reports, if applicable.
- 23 (g) A labor and delivery room report, if applicable.

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

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

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

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

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

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

11 7. Except for privileged medical information, the administration shall
12 make available for public inspection the cost and charge data and the
13 calculations used by the administration to determine payments under the
14 tiered per diem system, provided that individual hospitals are not identified
15 by name. The administration shall make the data and calculations available
16 for public inspection during regular business hours and shall provide copies
17 of the data and calculations to individuals requesting such copies within
18 thirty days of receipt of a written request. The administration may charge a
19 reasonable fee for the provision of the data or information.

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

31 9. For graduate medical education programs:

32 (a) Beginning September 30, 1997, the administration shall establish a
33 separate graduate medical education program to reimburse hospitals that had
34 graduate medical education programs that were approved by the administration
35 as of October 1, 1999. The administration shall separately account for
36 monies for the graduate medical education program based on the total
37 reimbursement for graduate medical education reimbursed to hospitals by the
38 system in federal fiscal year 1995-1996 pursuant to the tiered per diem
39 methodology specified in this section. The graduate medical education
40 program reimbursement shall be adjusted annually by the increase or decrease
41 in the index published by the global insight hospital market basket index for
42 prospective hospital reimbursement. Subject to legislative appropriation, on
43 an annual basis, each qualified hospital shall receive a single payment from
44 the graduate medical education program that is equal to the same percentage
45 of graduate medical education reimbursement that was paid by the system in

1 federal fiscal year 1995-1996. Any reimbursement for graduate medical
2 education made by the administration shall not be subject to future
3 settlements or appeals by the hospitals to the administration. The monies
4 available under this subdivision shall not exceed the fiscal year 2005-2006
5 appropriation adjusted annually by the increase or decrease in the index
6 published by the global insight hospital market basket index for prospective
7 hospital reimbursement, except for monies distributed for expansions pursuant
8 to subdivision (b) of this paragraph.

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

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

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

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

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

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

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

41 (e) Each graduate medical education program that receives funding
42 pursuant to subdivision (b) or (c) of this paragraph shall identify and
43 report to the administration the number of new residency positions created by
44 the funding provided in this paragraph, including positions in rural areas.
45 The program shall also report information related to the number of funded

1 residency positions that resulted in physicians locating their practice in
2 this state. The administration shall report to the joint legislative budget
3 committee by February 1 of each year on the number of new residency positions
4 as reported by the graduate medical education programs.

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

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

30 ~~10. The prospective tiered per diem payment methodology for inpatient
31 hospital services shall include a mechanism for the payment of claims with
32 extraordinary operating costs per day. For tiered per diem rates effective
33 beginning on October 1, 1999, outlier cost thresholds are frozen at the
34 levels in effect on January 1, 1999 and adjusted annually by the
35 administration by the global insight hospital market basket index for
36 prospective payment system hospitals. Beginning with dates of service on or
37 after October 1, 2007, the administration shall phase in the use of the most
38 recent statewide urban and statewide rural average medicare cost to charge
39 ratios or centers for medicare and medicaid services approved cost to charge
40 ratios to qualify and pay extraordinary operating costs. Cost to charge
41 ratios shall be updated annually. Routine maternity charges are not eligible
42 for outlier reimbursement. The administration shall complete full
43 implementation of the phase in on or before October 1, 2009.~~

44 ~~11.~~ 10. Notwithstanding section 41-1005, subsection A, paragraph 9,
45 the administration shall adopt rules pursuant to title 41, chapter 6

1 establishing the methodology for determining the prospective tiered per diem
2 payments.

3 11. FOR INPATIENT HOSPITAL SERVICES RENDERED ON OR AFTER OCTOBER 1,
4 2011, THE PROSPECTIVE TIERED PER DIEM PAYMENT RATES ARE PERMANENTLY RESET TO
5 THE AMOUNTS PAYABLE FOR THOSE SERVICES AS OF SEPTEMBER 30, 2011 PURSUANT TO
6 THIS SUBSECTION.

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

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

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

28 1. The type of third party payments to be monitored pursuant to this
29 subsection.

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

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

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

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

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

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

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

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

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

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

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.

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

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

43 T. IN ADDITION TO ANY REQUIREMENTS ADOPTED PURSUANT TO SUBSECTION D,
44 PARAGRAPH 4 OF THIS SECTION, NOTWITHSTANDING ANY OTHER LAW, SUBJECT TO
45 APPROVAL BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, BEGINNING JULY 1,

1 2011, MEMBERS ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 6, SUBDIVISION
2 (a), SECTION 36-2931 AND SECTION 36-2981, PARAGRAPH 6 SHALL PAY THE
3 FOLLOWING:

- 4 1. A MONTHLY PREMIUM OF FIFTEEN DOLLARS, EXCEPT THAT THE TOTAL MONTHLY
5 PREMIUM FOR AN ENTIRE HOUSEHOLD SHALL NOT EXCEED SIXTY DOLLARS.
- 6 2. A COPAYMENT OF FIVE DOLLARS FOR EACH PHYSICIAN OFFICE VISIT.
- 7 3. A COPAYMENT OF TEN DOLLARS FOR EACH URGENT CARE VISIT.
- 8 4. A COPAYMENT OF THIRTY DOLLARS FOR EACH EMERGENCY DEPARTMENT VISIT.

9 Sec. 12. Section 36-2906, Arizona Revised Statutes, is amended to
10 read:

11 36-2906. Qualified plan health services contracts; proposals;
12 administration

13 A. The administration shall:

- 14 1. Supervise the administrator.
- 15 2. Review the proposals.
- 16 3. Award contracts.

17 B. The director shall prepare and issue a request for proposal,
18 including a proposed contract format, in each of the counties of this state,
19 at least once every five years, to qualified group disability insurers,
20 hospital and medical service corporations, health care services organizations
21 and any other qualified public or private persons, including county-owned and
22 operated health care facilities. The contracts shall specify the
23 administrative requirements, the delivery of medically necessary services and
24 the subcontracting requirements.

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

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

- 29 (a) Inpatient hospital services.
- 30 (b) Outpatient services, including emergency dental care, and early
31 and periodic health screening and diagnostic services for children.
- 32 (c) Pharmacy services.
- 33 (d) Laboratory, x-ray and related diagnostic medical services and
34 appliances.

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

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

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

44 5. For the submittal of proposals by a group disability insurer,
45 hospital and medical service corporation, health care services organization

1 or any other qualified public or private person intending to submit a
2 proposal pursuant to this section. Each qualified proposal shall be entered
3 with separate categories for the distinct groups of persons to be covered by
4 the proposed contracts, as set forth in the request for proposal.

5 6. For the procurement of reinsurance for expenses incurred by any
6 contractor or member or the system in providing services in excess of amounts
7 specified by the director in any contract year. The director shall adopt
8 rules to provide that the administrator may specify guidelines on a case by
9 case basis for the types of care and services that may be provided to a
10 person whose care is covered by reinsurance. The rules shall provide that if
11 a contractor does not follow specified guidelines for care or services and if
12 the care or services could be provided pursuant to the guidelines at a lower
13 cost the contractor is entitled to reimbursement as if the care or services
14 specified in the guidelines had been provided.

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

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

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

35 D. Reinsurance may be obtained against expenses in excess of a
36 specified amount on behalf of any individual for system covered emergency or
37 inpatient services either through the purchase of a reinsurance policy or
38 through a system self-insurance program as determined by the director.
39 Reinsurance ~~may~~, subject to the approval of the director, ~~MAY~~ be obtained
40 against expenses in excess of a specified amount on behalf of any individual
41 for outpatient services either through the purchase of a reinsurance policy
42 or through a system self-insurance program as determined by the director.

43 E. Notwithstanding the other provisions of this section, the ~~system~~
44 ~~ADMINISTRATION~~ may procure, provide or coordinate system covered services by
45 interagency agreement with authorized agencies of this state or with a

1 federal agency for distinct groups of eligible persons, including persons
2 eligible for children's rehabilitative services ~~through the department of~~
3 ~~health services~~ and persons eligible for comprehensive medical and dental
4 program services through the department OF ECONOMIC SECURITY.

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

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

12 Sec. 13. Section 36-2907, Arizona Revised Statutes, is amended to
13 read:

14 36-2907. Covered health and medical services; modifications;
15 related delivery of service requirements; definition

16 A. Subject to the limitations and exclusions specified in this
17 section, contractors shall provide the following medically necessary health
18 and medical services:

19 1. Inpatient hospital services that are ordinarily furnished by a
20 hospital for the care and treatment of inpatients and that are provided under
21 the direction of a physician or a primary care practitioner. For the
22 purposes of this section, inpatient hospital services exclude services in an
23 institution for tuberculosis or mental diseases unless authorized under an
24 approved section 1115 waiver.

25 2. Outpatient health services that are ordinarily provided in
26 hospitals, clinics, offices and other health care facilities by licensed
27 health care providers. Outpatient health services include services provided
28 by or under the direction of a physician or a primary care practitioner.

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

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

38 5. Medical supplies, durable medical equipment and prosthetic devices
39 ordered by a physician or a primary care practitioner. Suppliers of durable
40 medical equipment shall provide the administration with complete information
41 about the identity of each person who has an ownership or controlling
42 interest in their business and shall comply with federal bonding requirements
43 in a manner prescribed by the administration.

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

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

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

15 9. Podiatry services ordered by a primary care physician or primary
16 care practitioner.

17 10. Nonexperimental transplants approved for title XIX reimbursement.

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

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

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

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

25 (a) Outpatient health services do not include occupational therapy or
26 speech therapy.

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

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

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

34 (e) Podiatry services do not include services performed by a
35 podiatrist.

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

37 (i) Pancreas only transplants.

38 (ii) Pancreas after kidney transplants.

39 (iii) Lung transplants.

40 (iv) Hemopoetic cell allogenic unrelated transplants.

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

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

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

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

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

6 D. The director shall adopt rules necessary to limit, to the extent
7 possible, the scope, duration and amount of services, including maximum
8 limitations for inpatient services that are consistent with federal
9 regulations under title XIX of the social security act (P.L. 89-97; 79 Stat.
10 344; 42 United States Code section 1396 (1980)). To the extent possible and
11 practicable, these rules shall provide for the prior approval of medically
12 necessary services provided pursuant to this chapter.

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

22 F. The director shall adopt rules for the coverage of behavioral
23 health services for persons who are eligible under section 36-2901, paragraph
24 6, subdivision (a). The administration shall contract with the department of
25 health services for the delivery of all medically necessary behavioral health
26 services to persons who are eligible under rules adopted pursuant to this
27 subsection. The division of behavioral health in the department of health
28 services shall establish a diagnostic and evaluation program to which other
29 state agencies shall refer children who are not already enrolled pursuant to
30 this chapter and who may be in need of behavioral health services. In
31 addition to an evaluation, the division of behavioral health shall also
32 identify children who may be eligible under section 36-2901, paragraph 6,
33 subdivision (a) or section 36-2931, paragraph 5 and shall refer the children
34 to the appropriate agency responsible for making the final eligibility
35 determination.

36 G. The director shall adopt rules for the provision of transportation
37 services and rules providing for copayment by members for transportation for
38 other than emergency purposes. Subject to approval by the centers for
39 medicare and medicaid services, nonemergency medical transportation shall not
40 be provided ~~to persons who are eligible pursuant to sections 36-2901.01 and~~
41 ~~36-2901.04 and who reside in a county with a population of more than five~~
42 ~~hundred thousand persons~~ EXCEPT FOR STRETCHER VANS AND AMBULANCE
43 TRANSPORTATION. PRIOR AUTHORIZATION IS REQUIRED FOR TRANSPORTATION BY
44 STRETCHER VAN AND FOR MEDICALLY NECESSARY AMBULANCE TRANSPORTATION INITIATED
45 PURSUANT TO A PHYSICIAN'S DIRECTION. Prior authorization is not required for

1 medically necessary ambulance transportation services rendered to members or
2 eligible persons initiated by dialing telephone number 911 or other
3 designated emergency response systems.

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

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

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

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

28 1. Emergency services and specialty services provided pursuant to
29 section 36-2908.

30 2. That the director may permit the delivery of health and medical
31 services in other than the geographic service area in this state or in an
32 adjoining state if the director determines that medical practice patterns
33 justify the delivery of services or a net reduction in transportation costs
34 can reasonably be expected. Notwithstanding the definition of physician as
35 prescribed in section 36-2901, if services are procured from a physician or
36 primary care practitioner in an adjoining state, the physician or primary
37 care practitioner shall be licensed to practice in that state pursuant to
38 licensing statutes in that state similar to title 32, chapter 13, 15, 17 or
39 25 and shall complete a provider agreement for this state.

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

1 M. The director shall adopt rules that prescribe the coordination of
2 medical care for persons who are eligible for system services. The rules
3 shall include provisions for the transfer of patients, the transfer of
4 medical records and the initiation of medical care.

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

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

9 36-2930. Prescription drug rebate fund; exemption; definition

10 A. THE PRESCRIPTION DRUG REBATE FUND IS ESTABLISHED CONSISTING OF
11 PRESCRIPTION DRUG REBATE COLLECTIONS, INTEREST FROM PRESCRIPTION DRUG REBATE
12 LATE PAYMENTS AND FEDERAL MONIES MADE AVAILABLE TO THIS STATE FOR THE
13 OPERATION OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PRESCRIPTION
14 DRUG REBATE PROGRAM. THE ADMINISTRATION SHALL ADMINISTER THE FUND.
15 NONFEDERAL MONIES IN THE FUND ARE SUBJECT TO ANNUAL LEGISLATIVE
16 APPROPRIATION. FEDERAL MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED AND
17 ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190 RELATING TO THE LAPSING OF
18 APPROPRIATIONS.

19 B. MONIES IN THE FUND SHALL BE USED TO RETURN THE FEDERAL SHARE OF
20 PRESCRIPTION DRUG REBATE COLLECTIONS AND INTEREST FROM LATE PAYMENTS TO THE
21 CENTERS FOR MEDICARE AND MEDICAID SERVICES BY OFFSETTING FUTURE FEDERAL
22 DRAWS, TO PAY FOR THE ADMINISTRATIVE COSTS OF THE PRESCRIPTION DRUG REBATE
23 PROGRAM AND AS THE NONFEDERAL SHARE FOR PAYMENTS TO CONTRACTORS OR PROVIDERS
24 IN THE ADMINISTRATION'S MEDICAL SERVICES PROGRAMS. THE NONFEDERAL SHARE OF
25 PRESCRIPTION DRUG REBATE COLLECTIONS AND INTEREST FROM LATE PAYMENTS INCLUDE
26 REBATES RELATING TO PROGRAMS ADMINISTERED BY THE DEPARTMENT OF ECONOMIC
27 SECURITY, THE DEPARTMENT OF HEALTH SERVICES AND OTHER GOVERNMENTAL ENTITIES
28 THAT CONTRIBUTE TO THE NONFEDERAL SHARE FOR PRESCRIPTION DRUGS.

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

31 1. PAYMENTS TO THE PRESCRIPTION DRUG REBATE VENDOR.

32 2. ADMINISTRATIVE COSTS OF THE ADMINISTRATION IN SUPPORT OF THE
33 PRESCRIPTION DRUG REBATE PROGRAM.

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

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

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

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

43 C. As determined by the director, reinsurance may be provided against
44 expenses in excess of a specified amount on behalf of any member for covered
45 emergency services, inpatient services or outpatient services in the same

1 manner as reinsurance provided under article 1 of this chapter. Subject to
2 the approval of the director, reinsurance may be obtained against expenses in
3 excess of a specified amount on behalf of any member.

4 D. Notwithstanding any other law, the administration may procure,
5 provide or coordinate covered services by interagency agreement with
6 authorized agencies of this state for distinct groups of members, including
7 persons eligible for children's rehabilitative services ~~through the~~
8 ~~department of health services~~ and members eligible for comprehensive medical
9 and dental benefits through the department of economic security.

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

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

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

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

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

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

1 Sec. 16. 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.

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

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

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

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

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

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

11 ~~H.~~ G. The department of administration shall submit an annual report
12 on the financial status of the special employee insurance trust fund to the
13 governor, the president of the senate, the speaker of the house of
14 representatives, the chairpersons of the house and senate appropriations
15 committees and the joint legislative budget committee staff by March 1. The
16 report shall include:

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

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

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

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

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

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

33 2. An explanation of why the change was implemented before the next
34 plan year.

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

37 43-1088. Credit for contribution to qualifying charitable
38 organizations; definitions

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

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

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

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

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

11 D. The credit allowed by this section:

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

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

16 E. Taxpayers taking a credit authorized by this section shall provide
17 the name of the qualifying charitable organization and the amount of the
18 contribution to the department of revenue on forms provided by the
19 department.

20 F. A qualifying charitable organization shall provide the department
21 of revenue with a written certification that it meets all criteria to be
22 considered a qualifying charitable organization. The organization shall also
23 notify the department of any changes that may affect the qualifications under
24 this section.

25 G. The charitable organization's written certification must be signed
26 by an officer of the organization under penalty of perjury. The written
27 certification must include the following:

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

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

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

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

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

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

43 H. The department shall review each written certification and
44 determine whether the organization meets all the criteria to be considered a
45 qualifying charitable organization and notify the organization of its

1 determination. The department may also periodically request recertification
2 from the organization. The department shall compile and make available to
3 the public a list of the qualifying charitable organizations.

4 I. For the purposes of this section:

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

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

9 3. "Qualifying charitable organization" means a charitable
10 organization that is exempt from federal income taxation under section
11 501(c)(3) of the internal revenue code or is a designated community action
12 agency that receives community services block grant program monies pursuant
13 to 42 United States Code section 9901. The organization must spend at least
14 fifty per cent of its budget on services to residents of this state who
15 receive temporary assistance for needy families benefits or low income
16 residents of this state and their households or to chronically ill or
17 physically disabled children who are residents of this state. Taxpayers
18 choosing to make donations through an umbrella charitable organization that
19 collects donations on behalf of member charities shall designate that the
20 donation be directed to a member charitable organization that would qualify
21 under this section on a stand-alone basis.

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

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

27 Sec. 13. ALICS: county contributions: fiscal year 2010-2011

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

33 1. Apache	\$ 469,400
34	\$ 485,000
35 2. Cochise	\$ 4,023,400
36	\$ 4,140,300
37 3. Coconino	\$ 1,408,800
38	\$ 1,455,400
39 4. Gila	\$ 1,623,600
40	\$ 1,670,700
41 5. Graham	\$ 1,072,900
42	\$ 1,098,000
43 6. Greenlee	\$ 122,200
44	\$ 124,600

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

19 B. The amounts specified in subsection A of this section reflect
20 ~~\$76,014,400~~ \$57,757,000 in decreases in county contributions for the Arizona
21 long-term care system.

22 C. The amounts specified in subsection A of this section reflect
23 ~~\$4,390,700~~ \$3,629,200 in decreases in county contributions for the Arizona
24 long-term care system for medicare clawback savings.

25 D. The county contributions for the Arizona long-term care system
26 would have otherwise totaled ~~\$267,912,100~~ \$250,635,000 in fiscal year
27 2010-2011.

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

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

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

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

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

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

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

44 B. The department of health services shall deposit the reimbursements,
45 pursuant to sections 35-146 and 35-147, Arizona Revised Statutes, in the

1 Arizona state hospital fund established by section 36-545.08, Arizona Revised
2 Statutes.

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

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

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

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

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

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

31 C. Each city and county shall make the reimbursements for these costs
32 as specified in subsection A of this section within thirty days after a
33 request by the department of health services. If the city or county does not
34 make the reimbursement, the superintendent of the Arizona state hospital
35 shall notify the state treasurer of the amount owed and the treasurer shall
36 withhold the amount, including any additional interest as provided in section
37 42-1123, Arizona Revised Statutes, from any transaction privilege tax
38 distributions to the city or county. The treasurer shall deposit the
39 withholdings, pursuant to sections 35-146 and 35-147, Arizona Revised
40 Statutes, in the Arizona state hospital fund established by section
41 36-545.08, Arizona Revised Statutes.

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

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

3 Sec. 22. State employee health benefits

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

8 Sec. 23. AHCCCS; disproportionate share payments

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

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

40 2. \$28,474,900 for the Arizona state hospital. The Arizona state
41 hospital shall provide a certified public expense form for the amount of
42 qualifying disproportionate share hospital expenditures made on behalf of the
43 state to the administration on or before March 31, 2012. The administration
44 shall assist the Arizona state hospital in determining the amount of
45 qualifying disproportionate share hospital expenditures. Once the

1 administration files a claim with the federal government and receives federal
2 funds participation based on the amount certified by the Arizona state
3 hospital, the administration shall distribute the entire amount of federal
4 financial participation to the state general fund. If the certification
5 provided is for an amount less than \$28,474,900, the administration shall
6 notify the governor, the president of the senate and the speaker of the house
7 of representatives and shall distribute the entire amount of federal
8 financial participation to the state general fund. The certified public
9 expense form provided by the Arizona state hospital shall contain both the
10 total amount of qualifying disproportionate share hospital expenditures and
11 the amount limited by section 1923(g) of the social security act.

12 3. \$9,284,800 for private qualifying disproportionate share hospitals.
13 The Arizona health care cost containment system administration shall make
14 payments to hospitals consistent with this appropriation and the terms of the
15 section 1115 waiver, however, payments shall be limited to those hospitals
16 that either:

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

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

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

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

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

1 Sec. 25. AHCCCS: fraudulent payments: verification

2 A. The Arizona health care cost containment system administration
3 shall issue a request for information on or before August 1, 2011 for
4 mechanisms to reduce erroneous and fraudulent payments in the Arizona health
5 care cost containment system, which may include mechanisms that verify the
6 identity of individual recipients and that verify the services provided to
7 individual recipients. The responses to the request for information may
8 address either reducing incorrect payments due to actions of the individual
9 recipient or the health care provider. Based on information received under
10 this subsection, the Arizona health care cost containment system
11 administration shall issue a request for proposals no later than October 1,
12 2011. The request for proposals shall be reviewed by the joint legislative
13 budget committee before it is issued.

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

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

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

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

35 B. If a county does not provide funding as specified in subsection A
36 of this section, the state treasurer shall subtract the amount owed by the
37 county to the Arizona health care cost containment system fund and the
38 long-term care system fund established by section 36-2913, Arizona Revised
39 Statutes, from any payments required to be made by the state treasurer to
40 that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona
41 Revised Statutes, plus interest on that amount pursuant to section 44-1201,
42 Arizona Revised Statutes, retroactive to the first day the funding was due.
43 If the monies the state treasurer withholds are insufficient to meet that
44 county's funding requirements as specified in subsection A of this section,
45 the state treasurer shall withhold from any other monies payable to that

1 county from whatever state funding source is available an amount necessary to
2 fulfill that county's requirement. The state treasurer shall not withhold
3 distributions from the highway user revenue fund pursuant to title 28,
4 chapter 18, article 2, Arizona Revised Statutes.

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

11 D. The state treasurer shall deposit the amounts paid pursuant to
12 subsection C of this section and amounts withheld pursuant to subsection B of
13 this section in the Arizona health care cost containment system fund and the
14 long-term care system fund established by section 36-2913, Arizona Revised
15 Statutes.

16 E. If payments made pursuant to subsection C of this section exceed
17 the amount required to meet the costs incurred by the Arizona health care
18 cost containment system for the hospitalization and medical care of those
19 persons defined as an eligible person pursuant to section 36-2901, paragraph
20 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of
21 the Arizona health care cost containment system administration may instruct
22 the state treasurer either to reduce remaining payments to be paid pursuant
23 to this section by a specified amount or to provide to the counties specified
24 amounts from the Arizona health care cost containment system fund and the
25 long-term care system fund.

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

31 Sec. 27. Hospitalization and medical care contribution: fiscal
32 year 2011-2012

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

42	1. Apache	\$ 87,300
43	2. Cochise	\$ 162,700
44	3. Coconino	\$ 160,500
45	4. Gila	\$ 65,900

1	5. Graham	\$ 46,800
2	6. Greenlee	\$ 12,000
3	7. La Paz	\$ 24,900
4	8. Mohave	\$ 187,400
5	9. Navajo	\$ 122,800
6	10. Pima	\$1,115,900
7	11. Pinal	\$ 218,300
8	12. Santa Cruz	\$ 51,600
9	13. Yavapai	\$ 206,200
10	14. Yuma	\$ 183,900

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

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

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

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

28 Sec. 28. Proposition 204 administration; county expenditure
29 limitation

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

34 Sec. 29. AHCCCS; ambulance services; reimbursement

35 A. Notwithstanding Laws 2010, chapter 86, section 7, subsection A and
36 section 36-2239, subsection H, Arizona Revised Statutes, for dates of service
37 on and after April 1, 2011 through September 30, 2012, the Arizona health
38 care cost containment system administration and its contractors shall
39 reimburse ambulance service providers in an amount equal to 72.2 per cent of
40 the amounts prescribed by the department of health services.

41 B. Notwithstanding Laws 2010, chapter 86, section 7, subsection A and
42 section 36-2239, subsection H, Arizona Revised Statutes, the Arizona health
43 care cost containment system administration shall not include any rate
44 increases approved by the department of health services between July 2, 2011
45 and September 30, 2011 in the administration's reimbursement rates. The

1 Arizona health care cost containment system administration shall make annual
2 adjustments to its fee schedule on October 1, 2011 as otherwise provided in
3 section 36-2239, subsection H, Arizona Revised Statutes, and shall reimburse
4 ambulance providers consistent with subsection A of this section.

5 C. For dates of service beginning October 1, 2011 through September
6 30, 2012, remuneration for ambulance services may be reduced by up to an
7 additional five per cent of the amounts otherwise provided in this section.

8 Sec. 30. AHCCCS; risk contingency rate setting

9 Notwithstanding any other law, for the contract year beginning
10 October 1, 2011 and ending September 30, 2012, the Arizona health care cost
11 containment system administration may continue the risk contingency rate
12 setting for all managed care organizations and the funding for all managed
13 care organizations administrative funding levels that was imposed for the
14 contract year beginning October 1, 2010 and ending September 30, 2011.

15 Sec. 31. AHCCCS; hospital reimbursement inflation adjustment
16 freeze

17 For the contract year beginning October 1, 2011:

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

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

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

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

33 Sec. 33. AHCCCS; social security administration; medicare
34 liability waiver

35 The Arizona health care cost containment system may participate in any
36 special disability workload 1115 demonstration waiver offered by the centers
37 for medicare and medicaid services. Any credits provided by the 1115
38 demonstration waiver process are to be used in the fiscal year when such
39 credits are made available to fund the state share of any medical assistance
40 expenditures that qualify for federal financial participation under the
41 medicaid program. The Arizona health care cost containment system shall
42 report the receipt of any credits to the director of the joint legislative
43 budget committee by December 31, 2011 and June 30, 2012.

1 1. It is the intent of the legislature that the Arizona health care
2 cost containment system implement a program within the available
3 appropriation.

4 2. The Arizona health care cost containment system is directed to
5 implement the copayment and nonemergency transportation provisions contained
6 in this act.

7 B. It is the intent of the legislature that coverage of transplant
8 services that were eliminated in Laws 2010, seventh special session, chapter
9 10 be funded.

10 Sec. 39. Transfer of powers; effect

11 A. The Arizona health care cost containment system administration
12 succeeds to the powers and duties of the department of health services
13 relating to children's rehabilitative services prescribed pursuant to title
14 36, chapter 2, article 3, Arizona Revised Statutes.

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

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

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

29 Sec. 40. Retroactivity

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

32 B. Section 36-260, Arizona Revised Statutes, as added by this act, is
33 effective, and sections 36-261, 36-262, 36-263, 36-264, 36-797.43, 36-797.44,
34 36-2903.01, 36-2988 and 43-1088, Arizona Revised Statutes, as amended by this
35 act, apply, retroactively to from and after June 30, 2011.

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