

State of Arizona
House of Representatives
Fiftieth Legislature
Second Regular Session
2012

HOUSE BILL 2534

AN ACT

AMENDING SECTIONS 8-142.01, 8-245, 8-512, 31-165, 36-210, 36-717, 36-2903.01, 36-2905.01, 36-2905.02, 36-2909, 36-2912, 36-2932, 36-2986, 36-2987, 36-3411, 41-1608, 41-1954, 41-2807, 48-5501 AND 48-5561.01, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Section 8-142.01, Arizona Revised Statutes, is amended to
3 read:

4 8-142.01. Adoption subsidy program; hospital reimbursement

5 A. Notwithstanding section 8-144, subsection B, for inpatient hospital
6 admissions and outpatient hospital services on or after March 1, 1993, the
7 department shall reimburse a hospital according to the ~~tiered per diem~~
8 ~~and outpatient cost to charge ratios~~ rates established by the Arizona health care
9 cost containment system pursuant to section 36-2903.01, subsection ~~H~~ G.

10 B. The department shall use the Arizona health care cost containment
11 system rates as identified in subsection A of this section for any child
12 enrolled in the adoption subsidy program. This requirement shall not be
13 construed to expand the liability of the adoption subsidy program beyond
14 eligible preexisting conditions on an adoption subsidy agreement entered into
15 between the department and the adoptive parent.

16 C. A hospital bill is considered received for purposes of subsection E
17 of this section ~~upon~~ ON initial receipt of the legible, error-free claim form
18 by the department if the claim includes the following error-free
19 documentation in legible form:

- 20 1. An admission face sheet.
- 21 2. An itemized statement.
- 22 3. An admission history and physical.
- 23 4. A discharge summary or an interim summary if the claim is split.
- 24 5. An emergency record, if admission was through the emergency room.
- 25 6. Operative reports, if applicable.
- 26 7. A labor and delivery room report, if applicable.

27 D. The department shall require that the hospital pursue other third
28 party payors before submitting a claim to the department. Payment received
29 by a hospital from the department pursuant to this section is considered
30 payment by the department of the department's liability for the hospital
31 bill. A hospital may collect any unpaid portion of its bill from other third
32 party payors or in situations covered by title 33, chapter 7, article 3.

33 E. For inpatient hospital admissions and outpatient hospital services
34 rendered on and after October 1, 1997, if the department receives the claim
35 directly from the hospital for services rendered, the department shall pay a
36 hospital's rate established according to this section subject to the
37 following:

- 38 1. If the hospital's bill is paid within thirty days of the date the
39 bill was received, the department shall pay ninety-nine per cent of the rate.
- 40 2. If the hospital's bill is paid after thirty days but within sixty
41 days of the date the bill was received, the department shall pay one hundred
42 per cent of the rate.
- 43 3. If the hospital's bill is paid any time after sixty days of the
44 date the bill was received, the department shall pay one hundred per cent of
45 the rate plus a fee of one per cent per month for each month or portion of a

1 month following the sixtieth day of receipt of the bill until the date of
2 payment.

3 F. For medical services other than those for which a rate has been
4 established pursuant to section 36-2903.01, subsection ~~H~~ G, the department
5 shall pay according to the Arizona health care cost containment system capped
6 fee-for-service schedule adopted pursuant to section 36-2904, subsection K.

7 G. For any hospital or medical claims not covered under subsection A
8 or F of this section, the department shall establish and adopt a schedule
9 setting out maximum allowable fees that the department deems reasonable for
10 such services after appropriate study and analysis of usual and customary
11 fees charged by providers.

12 Sec. 2. Section 8-245, Arizona Revised Statutes, is amended to read:
13 8-245. Physical and mental care

14 A. When a child under the jurisdiction of the juvenile court appears
15 to be in need of medical or surgical care, the juvenile court may order the
16 parent, guardian or custodian to provide treatment for the child in a
17 hospital or otherwise. If the parent, guardian or custodian fails to provide
18 the care as ordered, the juvenile court may enter an order therefor, and the
19 expense, when approved by the juvenile court, shall be a county charge. The
20 juvenile court may adjudge that the person required by law to support the
21 child pay part or all of the expenses of treatment in accordance with section
22 8-243.

23 B. A county with a population of more than one million persons shall
24 pay claims approved by the county from a facility or provider for medical or
25 surgical care to a child that is a county charge pursuant to subsection A of
26 this section, unless otherwise provided by an intergovernmental agreement, as
27 follows:

28 1. For inpatient and outpatient hospital services, the county shall
29 reimburse at a level that does not exceed the reimbursement methodology
30 established pursuant to section 36-2903.01, subsection ~~H~~ G.

31 2. For health and medical services, the county shall reimburse at a
32 level that does not exceed the capped fee-for-service schedule that is
33 adopted by the Arizona health care cost containment system administration
34 pursuant to title 36, chapter 29, article 1 and that is in effect at the time
35 the services are delivered.

36 Sec. 3. Section 8-512, Arizona Revised Statutes, is amended to read:
37 8-512. Comprehensive medical and dental care; guidelines

38 A. The department shall provide comprehensive medical and dental care,
39 as prescribed by rules of the department, for each child WHO IS:

40 1. Placed in a foster home.

41 2. In the custody of the department and placed with a relative.

42 3. In the custody of the department and placed in a certified adoptive
43 home before the entry of the final order of adoption.

44 4. In the custody of the department and in an independent living
45 program as provided in section 8-521.

- 1 5. In the custody of a probation department and placed in foster
2 care. The department shall not provide this care if the cost exceeds funds
3 currently appropriated and available for that purpose.
- 4 B. The care may include, but is not limited to:
- 5 1. A program of regular health examinations and immunizations
6 including as minimums:
- 7 (a) Vaccinations to prevent mumps, rubella, smallpox and polio.
8 (b) Tests for anemia, coccidioidomycosis and tuberculosis.
9 (c) Urinalysis, blood count and hemoglobin tests.
10 (d) Regular examinations for general health, hearing and vision,
11 including providing corrective devices when needed.
- 12 2. Inpatient and outpatient hospital care.
- 13 3. Necessary services of physicians, surgeons, psychologists and
14 psychiatrists.
- 15 4. Dental care consisting of at least oral examinations including
16 diagnostic radiographs, oral prophylaxis and topical fluoride applications,
17 restoration of permanent and primary teeth, pulp therapy, extraction when
18 necessary, fixed space maintainers where needed and other services for relief
19 of pain and infection.
- 20 5. Drug prescription service.
- 21 C. The facilities of any hospital or other institution within the
22 state, public or private, may be employed by the foster parent, relative,
23 certified adoptive parent, agency or division having responsibility for the
24 care of the child.
- 25 D. For inpatient hospital admissions and outpatient hospital services
26 on or after March 1, 1993, the department shall reimburse a hospital
27 according to the ~~tiered per diem rates and outpatient cost to charge ratios~~
28 established by the Arizona health care cost containment system pursuant to
29 section 36-2903.01, subsection ~~H~~ G.
- 30 E. The department shall use the Arizona health care cost containment
31 system rates as identified in subsection D of this section for any child
32 eligible for services under this section.
- 33 F. A hospital bill is considered received for purposes of subsection H
34 of this section ~~upon~~ ON initial receipt of the legible, error-free claim form
35 by the department if the claim includes the following error-free
36 documentation in legible form:
- 37 1. An admission face sheet.
38 2. An itemized statement.
39 3. An admission history and physical.
40 4. A discharge summary or an interim summary if the claim is split.
41 5. An emergency record, if admission was through the emergency room.
42 6. Operative reports, if applicable.
43 7. A labor and delivery room report, if applicable.

1 G. The department shall require that the hospital pursue other third
2 party payors before submitting a claim to the department. Payment received
3 by a hospital from the department is considered payment by the department of
4 the department's liability for the hospital bill. A hospital may collect any
5 unpaid portion of its bill from other third party payors or in situations
6 covered by title 33, chapter 7, article 3.

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

10 1. If the hospital's bill is paid within thirty days of the date the
11 bill was received, the department shall pay ninety-nine per cent of the rate.

12 2. If the hospital's bill is paid after thirty days but within sixty
13 days of the date the bill was received, the department shall pay one hundred
14 per cent of the rate.

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

20 I. For medical services other than those for which a rate has been
21 established pursuant to section 36-2903.01, subsection ~~H~~ G, the department
22 shall pay according to the Arizona health care cost containment system capped
23 fee-for-service schedule adopted pursuant to section 36-2904, subsection K.

24 J. For any hospital or medical claims not covered under subsection D
25 or I of this section, the department shall establish and adopt a schedule
26 setting out maximum allowable fees that the department deems reasonable for
27 such services after appropriate study and analysis of usual and customary
28 fees charged by providers. The department shall not pay to any plan or
29 intermediary that portion of the cost of any service provided that exceeds
30 allowable charges prescribed by the department pursuant to this subsection.

31 K. The department shall not pay claims for services pursuant to this
32 section that are submitted more than one hundred eighty days after the date
33 of the service for which the payment is claimed.

34 L. The department may provide for payment through an insurance plan,
35 hospital service plan, medical service plan, or any other health service plan
36 authorized to do business in this state, fiscal intermediary or a combination
37 of such plans or methods. The state shall not be liable for and the
38 department shall not pay to any plan or intermediary any portion of the cost
39 of comprehensive medical and dental care in excess of funds appropriated and
40 available for such purpose at the time the plan or intermediary incurs the
41 expense for such care.

42 M. The total amount of state monies that may be spent in any fiscal
43 year by the department for comprehensive medical and dental care shall not
44 exceed the amount appropriated or authorized by section 35-173 for that
45 purpose. This section shall not be construed to impose a duty on an officer,

1 agent or employee of this state to discharge a responsibility or to create
2 any right in a person or group if the discharge or right would require an
3 expenditure of state monies in excess of the expenditure authorized by
4 legislative appropriation for that specific purpose.

5 Sec. 4. Section 31-165, Arizona Revised Statutes, is amended to read:
6 31-165. Inmate medical services; rate structure

7 If an inmate in a county jail in a county with a population of more
8 than one million persons or a person who, but for the circumstances, would
9 otherwise be treated in the county jail requires health care services that
10 the county jail cannot provide, the county shall pay claims approved by the
11 county from a facility or provider that provides these services, unless
12 otherwise provided by an intergovernmental agreement, as follows:

13 1. For inpatient and outpatient hospital services, the county shall
14 reimburse at a level that does not exceed the reimbursement methodology
15 established pursuant to section 36-2903.01, subsection ~~H~~ G.

16 2. For health and medical services, the county shall reimburse at a
17 level that does not exceed the capped fee-for-service schedule that is
18 adopted by the Arizona health care cost containment system administration
19 pursuant to title 36, chapter 29, article 1 and that is in effect at the time
20 the services are delivered.

21 Sec. 5. Section 36-210, Arizona Revised Statutes, is amended to read:
22 36-210. Expenditures

23 A. This article does not give the director or any employee authority
24 to create a debt or obligation in excess of the amount appropriated by the
25 legislature to carry out its provisions. If monies are not appropriated to
26 carry out the purpose of this article, the director shall submit
27 recommendations to the legislature, with a statement of the cost when an
28 improvement is requested.

29 B. Except as provided by subsection D of this section, the director of
30 the department of administration shall not issue a warrant for expenditures
31 by the state hospital in excess of the estimate contained in the monthly
32 financial statement unless the superintendent submits a written request that
33 is approved in writing by the deputy director and that states the reasons for
34 the request. The director of the department of administration shall not issue
35 warrants in excess of the amount available for the current quarter.

36 C. If a patient in the state hospital requires a health care service
37 that the state hospital or a facility or provider contracted by the state
38 hospital cannot provide, the department of health services shall pay approved
39 claims from a facility or provider that provides these required services as
40 follows:

41 1. For inpatient and outpatient hospital services, the state shall
42 reimburse at a level that does not exceed the reimbursement methodology
43 established in section 36-2903.01, subsection ~~H~~ G.

44 2. For health and medical services, the state shall reimburse
45 providers at a level that does not exceed the capped fee-for-service schedule

1 that is adopted by the Arizona health care cost containment system
2 administration pursuant to chapter 29, article 1 of this title and that is in
3 effect at the time the service is delivered.

4 D. Monies appropriated for capital investment may be expended at any
5 time during the fiscal period for which the monies are appropriated as
6 directed by the director.

7 Sec. 6. Section 36-717, Arizona Revised Statutes, is amended to read:
8 36-717. Responsibility for care or treatment by counties

9 A. The local board of health, through the board of supervisors of the
10 county, shall be responsible for providing or arranging for the provision of
11 medical care and treatment of persons in the county infected with
12 tuberculosis.

13 B. A county with a population of more than one million persons shall
14 pay claims approved by the county from a facility or provider for medical
15 care or treatment that are a county charge pursuant to subsection A of this
16 section, unless otherwise provided by an intergovernmental agreement, as
17 follows:

18 1. For inpatient and outpatient hospital services, the county shall
19 reimburse at a level that does not exceed the reimbursement methodology
20 established pursuant to section 36-2903.01, subsection ~~H~~ G.

21 2. For health and medical services, the county shall reimburse at a
22 level that does not exceed the capped fee-for-service schedule that is
23 adopted by the Arizona health care cost containment system administration
24 pursuant to chapter 29, article 1 of this title and that is in effect at the
25 time the services are delivered.

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

28 36-2903.01. Additional powers and duties; report

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

35 B. The director shall:

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

42 2. Enter into an interagency agreement with the department to
43 establish a streamlined eligibility process to determine the eligibility of
44 all persons defined pursuant to section 36-2901, paragraph 6,
45 subdivision (a). At the administration's option, the interagency agreement

1 may allow the administration to determine the eligibility of certain persons,
2 including those defined pursuant to section 36-2901, paragraph 6,
3 subdivision (a).

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

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

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

8 (c) Establish the process for management evaluation reviews that the
9 administration shall perform to evaluate the eligibility determination
10 functions performed by the department.

11 (d) Establish eligibility quality control reviews by the
12 administration.

13 (e) Require the department to adopt rules, consistent with the rules
14 adopted by the administration for a hearing process, that applicants or
15 members may use for appeals of eligibility determinations or
16 redeterminations.

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

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

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

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

1 timely claim submission, whichever is later. A grievance for the denial of a
2 claim for reimbursement of services may contest the validity of any adverse
3 action, decision, policy implementation or rule that related to or resulted
4 in the full or partial denial of the claim. A policy implementation may be
5 subject to a grievance procedure, but it may not be appealed for a hearing.
6 The administration is not required to participate in a mandatory settlement
7 conference if it is not a real party in interest. In any proceeding before
8 the administration, including a grievance or hearing, persons may represent
9 themselves or be represented by a duly authorized agent who is not charging a
10 fee. A legal entity may be represented by an officer, partner or employee
11 who is specifically authorized by the legal entity to represent it in the
12 particular proceeding.

13 5. Apply for and accept federal funds available under title XIX of the
14 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section
15 1396 (1980)) in support of the system. The application made by the director
16 pursuant to this paragraph shall be designed to qualify for federal funding
17 primarily on a prepaid capitated basis. Such funds may be used only for the
18 support of persons defined as eligible pursuant to title XIX of the social
19 security act or the approved section 1115 waiver.

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

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

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

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

34 C. The director is authorized to apply for any federal funds available
35 for the support of programs to investigate and prosecute violations arising
36 from the administration and operation of the system. Available state funds
37 appropriated for the administration and operation of the system may be used
38 as matching funds to secure federal funds pursuant to this subsection.

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

40 1. Authorize advance payments based on estimated liability to a
41 contractor or a noncontracting provider after the contractor or
42 noncontracting provider has submitted a claim for services and before the
43 claim is ultimately resolved. The rules shall specify that any advance
44 payment shall be conditioned on the execution before payment of a contract
45 with the contractor or noncontracting provider that requires the

1 administration to retain a specified percentage, which shall be at least
2 twenty per cent, of the claimed amount as security and that requires
3 repayment to the administration if the administration makes any overpayment.

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

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

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

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

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

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

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

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

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

42 ~~(c) The schedule of rates and charges for a hospital that became
43 effective after May 31, 1984 but before July 2, 1984, limited to five per
44 cent over the hospital's previous rate schedule, and if the hospital's~~

1 ~~previous rate schedule became effective on or after April 30, 1983 but before~~
2 ~~October 1, 1983.~~

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

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

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

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

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

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

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

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

33 ~~H. G.~~ For inpatient hospital admissions and outpatient hospital
34 services on and after March 1, 1993, the administration shall adopt rules for
35 the reimbursement of hospitals according to the following procedures:

36 1. For inpatient hospital stays FROM MARCH 1, 1993 THROUGH SEPTEMBER
37 30, 2013, the administration shall use a prospective tiered per diem
38 methodology, using hospital peer groups if analysis shows that cost
39 differences can be attributed to independently definable features that
40 hospitals within a peer group share. In peer grouping the administration may
41 consider such factors as length of stay differences and labor market
42 variations. If there are no cost differences, the administration shall
43 implement a stop loss-stop gain or similar mechanism. Any stop loss-stop
44 gain or similar mechanism shall ensure that the tiered per diem rates
45 assigned to a hospital do not represent less than ninety per cent of its 1990

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

21 2. For rates effective on October 1, 1994, and annually ~~thereafter~~
22 ~~THROUGH SEPTEMBER 30, 2011~~, the administration shall adjust tiered per diem
23 payments for inpatient hospital care by the data resources incorporated
24 market basket index for prospective payment system hospitals. For rates
25 effective beginning on October 1, 1999, the administration shall adjust
26 payments to reflect changes in length of stay for the maternity and nursery
27 tiers.

28 3. Through June 30, 2004, for outpatient hospital services, the
29 administration shall reimburse a hospital by applying a hospital specific
30 outpatient cost-to-charge ratio to the covered charges. Beginning on July 1,
31 2004 through June 30, 2005, the administration shall reimburse a hospital by
32 applying a hospital specific outpatient cost-to-charge ratio to covered
33 charges. If the hospital increases its charges for outpatient services filed
34 with the Arizona department of health services pursuant to chapter 4, article
35 3 of this title, by more than 4.7 per cent for dates of service effective on
36 or after July 1, 2004, the hospital specific cost-to-charge ratio will be
37 reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7
38 per cent, the effective date of the increased charges will be the effective
39 date of the adjusted Arizona health care cost containment system
40 cost-to-charge ratio. The administration shall develop the methodology for a
41 capped fee-for-service schedule and a statewide cost-to-charge ratio. Any
42 covered outpatient service not included in the capped fee-for-service
43 schedule shall be reimbursed by applying the statewide cost-to-charge ratio
44 that is based on the services not included in the capped fee-for-service
45 schedule. Beginning on July 1, 2005, the administration shall reimburse

1 clean claims with dates of service on or after July 1, 2005, based on the
2 capped fee-for-service schedule or the statewide cost-to-charge ratio
3 established pursuant to this paragraph. The administration may make
4 additional adjustments to the outpatient hospital rates established pursuant
5 to this section based on other factors, including the number of beds in the
6 hospital, specialty services available to patients and the geographic
7 location of the hospital.

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

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

19 Payment received by a hospital from the administration pursuant to this
20 subsection or from a contractor either by contract or pursuant to section
21 36-2904, subsection I is considered payment by the administration or the
22 contractor of the administration's or contractor's liability for the hospital
23 bill. A hospital may collect any unpaid portion of its bill from other third
24 party payors or in situations covered by title 33, chapter 7, article 3.

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

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

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

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

39 6. In developing the reimbursement methodology, if a review of the
40 reports filed by a hospital pursuant to section 36-125.04 indicates that
41 further investigation is considered necessary to verify the accuracy of the
42 information in the reports, the administration may examine the hospital's
43 records and accounts related to the reporting requirements of section
44 36-125.04. The administration shall bear the cost incurred in connection
45 with this examination unless the administration finds that the records

1 examined are significantly deficient or incorrect, in which case the
2 administration may charge the cost of the investigation to the hospital
3 examined.

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

13 8. The prospective tiered per diem payment methodology for inpatient
14 hospital services shall include a mechanism for the prospective payment of
15 inpatient hospital capital related costs. The capital payment shall include
16 hospital specific and statewide average amounts. For tiered per diem rates
17 beginning on October 1, 1999, the capital related cost component is frozen at
18 the blended rate of forty per cent of the hospital specific capital cost and
19 sixty per cent of the statewide average capital cost in effect as of
20 January 1, 1999 and as further adjusted by the calculation of tier rates for
21 maternity and nursery as prescribed by law. **THROUGH SEPTEMBER 30, 2011**, the
22 administration shall adjust the capital related cost component by the data
23 resources incorporated market basket index for prospective payment system
24 hospitals.

25 9. For graduate medical education programs:

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

1 hospital reimbursement, except for monies distributed for expansions pursuant
2 to subdivision (b) of this paragraph.

3 (b) The monies available for graduate medical education programs
4 pursuant to this subdivision shall not exceed the fiscal year 2006-2007
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. Graduate medical education programs eligible for
8 such reimbursement are not precluded from receiving reimbursement for funding
9 under subdivision (c) of this paragraph. Beginning July 1, 2006, the
10 administration shall distribute any monies appropriated for graduate medical
11 education above the amount prescribed in subdivision (a) of this paragraph in
12 the following order or priority:

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

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

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

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

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

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

35 (e) Each graduate medical education program that receives funding
36 pursuant to subdivision (b) or (c) of this paragraph shall identify and
37 report to the administration the number of new residency positions created by
38 the funding provided in this paragraph, including positions in rural areas.
39 The program shall also report information related to the number of funded
40 residency positions that resulted in physicians locating their practice in
41 this state. The administration shall report to the joint legislative budget
42 committee by February 1 of each year on the number of new residency positions
43 as reported by the graduate medical education programs.

44 (f) Local, county and tribal governments and any university under the
45 jurisdiction of the Arizona board of regents may provide monies in addition

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

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

24 10. Notwithstanding section 41-1005, subsection A, paragraph 9, the
25 administration shall adopt rules pursuant to title 41, chapter 6 establishing
26 the methodology for determining the prospective tiered per diem payments **THAT**
27 **ARE IN EFFECT THROUGH SEPTEMBER 30, 2013.**

28 11. For inpatient hospital services rendered on or after October 1,
29 2011, the prospective tiered per diem payment rates are permanently reset to
30 the amounts payable for those services as of September 30, 2011 pursuant to
31 this subsection.

32 **12. THE ADMINISTRATION SHALL OBTAIN LEGISLATIVE APPROVAL BEFORE**
33 **ADOPTING A HOSPITAL REIMBURSEMENT METHODOLOGY CONSISTENT WITH TITLE XIX OF**
34 **THE SOCIAL SECURITY ACT FOR INPATIENT DATES OF SERVICE ON AND AFTER OCTOBER**
35 **1, 2013.**

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

43 ~~I.~~ I. The administration may make direct payments to hospitals for
44 hospitalization and medical care provided to a member in accordance with this
45 article and rules. The director may adopt rules to establish the procedures

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

7 ~~K.~~ J. The director shall establish a special unit within the
8 administration for the purpose of monitoring the third party payment
9 collections required by contractors and noncontracting providers pursuant to
10 section 36-2903, subsection B, paragraph 10 and subsection F and section
11 36-2915, subsection E. The director shall determine by rule:

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

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

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

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

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

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

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

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

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

25 ~~M.~~ L. The administration may conduct postpayment review of all claims
26 paid by the administration and may recoup any monies erroneously paid. The
27 director may adopt rules that specify procedures for conducting postpayment
28 review. A contractor may conduct a postpayment review of all claims paid by
29 the contractor and may recoup monies that are erroneously paid.

30 ~~N.~~ M. The director or the director's designee may employ and
31 supervise personnel necessary to assist the director in performing the
32 functions of the administration.

33 ~~O.~~ N. The administration may contract with contractors for
34 obstetrical care who are eligible to provide services under title XIX of the
35 social security act.

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

1 notification of such change or difference to the president and the minority
2 leader of the senate, the speaker and the minority leader of the house of
3 representatives, the director of the joint legislative budget committee, the
4 legislative committee of reference and any hospital trade association within
5 this state, within three working days not including weekends after receipt of
6 the notice of the change or difference. In calculating disproportionate
7 share payments as prescribed in this section, the administration may use
8 either a methodology based on claims and encounter data that is submitted to
9 the administration from contractors or a methodology based on data that is
10 reported to the administration by private hospitals and state operated
11 institutions for mental disease. The selected methodology applies to all
12 private hospitals and state operated institutions for mental disease
13 qualifying for disproportionate share payments. For the purposes of this
14 subsection, "disproportionate share payment" means a payment to a hospital
15 that serves a disproportionate share of low-income patients as described by
16 42 United States Code section 1396r-4.

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

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

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

27 ~~T.~~ S. In addition to any requirements adopted pursuant to subsection
28 D, paragraph 4 of this section, notwithstanding any other law, subject to
29 approval by the centers for medicare and medicaid services, beginning July 1,
30 2011, members eligible pursuant to section 36-2901, paragraph 6, subdivision
31 (a), section 36-2931 and section 36-2981, paragraph 6 shall pay the
32 following:

- 33 1. A monthly premium of fifteen dollars, except that the total monthly
34 premium for an entire household shall not exceed sixty dollars.
- 35 2. A copayment of five dollars for each physician office visit.
- 36 3. A copayment of ten dollars for each urgent care visit.
- 37 4. A copayment of thirty dollars for each emergency department visit.

38 Sec. 8. Section 36-2905.01, Arizona Revised Statutes, is amended to
39 read:

40 36-2905.01. Inpatient hospital reimbursement program; large
41 counties

42 A. Notwithstanding any other law, beginning on October 1, 2003,
43 pursuant to this chapter the administration shall establish and operate a
44 program for inpatient hospital reimbursement in each county with a population
45 of more than five hundred thousand persons.

1 B. Beginning on October 1, 2003, the director shall require
2 contractors to enter into contracts with one or more hospitals in these
3 counties and to reimburse those hospitals for services provided pursuant to
4 this chapter based on the reimbursement levels negotiated with each hospital
5 and specified in the contract and under the terms on which the contractor and
6 the hospital agree and under all of the following conditions:

7 1. The director may review and approve or disapprove the reimbursement
8 levels and the terms agreed on by the contractor and the hospital.

9 2. If the contractor implements an electronic claims submission system
10 it may adopt procedures requiring documentation of the system.

11 3. Payment received by a hospital from a contractor is considered
12 payment in full by the contractor. A hospital may collect any unpaid portion
13 of its bill from other third party payors or in situations covered by title
14 33, chapter 7, article 3.

15 C. If a contractor and a hospital do not enter into a contract
16 pursuant to subsection B of this section, the reimbursement level for
17 inpatient services provided on dates of admission on or after October 1, 2003
18 for that hospital is the reimbursement level prescribed in section 36-2903.01
19 multiplied by ninety-five per cent.

20 D. For outpatient hospital services provided under the program
21 prescribed in this section, a contractor may reimburse a hospital either
22 pursuant to rates and terms negotiated in a contract between the contractor
23 and the hospital or pursuant to section 36-2903.01, subsection ~~H~~ G,
24 paragraph 3.

25 E. Contracts established pursuant to this section shall specify that
26 arbitration may be used in lieu of the grievance and appeal procedure
27 prescribed in section 36-2903.01, subsection B, paragraph 4 to resolve any
28 disputes arising under the contract.

29 Sec. 9. Section 36-2905.02, Arizona Revised Statutes, is amended to
30 read:

31 36-2905.02. Inpatient reimbursement: rural hospitals:
32 definition

33 A. If monies are appropriated for rural hospitals, the Arizona health
34 care cost containment system administration shall request the centers for
35 medicare and medicaid services to approve federal matching medicaid funding
36 for the purposes specified in this section.

37 B. The administration shall distribute the available monies to
38 increase inpatient reimbursement for qualifying rural hospitals. At no time
39 shall the reimbursement exceed the cost of providing care. The
40 administration may make supplemental payments to qualifying rural hospitals
41 based on utilization or adjust ~~tier~~ rates, established pursuant to section
42 36-2903.01, subsection ~~H~~ G, for qualifying rural hospitals. No adjustments
43 to inpatient reimbursement under section 36-2903.01, subsection ~~H~~ G to
44 hospitals other than rural hospitals may be made as a result of this section.

1 C. For the purposes of this section, "rural hospital" means either:
2 1. A health care institution that is licensed as an acute care
3 hospital, that has one hundred or fewer beds and that is located in a county
4 with a population of less than five hundred thousand persons.
5 2. A health care institution that is licensed as a critical access
6 hospital.
7 Sec. 10. Section 36-2909, Arizona Revised Statutes, is amended to
8 read:
9 36-2909. Emergency hospital services; retroactive coverage;
10 costs
11 A. If a member receives emergency hospitalization and medical care on
12 or after the date of eligibility determination or the eligibility effective
13 date from a hospital that does not have a contract to care for the person,
14 the administration or the contractor is liable only for the costs of
15 emergency hospitalization and medical care up to the time the person is
16 discharged or until the time the person can be transferred. The
17 administration or the ~~prepaid capitated provider~~ CONTRACTOR is also liable
18 for further care in the following circumstances:
19 1. If the attending physician reasonably determines that the condition
20 of the person receiving emergency hospitalization and medical care is such
21 that it is medically inadvisable to transfer the person.
22 2. If the administration or the contractor does not transport the
23 person from the hospital providing care after it has been determined that the
24 person can be transferred.
25 B. Except for charges for services subject to section 36-2908,
26 subsection B, all charges incurred by an eligible person who has not yet
27 enrolled for hospitalization and medical care under subsection A of this
28 section are payable by the administration pursuant to section 36-2903.01,
29 subsection G ~~or H~~ or as specified in contract by the contractor pursuant to
30 the subcontracted rate or section 36-2904, subsection H or I.
31 C. As a condition to receiving reimbursement pursuant to subsection B
32 of this section, a hospital that is not a contractor or subcontractor under
33 the system must designate a primary care physician or primary care
34 practitioner to act as a coordinator of the services provided to persons who
35 have been determined eligible but have not yet enrolled, before the persons'
36 enrollment, discharge or transfer.
37 D. Emergency hospitalization and medical care provided pursuant to
38 this section shall be in accordance with rules adopted pursuant to section
39 36-2903.01, subsection E in order to qualify for reimbursement.
40 E. The director shall adopt rules that provide that members who have
41 been determined eligible shall be enrolled with contractors as soon as
42 practicable.
43 F. This section does not prevent the director or the contractor from
44 denying payment for hospitalization or medical care that is not authorized or
45 deemed medically necessary in accordance with rules adopted by the director.

1 Sec. 11. Section 36-2912, Arizona Revised Statutes, is amended to
2 read:

3 36-2912. Healthcare group coverage; program requirements for
4 small businesses and public employers; related
5 requirements; definitions

6 A. The administration shall administer a healthcare group program to
7 allow willing contractors to deliver health care services to persons defined
8 as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c),
9 (d) and (e). In counties with a population of less than five hundred
10 thousand persons, the administration may contract directly with any health
11 care provider or entity. The administration may enter into a contract with
12 another entity to provide administrative functions for the healthcare group
13 program.

14 B. Employers with two eligible employees or up to an average of fifty
15 eligible employees under section 36-2901, paragraph 6, subdivision (d):

16 1. May contract with the administration to be the exclusive health
17 benefit plan if the employer has five or fewer eligible employees and enrolls
18 one hundred per cent of these employees into the health benefit plan.

19 2. May contract with the administration for coverage available
20 pursuant to this section if the employer has six or more eligible employees
21 and enrolls eighty per cent of these employees into the healthcare group
22 program.

23 3. Shall have a minimum of two and a maximum of fifty eligible
24 employees at the effective date of their first contract with the
25 administration.

26 C. The administration shall not enroll an employer group in healthcare
27 group sooner than ninety days after the date that the employer's health
28 insurance coverage under an accountable health plan is discontinued.
29 Enrollment in healthcare group is effective on the first day of the month
30 after the ninety day period. This subsection does not apply to an employer
31 group if the employer's accountable health plan discontinues offering the
32 health plan of which the employer is a member.

33 D. Employees with proof of other existing health care coverage who
34 elect not to participate in the healthcare group program shall not be
35 considered when determining the percentage of enrollment requirements under
36 subsection B of this section if either:

37 1. Group health coverage is provided through a spouse, parent or legal
38 guardian, or insured through individual insurance or another employer.

39 2. Medical assistance is provided by a government subsidized health
40 care program.

41 3. Medical assistance is provided pursuant to section 36-2982,
42 subsection I.

43 E. An employer shall not offer coverage made available pursuant to
44 this section to persons defined as eligible pursuant to section 36-2901,

1 paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally
2 designated plan.

3 F. An employee or dependent defined as eligible pursuant to section
4 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may participate in
5 healthcare group on a voluntary basis only.

6 G. Notwithstanding subsection B, paragraph 2 of this section, the
7 administration shall adopt rules to allow a business that offers healthcare
8 group coverage pursuant to this section to continue coverage if it expands
9 its employment to include more than fifty employees.

10 H. The administration shall provide eligible employees with disclosure
11 information about the health benefit plan.

12 I. The director shall:

13 1. Require that any contractor that provides covered services to
14 persons defined as eligible pursuant to section 36-2901, paragraph 6,
15 subdivision (a) provide separate audited reports on the assets, liabilities
16 and financial status of any corporate activity involving providing coverage
17 pursuant to this section to persons defined as eligible pursuant to section
18 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

19 2. Prohibit the administration and program contractors from
20 reimbursing a noncontracting hospital for services provided to a member at a
21 noncontracting hospital except for services for an emergency medical
22 condition.

23 3. Require that a contractor, the administration or an accountable
24 health plan negotiate reimbursement rates. The reimbursement rate for an
25 emergency medical condition for a noncontracting hospital is:

26 (a) In counties with a population of more than five hundred thousand
27 persons, one hundred fourteen per cent of the reimbursement rates established
28 pursuant to section 36-2903.01, subsection ~~H~~ G. The hospital shall notify
29 the contractor when a member is stabilized.

30 (b) In counties with a population of less than five hundred thousand
31 persons, one hundred twenty-five per cent of the reimbursement rates
32 established pursuant to section 36-2903.01, subsection ~~H~~ G. The hospital
33 shall notify the contractor when a member is stabilized.

34 4. Use monies from the healthcare group fund established by section
35 36-2912.01 for the administration's costs of operating the healthcare group
36 program.

37 5. Ensure that the contractors are required to meet contract terms as
38 are necessary in the judgment of the director to ensure adequate performance
39 by the contractor. Contract provisions shall include, at a minimum, the
40 maintenance of deposits, performance bonds, financial reserves or other
41 financial security. The director may waive requirements for the posting of
42 bonds or security for contractors that have posted other security, equal to
43 or greater than that required for the healthcare group program, with the
44 administration or the department of insurance for the performance of health
45 service contracts if funds would be available to the administration from the

1 other security on the contractor's default. In waiving, or approving waivers
2 of, any requirements established pursuant to this section, the director shall
3 ensure that the administration has taken into account all the obligations to
4 which a contractor's security is associated. The director may also adopt
5 rules that provide for the withholding or forfeiture of payments to be made
6 to a contractor for the failure of the contractor to comply with provisions
7 of its contract or with provisions of adopted rules.

8 6. Adopt rules.

9 7. Provide reinsurance to the contractors for clean claims based on
10 thresholds established by the administration. For the purposes of this
11 paragraph, "clean claims" has the same meaning prescribed in section 36-2904.

12 J. With respect to services provided by contractors to persons defined
13 as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c),
14 (d) or (e), a contractor is the payor of last resort and has the same lien or
15 subrogation rights as those held by health care services organizations
16 licensed pursuant to title 20, chapter 4, article 9.

17 K. The administration shall offer a health benefit plan on a
18 guaranteed issuance basis to small employers as required by this section.
19 All small employers qualify for this guaranteed offer of coverage. The
20 administration shall offer to all small employers the available health
21 benefit plan and shall accept any small employer that applies and meets the
22 eligibility requirements. In addition to the requirements prescribed in this
23 section, for any offering of any health benefit plan to a small employer, as
24 part of the administration's solicitation and sales materials, the
25 administration shall make a reasonable disclosure to the employer of the
26 availability of the information described in this subsection and, on request
27 of the employer, shall provide that information to the employer. The
28 administration shall provide information concerning the following:

29 1. Provisions of coverage relating to the following, if applicable:

30 (a) The administration's right to establish premiums and to change
31 premium rates and the factors that may affect changes in premium rates.

32 (b) Renewability of coverage.

33 (c) Any preexisting condition exclusion.

34 (d) The geographic areas served by the contractor.

35 2. The benefits and premiums available under all health benefit plans
36 for which the employer is qualified.

37 L. The administration shall describe the information required by
38 subsection K of this section in language that is understandable by the
39 average small employer and with a level of detail that is sufficient to
40 reasonably inform a small employer of the employer's rights and obligations
41 under the health benefit plan. This requirement is satisfied if the
42 administration provides the following information:

43 1. An outline of coverage that describes the benefits in summary form.

44 2. The rate or rating schedule that applies to the product,
45 preexisting condition exclusion or affiliation period.

1 3. The minimum employer contribution and group participation rules
2 that apply to any particular type of coverage.

3 4. In the case of a network plan, a map or listing of the areas
4 served.

5 M. A contractor is not required to disclose any information that is
6 proprietary and protected trade secret information under applicable law.

7 N. At least sixty days before the date of expiration of a health
8 benefit plan, the administration shall provide a written notice to the
9 employer of the terms for renewal of the plan.

10 O. The administration shall increase or decrease premiums based on
11 actuarial reviews by an independent actuary of the projected and actual costs
12 of providing health care benefits to eligible members. Before changing
13 premiums, the administration must give sixty days' written notice to the
14 employer. For each contract period the administration shall set premiums
15 that in the aggregate cover projected medical and administrative costs for
16 that contract period and that are determined pursuant to generally accepted
17 actuarial principles and practices by an independent actuary.

18 P. The administration shall consider age, sex, health status-related
19 factors, group size, geographic area and community rating when it establishes
20 premiums for the healthcare group program.

21 Q. Except as provided in subsection R of this section, a health
22 benefit plan may not deny, limit or condition the coverage or benefits based
23 on a person's health status-related factors or a lack of evidence of
24 insurability. A health benefit plan shall not provide or offer any service,
25 benefit or coverage that is not part of the health benefit plan contract.

26 R. A health benefit plan shall not exclude coverage for preexisting
27 conditions, except that:

28 1. A health benefit plan may exclude coverage for preexisting
29 conditions for a period of not more than twelve months or, in the case of a
30 late enrollee, eighteen months. The exclusion of coverage does not apply to
31 services that are furnished to newborns who were otherwise covered from the
32 time of their birth or to persons who satisfy the portability requirements
33 under this section.

34 2. The contractor shall reduce the period of any applicable
35 preexisting condition exclusion by the aggregate of the periods of creditable
36 coverage that apply to the individual.

37 S. The contractor shall calculate creditable coverage according to the
38 following:

39 1. The contractor shall give an individual credit for each portion of
40 each month the individual was covered by creditable coverage.

41 2. The contractor shall not count a period of creditable coverage for
42 an individual enrolled in a health benefit plan if after the period of
43 coverage and before the enrollment date there were sixty-three consecutive
44 days during which the individual was not covered under any creditable
45 coverage.

1 3. The contractor shall give credit in the calculation of creditable
2 coverage for any period that an individual is in a waiting period for any
3 health coverage.

4 T. The contractor shall not count a period of creditable coverage with
5 respect to enrollment of an individual if, after the most recent period of
6 creditable coverage and before the enrollment date, sixty-three consecutive
7 days lapse during all of which the individual was not covered under any
8 creditable coverage. The contractor shall not include in the determination
9 of the period of continuous coverage described in this section any period
10 that an individual is in a waiting period for health insurance coverage
11 offered by a health care insurer or is in a waiting period for benefits under
12 a health benefit plan offered by a contractor. In determining the extent to
13 which an individual has satisfied any portion of any applicable preexisting
14 condition period the contractor shall count a period of creditable coverage
15 without regard to the specific benefits covered during that period. A
16 contractor shall not impose any preexisting condition exclusion in the case
17 of an individual who is covered under creditable coverage thirty-one days
18 after the individual's date of birth. A contractor shall not impose any
19 preexisting condition exclusion in the case of a child who is adopted or
20 placed for adoption before age eighteen and who is covered under creditable
21 coverage thirty-one days after the adoption or placement for adoption.

22 U. The written certification provided by the administration must
23 include:

24 1. The period of creditable coverage of the individual under the
25 contractor and any applicable coverage under a COBRA continuation provision.

26 2. Any applicable waiting period or affiliation period imposed on an
27 individual for any coverage under the health plan.

28 V. The administration shall issue and accept a written certification
29 of the period of creditable coverage of the individual that contains at least
30 the following information:

31 1. The date that the certificate is issued.

32 2. The name of the individual or dependent for whom the certificate
33 applies and any other information that is necessary to allow the issuer
34 providing the coverage specified in the certificate to identify the
35 individual, including the individual's identification number under the policy
36 and the name of the policyholder if the certificate is for or includes a
37 dependent.

38 3. The name, address and telephone number of the issuer providing the
39 certificate.

40 4. The telephone number to call for further information regarding the
41 certificate.

42 5. One of the following:

43 (a) A statement that the individual has at least eighteen months of
44 creditable coverage. For the purposes of this subdivision, "eighteen months"
45 means five hundred forty-six days.

1 (b) Both the date that the individual first sought coverage, as
2 evidenced by a substantially complete application, and the date that
3 creditable coverage began.

4 6. The date creditable coverage ended, unless the certificate
5 indicates that creditable coverage is continuing from the date of the
6 certificate.

7 W. The administration shall provide any certification pursuant to this
8 section within thirty days after the event that triggered the issuance of the
9 certification. Periods of creditable coverage for an individual are
10 established by presentation of the certifications in this section.

11 X. The healthcare group program shall comply with all applicable
12 federal requirements.

13 Y. Healthcare group may pay a commission to an insurance producer. To
14 receive a commission, the producer must certify that to the best of the
15 producer's knowledge the employer group has not had insurance in the ninety
16 days before applying to healthcare group. For the purposes of this
17 subsection, "commission" means a one-time payment on the initial enrollment
18 of an employer.

19 Z. On or before September 30 of each year, the director shall submit a
20 report to the joint legislative budget committee regarding the number and
21 type of businesses participating in healthcare group and that includes
22 updated information on healthcare group marketing activities. The director,
23 within thirty days of implementation, shall notify the joint legislative
24 budget committee of any changes in healthcare group benefits or cost sharing
25 arrangements.

26 AA. The administration shall submit the following to the joint
27 legislative budget committee:

28 1. On or before September 30 of each year, a report regarding the
29 financial condition of the healthcare group program. The report shall
30 include the number of persons and employer groups enrolled in the program and
31 medical loss information and projections.

32 2. An annual financial audit.

33 3. The analysis that is used to determine premiums pursuant to
34 subsection 0 of this section.

35 BB. ~~Beginning July 1, 2009, and~~ Each fiscal year ~~thereafter~~,
36 healthcare group shall limit employer group enrollment to not more than five
37 per cent more than the number of employer groups enrolled in the program at
38 the end of the preceding fiscal year. Healthcare group shall give enrollment
39 priority to uninsured groups.

40 CC. For the purposes of this section:

41 1. "Accountable health plan" has the same meaning prescribed in
42 section 20-2301.

43 2. "COBRA continuation provision" means:

44 (a) Section 4980B, except subsection (f)(1) as it relates to pediatric
45 vaccines, of the internal revenue code of 1986.

- 1 (b) Title I, subtitle B, part 6, except section 609, of the employee
2 retirement income security act of 1974.
- 3 (c) Title XXII of the public health service act.
- 4 (d) Any similar provision of the law of this state or any other state.
- 5 3. "Creditable coverage" means coverage solely for an individual,
6 other than limited benefits coverage, under any of the following:
- 7 (a) An employee welfare benefit plan that provides medical care to
8 employees or the employees' dependents directly or through insurance,
9 reimbursement or otherwise pursuant to the employee retirement income
10 security act of 1974.
- 11 (b) A church plan as defined in the employee retirement income
12 security act of 1974.
- 13 (c) A health benefits plan, as defined in section 20-2301, issued by a
14 health plan.
- 15 (d) Part A or part B of title XVIII of the social security act.
- 16 (e) Title XIX of the social security act, other than coverage
17 consisting solely of benefits under section 1928.
- 18 (f) Title 10, chapter 55 of the United States Code.
- 19 (g) A medical care program of the Indian health service or of a tribal
20 organization.
- 21 (h) A health benefits risk pool operated by any state of the United
22 States.
- 23 (i) A health plan offered pursuant to title 5, chapter 89 of the
24 United States Code.
- 25 (j) A public health plan as defined by federal law.
- 26 (k) A health benefit plan pursuant to section 5(e) of the peace corps
27 act (22 United States Code section 2504(e)).
- 28 (l) A policy or contract, including short-term limited duration
29 insurance, issued on an individual basis by an insurer, a health care
30 services organization, a hospital service corporation, a medical service
31 corporation or a hospital, medical, dental and optometric service corporation
32 or made available to persons defined as eligible under section 36-2901,
33 paragraph 6, subdivisions (b), (c), (d) and (e).
- 34 (m) A policy or contract issued by a health care insurer or the
35 administration to a member of a bona fide association.
- 36 4. "Eligible employee" means a person who is one of the following:
- 37 (a) Eligible pursuant to section 36-2901, paragraph 6, subdivisions
38 (b), (c), (d) and (e).
- 39 (b) A person who works for an employer for a minimum of twenty hours
40 per week or who is self-employed for at least twenty hours per week.
- 41 (c) An employee who elects coverage pursuant to section 36-2982,
42 subsection I. The restriction prohibiting employees employed by public
43 agencies prescribed in section 36-2982, subsection I does not apply to this
44 subdivision.

1 (d) A person who meets all of the eligibility requirements, who is
2 eligible for a federal health coverage tax credit pursuant to section 35 of
3 the internal revenue code of 1986 and who applies for health care coverage
4 through the healthcare group program. The requirement that a person be
5 employed with a small business that elects healthcare group coverage does not
6 apply to this eligibility group.

7 5. "Emergency medical condition" has the same meaning prescribed in
8 the emergency medical treatment and active labor act (P.L. 99-272; 100 Stat.
9 164; 42 United States Code section 1395dd(e)).

10 6. "Genetic information" means information about genes, gene products
11 and inherited characteristics that may derive from the individual or a family
12 member, including information regarding carrier status and information
13 derived from laboratory tests that identify mutations in specific genes or
14 chromosomes, physical medical examinations, family histories and direct
15 analyses of genes or chromosomes.

16 7. "Health benefit plan" means coverage offered by the administration
17 for the healthcare group program pursuant to this section.

18 8. "Health status-related factor" means any factor in relation to the
19 health of the individual or a dependent of the individual enrolled or to be
20 enrolled in a health plan, including:

21 (a) Health status.

22 (b) Medical condition, including physical and mental illness.

23 (c) Claims experience.

24 (d) Receipt of health care.

25 (e) Medical history.

26 (f) Genetic information.

27 (g) Evidence of insurability, including conditions arising out of acts
28 of domestic violence as defined in section 20-448.

29 (h) The existence of a physical or mental disability.

30 9. "Hospital" means a health care institution licensed as a hospital
31 pursuant to chapter 4, article 2 of this title.

32 10. "Late enrollee" means an employee or dependent who requests
33 enrollment in a health benefit plan after the initial enrollment period that
34 is provided under the terms of the health benefit plan if the initial
35 enrollment period is at least thirty-one days. Coverage for a late enrollee
36 begins on the date the person becomes a dependent if a request for enrollment
37 is received within thirty-one days after the person becomes a dependent. An
38 employee or dependent shall not be considered a late enrollee if:

39 (a) The person:

40 (i) At the time of the initial enrollment period was covered under a
41 public or private health insurance policy or any other health benefit plan.

42 (ii) Lost coverage under a public or private health insurance policy
43 or any other health benefit plan due to the employee's termination of
44 employment or eligibility, the reduction in the number of hours of
45 employment, the termination of the other plan's coverage, the death of the

1 spouse, legal separation or divorce or the termination of employer
2 contributions toward the coverage.

3 (iii) Requests enrollment within thirty-one days after the termination
4 of creditable coverage that is provided under a COBRA continuation provision.

5 (iv) Requests enrollment within thirty-one days after the date of
6 marriage.

7 (b) The person is employed by an employer that offers multiple health
8 benefit plans and the person elects a different plan during an open
9 enrollment period.

10 (c) The person becomes a dependent of an eligible person through
11 marriage, birth, adoption or placement for adoption and requests enrollment
12 no later than thirty-one days after becoming a dependent.

13 11. "Preexisting condition" means a condition, regardless of the cause
14 of the condition, for which medical advice, diagnosis, care or treatment was
15 recommended or received within not more than six months before the date of
16 the enrollment of the individual under a health benefit plan issued by a
17 contractor. Preexisting condition does not include a genetic condition in
18 the absence of a diagnosis of the condition related to the genetic
19 information.

20 12. "Preexisting condition limitation" or "preexisting condition
21 exclusion" means a limitation or exclusion of benefits for a preexisting
22 condition under a health benefit plan offered by a contractor.

23 13. "Small employer" means an employer who employs at least one but not
24 more than fifty eligible employees on a typical business day during any one
25 calendar year.

26 14. "Waiting period" means the period that must pass before a potential
27 participant or eligible employee in a health benefit plan offered by a health
28 plan is eligible to be covered for benefits as determined by the individual's
29 employer.

30 Sec. 12. Section 36-2932, Arizona Revised Statutes, is amended to
31 read:

32 36-2932. Arizona long-term care system; powers and duties of
33 the director; expenditure limitation

34 A. The Arizona long-term care system is established. The system
35 includes the management and delivery of hospitalization, medical care,
36 institutional services and home and community based services to members
37 through the administration, the program contractors and providers pursuant to
38 this article together with federal participation under title XIX of the
39 social security act. The director in the performance of all duties shall
40 consider the use of existing programs, rules and procedures in the counties
41 and department where appropriate in meeting federal requirements.

42 B. The administration has full operational responsibility for the
43 system, which shall include the following:

44 1. Contracting with and certification of program contractors in
45 compliance with all applicable federal laws.

- 1 2. Approving the program contractors' comprehensive service delivery
2 plans pursuant to section 36-2940.
- 3 3. Providing by rule for the ability of the director to review and
4 approve or disapprove program contractors' ~~request~~ REQUESTS for proposals for
5 providers and provider subcontracts.
- 6 4. Providing technical assistance to the program contractors.
- 7 5. Developing a uniform accounting system to be implemented by program
8 contractors and providers of institutional services and home and community
9 based services.
- 10 6. Conducting quality control on eligibility determinations and
11 preadmission screenings.
- 12 7. Establishing and managing a comprehensive system for assuring the
13 quality of care delivered by the system as required by federal law.
- 14 8. Establishing an enrollment system.
- 15 9. Establishing a member case management tracking system.
- 16 10. Establishing and managing a method to prevent fraud by applicants,
17 members, eligible persons, program contractors, providers and noncontracting
18 providers as required by federal law.
- 19 11. Coordinating benefits as provided in section 36-2946.
- 20 12. Establishing standards for the coordination of services.
- 21 13. Establishing financial and performance audit requirements for
22 program contractors, providers and noncontracting providers.
- 23 14. Prescribing remedies as required pursuant to 42 United States Code
24 section 1396r. These remedies may include the appointment of temporary
25 management by the director, acting in collaboration with the director of the
26 department of health services, in order to continue operation of a nursing
27 care institution providing services pursuant to this article.
- 28 15. Establishing a system to implement medical child support
29 requirements, as required by federal law. The administration may enter into
30 an intergovernmental agreement with the department of economic security to
31 implement this paragraph.
- 32 16. Establishing requirements and guidelines for the review of trusts
33 for the purposes of establishing eligibility for the system pursuant to
34 section 36-2934.01 and ~~posteligibility~~ POSTELIGIBILITY treatment of income
35 pursuant to subsection L of this section.
- 36 17. Accepting the delegation of authority from the department of health
37 services to enforce rules that prescribe minimum certification standards for
38 adult foster care providers pursuant to section 36-410, subsection B. The
39 administration may contract with another entity to perform the certification
40 functions.
- 41 18. Assessing civil penalties for improper billing as prescribed in
42 section 36-2903.01, subsection ~~L~~ K.
- 43 C. For nursing care institutions and hospices that provide services
44 pursuant to this article, the director shall CONTRACT periodically as deemed
45 necessary and as required by federal law ~~contract~~ for a financial audit of

1 the institutions and hospices that is certified by a certified public
2 accountant in accordance with generally accepted auditing standards or
3 conduct or contract for a financial audit or review of the institutions and
4 hospices. The director shall notify the nursing care institution and hospice
5 at least sixty days before beginning a periodic audit. The administration
6 shall reimburse a nursing care institution or hospice for any additional
7 expenses incurred for professional accounting services obtained in response
8 to a specific request by the administration. On request, the director of the
9 administration shall provide a copy of an audit performed pursuant to this
10 subsection to the director of the department of health services or that
11 person's designee.

12 D. Notwithstanding any other provision of this article, the
13 administration may contract by an intergovernmental agreement with an Indian
14 tribe, a tribal council or a tribal organization for the provision of
15 long-term care services pursuant to section 36-2939, subsection A, paragraphs
16 1, 2, 3 and 4 and the home and community based services pursuant to section
17 36-2939, subsection B, paragraph 2 and subsection C, subject to the
18 restrictions in section 36-2939, subsections D and E for eligible members.

19 E. The director shall require as a condition of a contract that all
20 records relating to contract compliance are available for inspection by the
21 administration subject to subsection F of this section and that these records
22 are maintained for five years. The director shall also require that these
23 records are available on request of the secretary of the United States
24 department of health and human services or its successor agency.

25 F. Subject to applicable law relating to privilege and protection, the
26 director shall adopt rules prescribing the types of information that are
27 confidential and circumstances under which that information may be used or
28 released, including requirements for physician-patient confidentiality.
29 Notwithstanding any other law, these rules shall provide for the exchange of
30 necessary information among the program contractors, the administration and
31 the department for the purposes of eligibility determination under this
32 article.

33 G. The director shall adopt rules ~~which~~ TO specify methods for the
34 transition of members into, within and out of the system. The rules shall
35 include provisions for the transfer of members, the transfer of medical
36 records and the initiation and termination of services.

37 H. The director shall adopt rules ~~which~~ THAT provide for withholding
38 or forfeiting payments made to a program contractor if it fails to comply
39 with a provision of its contract or with the director's rules.

40 I. The director shall:

41 1. Establish by rule the time frames and procedures for all grievances
42 and requests for hearings consistent with section 36-2903.01, subsection B,
43 paragraph 4.

44 2. Apply for and accept federal monies available under title XIX of
45 the social security act in support of the system. In addition, the director

1 may apply for and accept grants, contracts and private donations in support
2 of the system.

3 3. Not less than thirty days before the administration implements a
4 policy or a change to an existing policy relating to reimbursement, provide
5 notice to interested parties. Parties interested in receiving notification
6 of policy changes shall submit a written request for notification to the
7 administration.

8 J. The director may apply for federal monies available for the support
9 of programs to investigate and prosecute violations arising from the
10 administration and operation of the system. Available state monies
11 appropriated for the administration of the system may be used as matching
12 monies to secure federal monies pursuant to this subsection.

13 K. The director shall adopt rules ~~which~~ THAT establish requirements of
14 state residency and qualified alien status as prescribed in section
15 36-2903.03. The administration shall enforce these requirements as part of
16 the eligibility determination process. The rules shall also provide for the
17 determination of the applicant's county of residence for the purpose of
18 assignment of the appropriate program contractor.

19 L. The director shall adopt rules in accordance with the state plan
20 regarding posteligibility treatment of income and resources ~~which~~ THAT
21 determine the portion of a member's income ~~which~~ THAT shall be available for
22 payment for services under this article. The rules shall provide that a
23 portion of income may be retained for:

24 1. A personal needs allowance for members receiving institutional
25 services of at least fifteen per cent of the maximum monthly supplemental
26 security income payment for an individual or a personal needs allowance for
27 members receiving home and community based services based on a reasonable
28 assessment of need.

29 2. The maintenance needs of a spouse or family at home ~~shall be~~ in
30 accordance with federal law. The minimum resource allowance for the spouse
31 or family at home is twelve thousand dollars adjusted annually by the same
32 percentage as the percentage change in the consumer price index for all urban
33 consumers (all items; United States city average) between September 1988 and
34 the September before the calendar year involved.

35 3. Expenses incurred for noncovered medical or remedial care that are
36 not subject to payment by a third party payor.

37 M. In addition to the rules otherwise specified in this article, the
38 director may adopt necessary rules pursuant to title 41, chapter 6 to carry
39 out this article. Rules adopted by the director pursuant to this subsection
40 may consider the differences between rural and urban conditions on the
41 delivery of services.

42 N. The director shall not adopt any rule or enter into or approve any
43 contract or subcontract ~~which~~ THAT does not conform to federal requirements
44 or ~~which~~ THAT may cause the system to lose any federal monies to which it is
45 otherwise entitled.

1 O. The administration, program contractors and providers may establish
2 and maintain review committees dealing with the delivery of care. Review
3 committees and their staff are subject to the same requirements, protections,
4 privileges and immunities prescribed pursuant to section 36-2917.

5 P. If the director determines that the financial viability of a
6 nursing care institution or hospice is in question, the director may require
7 a nursing care institution and a hospice providing services pursuant to this
8 article to submit quarterly financial statements within thirty days after the
9 end of its financial quarter unless the director grants an extension in
10 writing before that date. Quarterly financial statements submitted to the
11 department shall include the following:

12 1. A balance sheet detailing the institution's assets, liabilities and
13 net worth.

14 2. A statement of income and expenses, including current personnel
15 costs and full-time equivalent statistics.

16 Q. The director may require monthly financial statements if the
17 director determines that the financial viability of a nursing care
18 institution or hospice is in question. The director shall prescribe the
19 requirements of these statements.

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

28 Sec. 13. Section 36-2986, Arizona Revised Statutes, is amended to
29 read:

30 36-2986. Administration; powers and duties of director

31 A. The director has full operational authority to adopt rules or to
32 use the appropriate rules adopted for article 1 of this chapter to implement
33 this article, including any of the following:

34 1. Contract administration and oversight of contractors.

35 2. Development of a complete system of accounts and controls for the
36 program, including provisions designed to ensure that covered health and
37 medical services provided through the system are not used unnecessarily or
38 unreasonably, including inpatient behavioral health services provided in a
39 hospital.

40 3. Establishment of peer review and utilization review functions for
41 all contractors.

42 4. Development and management of a contractor payment system.

43 5. Establishment and management of a comprehensive system for assuring
44 quality of care.

1 6. Establishment and management of a system to prevent fraud by
2 members, contractors and health care providers.

3 7. Development of an outreach program. The administration shall
4 coordinate with public and private entities to provide outreach services for
5 children under this article. Priority shall be given to those families who
6 are moving off welfare. Outreach activities shall include strategies to
7 inform communities, including tribal communities, about the program, ensure a
8 wide distribution of applications and provide training for other entities to
9 assist with the application process.

10 8. Coordination of benefits provided under this article for any
11 member. The director may require that contractors and noncontracting
12 providers are responsible for the coordination of benefits for services
13 provided under this article. Requirements for coordination of benefits by
14 noncontracting providers under this section are limited to coordination with
15 standard health insurance and disability insurance policies and similar
16 programs for health coverage. The director may require members to assign to
17 the administration rights to all types of medical benefits to which the
18 person is entitled, including first party medical benefits under automobile
19 insurance policies. The state has a right of subrogation against any other
20 person or firm to enforce the assignment of medical benefits. The provisions
21 of this paragraph are controlling over the provisions of any insurance policy
22 that provides benefits to a member if the policy is inconsistent with this
23 paragraph.

24 9. Development and management of an eligibility, enrollment and
25 redetermination system including a process for quality control.

26 10. Establishment and maintenance of an encounter claims system that
27 ensures that ninety per cent of the clean claims are paid within thirty days
28 after receipt and ninety-nine per cent of the remaining clean claims are paid
29 within ninety days after receipt by the administration or contractor unless
30 an alternative payment schedule is agreed to by the contractor and the
31 provider. For the purposes of this paragraph, "clean claims" has the same
32 meaning prescribed in section 36-2904, subsection G.

33 11. Establishment of standards for the coordination of medical care and
34 member transfers.

35 12. Requiring contractors to submit encounter data in a form specified
36 by the director.

37 13. Assessing civil penalties for improper billing as prescribed in
38 section 36-2903.01, subsection ~~L~~ K.

39 B. Notwithstanding any other law, if Congress amends title XXI of the
40 social security act and the administration is required to make conforming
41 changes to rules adopted pursuant to this article, the administration shall
42 request a hearing with the joint health committee of reference for review of
43 the proposed rule changes.

44 C. The director may subcontract distinct administrative functions to
45 one or more persons who may be contractors within the system.

1 D. The director shall require as a condition of a contract with any
2 contractor that all records relating to contract compliance are available for
3 inspection by the administration and that these records be maintained by the
4 contractor for five years. The director shall also require that these
5 records are available by a contractor on request of the secretary of the
6 United States department of health and human services.

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

18 F. The director shall provide for the transition of members between
19 contractors and noncontracting providers and the transfer of members who have
20 been determined eligible from hospitals that do not have contracts to care
21 for these persons.

22 G. To the extent that services are furnished pursuant to this article,
23 a contractor is not subject to title 20 unless the contractor is a qualifying
24 plan and has elected to provide services pursuant to this article.

25 H. As a condition of a contract, the director shall require contract
26 terms that are necessary to ensure adequate performance by the contractor.
27 Contract provisions required by the director include the maintenance of
28 deposits, performance bonds, financial reserves or other financial security.
29 The director may waive requirements for the posting of bonds or security for
30 contractors who have posted other security, equal to or greater than that
31 required by the administration, with a state agency for the performance of
32 health service contracts if monies would be available from that security for
33 the system on default by the contractor.

34 I. The director shall establish solvency requirements in contract that
35 may include withholding or forfeiture of payments to be made to a contractor
36 by the administration for the failure of the contractor to comply with a
37 provision of the contract with the administration. The director may also
38 require contract terms allowing the administration to operate a contractor
39 directly under circumstances specified in the contract. The administration
40 shall operate the contractor only as long as it is necessary to assure
41 delivery of uninterrupted care to members enrolled with the contractor and to
42 accomplish the orderly transition of members to other contractors or until
43 the contractor reorganizes or otherwise corrects the contract performance
44 failure. The administration shall not operate a contractor unless, before
45 that action, the administration delivers notice to the contractor providing

1 an opportunity for a hearing in accordance with procedures established by the
2 director. Notwithstanding the provisions of a contract, if the
3 administration finds that the public health, safety or welfare requires
4 emergency action, it may operate as the contractor on notice to the
5 contractor and pending an administrative hearing, which it shall promptly
6 institute.

7 J. For the sole purpose of matters concerning and directly related to
8 this article, the administration is exempt from section 41-192.

9 K. The director may withhold payments to a noncontracting provider if
10 the noncontracting provider does not comply with this article or adopted
11 rules that relate to the specific services rendered and billed to the
12 administration.

13 L. The director shall:

14 1. Prescribe uniform forms to be used by all contractors and furnish
15 uniform forms and procedures, including methods of identification of members.
16 The rules shall include requirements that an applicant personally complete or
17 assist in the completion of eligibility application forms, except in
18 situations in which the person is disabled.

19 2. By rule, establish a grievance and appeal procedure that conforms
20 with the process and the time frames specified in article 1 of this chapter.
21 If the program is suspended or terminated pursuant to section 36-2985, an
22 applicant or member is not entitled to contest the denial, suspension or
23 termination of eligibility for the program.

24 3. Apply for and accept federal monies available under title XXI of
25 the social security act. Available state monies appropriated to the
26 administration for the operation of the program shall be used as matching
27 monies to secure federal monies pursuant to this subsection.

28 M. The administration is entitled to all rights provided to the
29 administration for liens and release of claims as specified in sections
30 36-2915 and 36-2916 and shall coordinate benefits pursuant to section
31 36-2903, subsection F and be a payor of last resort for persons who are
32 eligible pursuant to this article.

33 N. The director shall follow the same procedures for review
34 committees, immunity and confidentiality that are prescribed in article 1 of
35 this chapter.

36 Sec. 14. Section 36-2987, Arizona Revised Statutes, is amended to
37 read:

38 36-2987. Reimbursement for the program

39 A. For inpatient hospital services, the administration shall reimburse
40 the Indian health service or a tribal facility based on the reimbursement
41 rates for the Indian health service as published annually in the federal
42 register. For outpatient services, the administration shall reimburse the
43 Indian health service or a tribal facility based on the capped
44 fee-for-service schedule established by the director. If Congress authorizes
45 one hundred per cent pass-through of title XXI monies for services provided

1 in an Indian health service facility or a tribal facility, the administration
2 shall reimburse the Indian health service or the tribal facility with this
3 enhanced federal funding based on the reimbursement rates for the Indian
4 health service or the tribal facility as published annually in the federal
5 register.

6 B. Contractors shall reimburse inpatient and outpatient services based
7 on the reimbursement methodology established in section 36-2904 or the
8 hospital reimbursement pilot program established by this state.

9 C. For services rendered on and after October 1, 1998, the
10 administration and the contractors shall pay a hospital's rate established
11 according to this section subject to the following:

12 1. If the hospital's bill is paid within thirty days after the date
13 the bill was received, the administration shall pay ninety-nine per cent of
14 the rate.

15 2. If the hospital's bill is paid after thirty days but within sixty
16 days after the date the bill was received, the administration shall pay one
17 hundred per cent of the rate.

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

23 D. The administration and the contractors shall pay claims pursuant to
24 the methodology, definitions and time frames specified for clean claims in
25 section 36-2904, subsection G.

26 E. The director shall specify enrollment procedures, including notice
27 to contractors of enrollment. The administration shall specify in contract
28 when a person who has been determined eligible will be enrolled with a
29 contractor and the date on which the contractor will be financially
30 responsible for health and medical services to the person.

31 F. The director shall monitor any third party payment collections
32 collected by contractors and noncontracting providers according to the same
33 procedures specified for title XIX pursuant to section 36-2903.01,
34 subsection ~~K~~ J.

35 G. On oral or written notice from the member, or the member's parent
36 or legal guardian, that the member, parent or legal guardian believes a claim
37 should be covered by the program, a contractor or noncontracting provider
38 shall not do either of the following unless the contractor or noncontracting
39 provider has verified through the administration that the person is
40 ineligible for the program, has not yet been determined eligible or, at the
41 time services were rendered, was not eligible or enrolled in the program:

42 1. Charge, submit a claim to or demand or otherwise collect payment
43 from a member or person who has been determined eligible.

44 2. Refer or report a member or person who has been determined eligible
45 to a collection agency or credit reporting agency for the failure of the

1 member or person who has been determined eligible to pay charges for covered
2 services unless specifically authorized by this article or rules adopted
3 pursuant to this article.

4 H. The administration may conduct postpayment review of all payments
5 made by the administration and may recoup any monies erroneously paid. The
6 director may adopt rules that specify procedures for conducting postpayment
7 review. Contractors may conduct a postpayment review of all claims paid to
8 providers and may recoup monies that are erroneously paid.

9 I. The director or the director's designee may employ and supervise
10 personnel necessary to assist the director in performing the functions of the
11 program.

12 Sec. 15. Section 36-3411, Arizona Revised Statutes, is amended to
13 read:

14 36-3411. Behavioral health services; timely reimbursement;
15 penalties

16 A. The division shall ensure that behavioral health service providers
17 are reimbursed within ninety days after the service provider submits a clean
18 claim to a regional behavioral health authority.

19 B. Any contract issued by or on behalf of the division for the
20 provision of behavioral health services shall include language outlining
21 provisions for penalties for noncompliance with contract requirements.

22 C. If the regional behavioral health authority does not reimburse a
23 provider as required by this section, the director shall subject the regional
24 behavioral health authority to the penalty provisions prescribed in the
25 contract, which shall not exceed the interest charges prescribed in section
26 44-1201. The director shall impose any financial penalties levied ~~upon~~ ON
27 the regional behavioral health authority through a reduction in the amount of
28 funds payable to the regional behavioral health authority for administrative
29 expenses.

30 D. The ninety day deadline imposed by this section is suspended while
31 a formal grievance regarding the legitimacy of a claim is pending.

32 E. The department or a regional behavioral health authority shall not
33 pay claims for covered services that are initially submitted more than nine
34 months after the date of the services for which payment is claimed or that
35 are submitted as clean claims more than twelve months after the date of
36 service for which payment is claimed. A person dissatisfied with the denial
37 of a claim by the department or by the regional behavioral health authority
38 has twelve months from the date of the service for which payment is claimed
39 to institute a grievance against the department or regional behavioral health
40 authority.

41 F. For claims paid by the department, either directly or through a
42 third party payor, the director may impose a penalty on a regional behavioral
43 health authority or a service provider who submits a claim to the department
44 for payment more than one time after the same claim had been previously
45 denied by the department without having attempted to address the reason given

1 for the denial. The penalty imposed by the director shall not exceed the
2 average cost incurred by the department for processing a claim and shall be
3 levied ~~upon~~ ON the regional behavioral health authority or service provider
4 through reducing any future payment or payments until the amount of the
5 penalty has been paid.

6 G. This section does not apply to services provided by a hospital
7 pursuant to section 36-2903.01, subsection G ~~or H~~, or section 36-2904,
8 subsection H or I.

9 Sec. 16. Section 41-1608, Arizona Revised Statutes, is amended to
10 read:

11 41-1608. Inmate medical services; rate structure

12 If a prisoner in a secure care facility requires health care services
13 that the department, the facility or a private prison provider contracted by
14 the department cannot provide, the department shall pay approved claims from
15 a facility or provider that provides these services as follows:

16 1. For inpatient and outpatient hospital services, the department
17 shall reimburse at a level that does not exceed the reimbursement methodology
18 established pursuant to section 36-2903.01, subsection ~~H~~ G.

19 2. For health and medical services, the department shall reimburse at
20 a level that does not exceed the capped fee-for-service schedule that is
21 adopted by the Arizona health care cost containment system administration
22 pursuant to title 36, chapter 29, article 1 and that is in effect at the time
23 the services are delivered.

24 Sec. 17. Section 41-1954, Arizona Revised Statutes, is amended to
25 read:

26 41-1954. Powers and duties

27 A. In addition to the powers and duties of the agencies listed in
28 section 41-1953, subsection E, the department shall:

29 1. Administer the following services:

30 (a) Employment services, which shall include manpower programs and
31 work training, field operations, technical services, unemployment
32 compensation, community work and training and other related functions in
33 furtherance of programs under the social security act, as amended, the
34 Wagner-Peyser act, as amended, the federal unemployment tax act, as amended,
35 33 United States Code, the family support act of 1988 (P.L. 100-485) and
36 other related federal acts and titles.

37 (b) Individual and family services, which shall include a section on
38 aging, services to children, youth and adults and other related functions in
39 furtherance of social service programs under the social security act, as
40 amended, title IV, grants to states for aid and services to needy families
41 with children and for child-welfare services, title XX, grants to states for
42 services, the older Americans act, as amended, the family support act of 1988
43 (P.L. 100-485) and other related federal acts and titles.

44 (c) Income maintenance services, which shall include categorical
45 assistance programs, special services unit, child support collection

1 services, establishment of paternity services, maintenance and operation of a
2 state case registry of child support orders, a state directory of new hires,
3 a support payment clearinghouse and other related functions in furtherance of
4 programs under the social security act, title IV, grants to states for aid
5 and services to needy families with children and for child-welfare services,
6 title XX, grants to states for services, as amended, and other related
7 federal acts and titles.

8 (d) Rehabilitation services, which shall include vocational
9 rehabilitation services and sections for the blind and visually impaired,
10 communication disorders, correctional rehabilitation and other related
11 functions in furtherance of programs under the vocational rehabilitation act,
12 as amended, the Randolph-Sheppard act, as amended, and other related federal
13 acts and titles.

14 (e) Administrative services, which shall include the coordination of
15 program evaluation and research, interagency program coordination and
16 in-service training, planning, grants, development and management,
17 information, legislative liaison, budget, licensing and other related
18 functions.

19 (f) Manpower planning, which shall include a state manpower planning
20 council for the purposes of the federal-state-local cooperative manpower
21 planning system and other related functions in furtherance of programs under
22 the comprehensive employment and training act of 1973, as amended, and other
23 related federal acts and titles.

24 (g) Economic opportunity services, which shall include the furtherance
25 of programs prescribed under the economic opportunity act of 1967, as
26 amended, and other related federal acts and titles.

27 (h) Intellectual disability and other developmental disability
28 programs, with emphasis on referral and purchase of services. The program
29 shall include educational, rehabilitation, treatment and training services
30 and other related functions in furtherance of programs under the
31 developmental disabilities services and facilities construction act, Public
32 Law 91-517, and other related federal acts and titles.

33 (i) Nonmedical home and community based services and functions,
34 including department designated case management, housekeeping services, chore
35 services, home health aid, personal care, visiting nurse services, adult day
36 care or adult day health, respite sitter care, attendant care, home delivered
37 meals and other related services and functions.

38 2. Provide a coordinated system of initial intake, screening,
39 evaluation and referral of persons served by the department.

40 3. Adopt rules it deems necessary or desirable to further the
41 objectives and programs of the department.

42 4. Formulate policies, plans and programs to effectuate the missions
43 and purposes of the department.

44 5. Employ, determine the conditions of employment and prescribe the
45 duties and powers of administrative, professional, technical, secretarial,

1 clerical and other persons as may be necessary in the performance of its
2 duties, contract for the services of outside advisors, consultants and aides
3 as may be reasonably necessary and reimburse department volunteers,
4 designated by the director, for expenses in transporting clients of the
5 department on official business.

6 6. Make contracts and incur obligations within the general scope of
7 its activities and operations subject to the availability of funds.

8 7. Contract with or assist other departments, agencies and
9 institutions of the state, local and federal governments in the furtherance
10 of its purposes, objectives and programs.

11 8. Be designated as the single state agency for the purposes of
12 administering and in furtherance of each federally supported state plan.

13 9. Accept and disburse grants, matching funds and direct payments from
14 public or private agencies for the conduct of programs that are consistent
15 with the overall purposes and objectives of the department.

16 10. Provide information and advice on request by local, state and
17 federal agencies and by private citizens, business enterprises and community
18 organizations on matters within the scope of its duties subject to the
19 departmental rules on the confidentiality of information.

20 11. Establish and maintain separate financial accounts as required by
21 federal law or regulations.

22 12. Advise and make recommendations to the governor and the legislature
23 on all matters concerning its objectives.

24 13. Have an official seal that shall be judicially noticed.

25 14. Annually estimate the current year's population of each county,
26 city and town in this state, using the periodic census conducted by the
27 United States department of commerce, or its successor agency, as the basis
28 for such estimates and deliver such estimates to the economic estimates
29 commission before December 15.

30 15. Estimate the population of any newly annexed areas of a political
31 subdivision as of July 1 of the fiscal year in which the annexation occurs
32 and deliver such estimates as promptly as is feasible after the annexation
33 occurs to the economic estimates commission.

34 16. Establish and maintain a statewide program of services for persons
35 who are both hearing impaired and visually impaired and coordinate
36 appropriate services with other agencies and organizations to avoid
37 duplication of these services and to increase efficiency. The department of
38 economic security shall enter into agreements for the utilization of the
39 personnel and facilities of the department of economic security, the
40 department of health services and other appropriate agencies and
41 organizations in providing these services.

42 17. Establish and charge fees for deposit in the department of economic
43 security prelayoff assistance services fund to employers who voluntarily
44 participate in the services of the department that provide job service and
45 retraining for persons who have been or are about to be laid off from

1 employment. The department shall charge only those fees necessary to cover
2 the costs of administering the job service and retraining services.

3 18. Establish a focal point for addressing the issue of hunger in
4 Arizona and provide coordination and assistance to public and private
5 nonprofit organizations that aid hungry persons and families throughout this
6 state. Specifically such activities shall include:

7 (a) Collecting and disseminating information regarding the location
8 and availability of surplus food for distribution to needy persons, the
9 availability of surplus food for donation to charity food bank organizations,
10 and the needs of charity food bank organizations for surplus food.

11 (b) Coordinating the activities of federal, state, local and private
12 nonprofit organizations that provide food assistance to the hungry.

13 (c) Accepting and disbursing federal monies, and any state monies
14 appropriated by the legislature, to private nonprofit organizations in
15 support of the collection, receipt, handling, storage and distribution of
16 donated or surplus food items.

17 (d) Providing technical assistance to private nonprofit organizations
18 that provide or intend to provide services to the hungry.

19 (e) Developing a state plan on hunger that, at a minimum, identifies
20 the magnitude of the hunger problem in this state, the characteristics of the
21 population in need, the availability and location of charity food banks and
22 the potential sources of surplus food, assesses the effectiveness of the
23 donated food collection and distribution network and other efforts to
24 alleviate the hunger problem, and recommends goals and strategies to improve
25 the status of the hungry. The state plan on hunger shall be incorporated
26 into the department's state comprehensive plan prepared pursuant to section
27 41-1956.

28 (f) Establishing a special purpose advisory council on hunger pursuant
29 to section 41-1981.

30 19. Establish an office to address the issue of homelessness and to
31 provide coordination and assistance to public and private nonprofit
32 organizations that prevent homelessness or aid homeless individuals and
33 families throughout this state. These activities shall include:

34 (a) Promoting and participating in planning for the prevention of
35 homelessness and the development of services to homeless persons.

36 (b) Identifying and developing strategies for resolving barriers in
37 state agency service delivery systems that inhibit the provision and
38 coordination of appropriate services to homeless persons and persons in
39 danger of being homeless.

40 (c) Assisting in the coordination of the activities of federal, state
41 and local governments and the private sector that prevent homelessness or
42 provide assistance to homeless people.

43 (d) Assisting in obtaining and increasing funding from all appropriate
44 sources to prevent homelessness or assist in alleviating homelessness.

1 (e) Serving as a clearinghouse on information regarding funding and
2 services available to assist homeless persons and persons in danger of being
3 homeless.

4 (f) Developing an annual state comprehensive homeless assistance plan
5 to prevent and alleviate homelessness.

6 (g) Submitting an annual report to the governor, the president of the
7 senate and the speaker of the house of representatives on the status of
8 homelessness and efforts to prevent and alleviate homelessness.

9 20. Cooperate with the Arizona-Mexico commission in the governor's
10 office and with researchers at universities in this state to collect data and
11 conduct projects in the United States and Mexico on issues that are within
12 the scope of the department's duties and that relate to quality of life,
13 trade and economic development in this state in a manner that will help the
14 Arizona-Mexico commission to assess and enhance the economic competitiveness
15 of this state and of the Arizona-Mexico region.

16 B. If the department OF ECONOMIC SECURITY has responsibility for the
17 care, custody or control of a child or is paying the cost of care for a
18 child, it may serve as representative payee to receive and administer social
19 security and ~~veterans-administration~~ UNITED STATES DEPARTMENT OF VETERANS
20 AFFAIRS benefits and other benefits payable to such child. Notwithstanding
21 any law to the contrary, the department OF ECONOMIC SECURITY:

22 1. Shall deposit, pursuant to sections 35-146 and 35-147, such monies
23 as it receives to be retained separate and apart from the state general fund
24 on the books of the department of administration.

25 2. May use such monies to defray the cost of care and services
26 expended by the department OF ECONOMIC SECURITY for the benefit, welfare and
27 best interests of the child and invest any of the monies that the director
28 determines are not necessary for immediate use.

29 3. Shall maintain separate records to account for the receipt,
30 investment and disposition of funds received for each child.

31 4. On termination of the ~~department's~~ DEPARTMENT OF ECONOMIC
32 SECURITY'S responsibility for the child, shall release any funds remaining to
33 the child's credit in accordance with the requirements of the funding source
34 or in the absence of such requirements shall release the remaining funds to:

35 (a) The child, if the child is at least eighteen years of age or is
36 emancipated.

37 (b) The person responsible for the child if the child is a minor and
38 not emancipated.

39 C. Subsection B of this section does not pertain to benefits payable
40 to or for the benefit of a child receiving services under title 36.

41 D. Volunteers reimbursed for expenses pursuant to subsection A,
42 paragraph 5 of this section are not eligible for workers' compensation under
43 title 23, chapter 6.

44 E. In implementing the temporary assistance for needy families program
45 pursuant to Public Law 104-193, the department shall provide for cash

1 assistance to two parent families if both parents are able to work only on
2 documented participation by both parents in work activities described in
3 title 46, chapter 2, article 5, except that payments may be made to families
4 who do not meet the participation requirements if:

5 1. It is determined on an individual case basis that they have
6 emergency needs.

7 2. The family is determined to be eligible for diversion from
8 long-term cash assistance pursuant to title 46, chapter 2, article 5.

9 F. The department shall provide for cash assistance under temporary
10 assistance for needy families pursuant to Public Law 104-193 to two parent
11 families for no longer than six months if both parents are able to work,
12 except that additional assistance may be provided on an individual case basis
13 to families with extraordinary circumstances. The department shall establish
14 by rule the criteria to be used to determine eligibility for additional cash
15 assistance.

16 G. The department shall adopt the following discount medical payment
17 system for persons who the department determines are eligible and who are
18 receiving rehabilitation services pursuant to subsection A, paragraph 1,
19 subdivision (d) of this section:

20 1. For inpatient hospital admissions and outpatient hospital services
21 the department shall reimburse a hospital according to the ~~tiered per diem~~
22 rates ~~and outpatient cost-to-charge ratios~~ established by the Arizona health
23 care cost containment system administration pursuant to section 36-2903.01,
24 subsection ~~H~~ G.

25 2. The department's liability for a hospital claim under this
26 subsection is subject to availability of funds.

27 3. A hospital bill is considered received for purposes of paragraph 5
28 of this subsection on initial receipt of the legible, error-free claim form
29 by the department if the claim includes the following error-free
30 documentation in legible form:

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

38 4. The department shall require that the hospital pursue other
39 third-party payors before submitting a claim to the department. Payment
40 received by a hospital from the department pursuant to this subsection is
41 considered payment by the department of the department's liability for the
42 hospital bill. A hospital may collect any unpaid portion of its bill from
43 other third party payors or in situations covered by title 33, chapter 7,
44 article 3.

1 5. For inpatient hospital admissions and outpatient hospital services
2 rendered on and after October 1, 1997, if the department receives the claim
3 directly from the hospital, the department shall pay a hospital's rate
4 established according to this section subject to the following:

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

7 (b) If the hospital's bill is paid after thirty days but within sixty
8 days of the date the bill was received, the department shall pay one hundred
9 per cent of the rate.

10 (c) If the hospital's bill is paid any time after sixty days of the
11 date the bill was received, the department shall pay one hundred per cent of
12 the rate plus a fee of one per cent per month for each month or portion of a
13 month following the sixtieth day of receipt of the bill until the date of
14 payment.

15 6. For medical services other than those for which a rate has been
16 established pursuant to section 36-2903.01, subsection ~~H~~ G, the department
17 shall pay according to the Arizona health care cost containment system capped
18 fee-for-service schedule adopted pursuant to section 36-2904, subsection K or
19 any other established fee schedule the department determines reasonable.

20 H. The department shall not pay claims for services pursuant to this
21 section that are submitted more than nine months after the date of service
22 for which the payment is claimed.

23 I. To assist in the location of persons or assets for the purpose of
24 establishing paternity, establishing, modifying or enforcing child support
25 obligations and other related functions, the department has access, including
26 automated access if the records are maintained in an automated database, to
27 records of state and local government agencies, including:

28 1. Vital statistics, including records of marriage, birth and divorce.

29 2. State and local tax and revenue records, including information on
30 residence address, employer, income and assets.

31 3. Records concerning real and titled personal property.

32 4. Records of occupational and professional licenses.

33 5. Records concerning the ownership and control of corporations,
34 partnerships and other business entities.

35 6. Employment security records.

36 7. Records of agencies administering public assistance programs.

37 8. Records of the motor vehicle division of the department of
38 transportation.

39 9. Records of the state department of corrections.

40 10. Any system used by a state agency to locate a person for motor
41 vehicle or law enforcement purposes, including access to information
42 contained in the Arizona criminal justice information system.

43 J. Notwithstanding subsection I of this section, the department or its
44 agents shall not seek or obtain information on the assets of an individual
45 unless paternity is presumed pursuant to section 25-814 or established.

1 K. Access to records of the department of revenue pursuant to
2 subsection I of this section shall be provided in accordance with section
3 42-2003.

4 L. The department also has access to certain records held by private
5 entities with respect to child support obligors or obligees, or individuals
6 against whom such an obligation is sought. The information shall be obtained
7 as follows:

8 1. In response to a child support subpoena issued by the department
9 pursuant to section 25-520, the names and addresses of these persons and the
10 names and addresses of the employers of these persons, as appearing in
11 customer records of public utilities and cable television companies.

12 2. Information on these persons held by financial institutions.

13 M. Pursuant to department rules, the department may compromise or
14 settle any support debt owed to the department if the director or an
15 authorized agent determines that it is in the best interest of the state and
16 after considering each of the following factors:

17 1. The obligor's financial resources.

18 2. The cost of further enforcement action.

19 3. The likelihood of recovering the full amount of the debt.

20 N. Notwithstanding any law to the contrary, a state or local
21 governmental agency or private entity is not subject to civil liability for
22 the disclosure of information made in good faith to the department pursuant
23 to this section.

24 Sec. 18. Section 41-2807, Arizona Revised Statutes, is amended to
25 read:

26 41-2807. Medical services; rate structure

27 If a youth in a secure care facility requires health care services that
28 the department, the facility or a provider contracted by the department
29 cannot provide, the department shall pay approved claims from a facility or
30 provider that provides these services as follows:

31 1. For inpatient and outpatient hospital services, the department
32 shall reimburse at a level that does not exceed the reimbursement methodology
33 established pursuant to section 36-2903.01, subsection ~~H~~ G, unless the
34 department has a contract with the vendor.

35 2. For health and medical services, the department shall reimburse at
36 a level that does not exceed the capped fee-for-service schedule that is
37 adopted by the Arizona health care cost containment system administration
38 pursuant to title 36, chapter 29, article 1 and that is in effect at the time
39 the services are delivered.

40 Sec. 19. Section 48-5501, Arizona Revised Statutes, is amended to
41 read:

42 48-5501. Definitions

43 In this chapter, unless the context otherwise requires:

44 1. "Freestanding urgent care center":

- 1 (a) Means an outpatient treatment center that, regardless of its
2 posted or advertised name, meets any of the following requirements:
- 3 (i) Is open twenty-four hours a day, excluding at its option weekends
4 or certain holidays, but is not licensed as a hospital.
- 5 (ii) Claims to provide unscheduled medical services that are not
6 otherwise routinely available in primary care physician offices.
- 7 (iii) By its posted or advertised name, gives the impression to the
8 public that it provides medical care for urgent, immediate or emergency
9 conditions.
- 10 (iv) Routinely provides ongoing unscheduled medical services for more
11 than eight consecutive hours for an individual patient.
- 12 (b) Does not include the following:
- 13 (i) A medical facility that is licensed under a hospital's license and
14 that uses the hospital's medical provider number.
- 15 (ii) A qualifying community health center pursuant to section
16 36-2907.06.
- 17 (iii) Any other health care institution that is licensed pursuant to
18 this chapter.
- 19 (iv) A physician's office that offers extended hours or same day
20 appointments to existing and new patients and that does not meet the
21 requirements of subdivision (a), item (i), (iii) or (iv). For the purposes
22 of this item, "physician" means a person licensed pursuant to title 32,
23 chapter 13 or 17.
- 24 2. "Home health agency" has the same meaning prescribed in section
25 36-151.
- 26 3. "Medical clinic" means a facility that provides for physical
27 evaluation, diagnosis and treatment of patients and that does not keep
28 patients overnight as bed patients or treat patients under general
29 anesthesia.
- 30 4. "Medically underserved" means populations that exhibit one or more
31 of the following indicators:
- 32 (a) Limitations on the availability of primary care providers,
33 prenatal care or other health care services.
- 34 (b) Residence in a health professional shortage area as defined in 42
35 Code of Federal Regulations part 5.
- 36 (c) A standard of living at or below a designated federal poverty
37 level.
- 38 (d) Other factors indicative of being medically underserved, including
39 levels of unemployment, incidence of infant mortality or low birth weights
40 and the elderly.
- 41 5. "Nursing care institution" has the same meaning prescribed in
42 section 36-401.
- 43 6. "Qualified electors" means persons who are qualified to vote
44 pursuant to title 16.

