

COMMITTEE ON APPROPRIATIONS

HOUSE OF REPRESENTATIVES AMENDMENTS TO S.B. 1069

(Reference to Senate engrossed bill)

1 Strike everything after the enacting clause and insert:

2 "Section 1. Section 36-449.02, Arizona Revised Statutes, is amended to
3 read:

4 36-449.02. Abortion clinics; licensure requirements; rules;
5 inspections

6 A. Beginning on April 1, 2000, an abortion clinic shall meet the same
7 licensure requirements as prescribed in article 2 of this chapter for health
8 care institutions.

9 B. An abortion clinic that holds an unclassified health care facility
10 license issued before ~~the effective date of this article~~ AUGUST 6, 1999 may
11 retain that classification until April 1, 2000 subject to compliance with all
12 laws that relate to unclassified health care facilities.

13 C. Beginning on April 1, 2000, abortion clinics shall comply with
14 department requirements for abortion clinics and department rules that govern
15 abortion clinics.

16 D. IF THE DIRECTOR DETERMINES THAT THERE IS REASONABLE CAUSE TO
17 BELIEVE AN ABORTION CLINIC IS NOT ADHERING TO THE LICENSING REQUIREMENTS OF
18 THIS ARTICLE OR ANY OTHER LAW OR REGULATION CONCERNING ABORTION, THE DIRECTOR
19 AND ANY DULY DESIGNATED EMPLOYEE OR AGENT OF THE DIRECTOR, INCLUDING COUNTY
20 HEALTH REPRESENTATIVES AND COUNTY OR MUNICIPAL FIRE INSPECTORS, CONSISTENT
21 WITH STANDARD MEDICAL PRACTICES, MAY ENTER ON AND INTO THE PREMISES OF THE
22 ABORTION CLINIC THAT IS LICENSED OR REQUIRED TO BE LICENSED PURSUANT TO THIS
23 CHAPTER DURING REGULAR BUSINESS HOURS OF THE ABORTION CLINIC TO DETERMINE
24 COMPLIANCE WITH THIS CHAPTER, RULES ADOPTED PURSUANT TO THIS CHAPTER, LOCAL
25 FIRE ORDINANCES OR RULES AND ANY OTHER LAW OR REGULATION RELATING TO
26 ABORTION.

27 E. AN APPLICATION FOR LICENSURE PURSUANT TO THIS CHAPTER CONSTITUTES
28 PERMISSION FOR, AND COMPLETE ACQUIESCENCE IN, AN ENTRY OR INSPECTION OF THE
29 PREMISES DURING THE PENDENCY OF THE APPLICATION AND, IF LICENSED, DURING THE
30 TERM OF THE LICENSE.

31 F. IF AN INSPECTION CONDUCTED PURSUANT TO THIS SECTION REVEALS THAT AN
32 ABORTION CLINIC IS NOT ADHERING TO THE LICENSING REQUIREMENTS PRESCRIBED

PURSUANT TO THIS CHAPTER OR ANY OTHER LAW OR REGULATION CONCERNING ABORTION,
THE DIRECTOR MAY TAKE ACTION AUTHORIZED BY THIS CHAPTER.

G. AN ABORTION CLINIC WHOSE LICENSE HAS BEEN SUSPENDED OR REVOKED
PURSUANT TO THIS ARTICLE OR SECTION 36-424 IS SUBJECT TO INSPECTION ON
APPLICATION FOR RELICENSURE OR REINSTATEMENT OF THE LICENSE.

Sec. 2. Section 36-2161, Arizona Revised Statutes, is amended to read:

~~36-2161.~~ Abortions: reporting requirements

A. A hospital or facility in this state where abortions are performed
must submit to the department of health services on a form prescribed by the
department a report of each abortion performed in the hospital or facility.
The report shall not identify the individual patient by name but must include
the following information:

1. The name and address of the facility where the abortion was
performed.

2. The type of facility where the abortion was performed.

3. The county where the abortion was performed.

4. WHETHER THE HOSPITAL OR FACILITY PROVIDES HEALTH CARE SERVICES TO
PERSONS WHO ARE ENROLLED MEMBERS PURSUANT TO CHAPTER 29 OF THIS TITLE.

~~4.~~ 5. The woman's age.

~~5.~~ 6. The woman's educational background by highest grade completed
and, if applicable, level of college completed.

~~6.~~ 7. The county and state in which the woman resides.

~~7.~~ 8. The woman's race and ethnicity.

~~8.~~ 9. The woman's marital status.

~~9.~~ 10. The number of prior pregnancies and prior abortions of the
woman.

~~10.~~ 11. The number of previous spontaneous terminations of pregnancy
of the woman.

~~11.~~ 12. The gestational age of the unborn child at the time of the
abortion.

~~12.~~ 13. The reason for the abortion, including whether the abortion is
elective or due to maternal or fetal health considerations.

~~13.~~ 14. The type of procedure performed or prescribed and the date of
the abortion.

1 ~~14.~~ 15. Any preexisting medical conditions of the woman that would
2 complicate pregnancy and any known medical complication that resulted from
3 the abortion.

4 ~~15.~~ 16. The basis for any medical judgment that a medical emergency
5 existed that excused the physician from compliance with the requirements of
6 this chapter.

7 ~~16.~~ 17. The physician's statement if required pursuant to section
8 36-2301.01.

9 ~~17.~~ 18. If applicable, the weight of the aborted fetus for any
10 abortion performed pursuant to section 36-2301.01.

11 B. The report must be signed by the physician who performed the
12 abortion or, if a health professional other than a physician is authorized by
13 law to prescribe or administer abortion medication, the signature and title
14 of the person who prescribed or administered the abortion medication. The
15 form may be signed electronically and shall indicate that the person who
16 signs the report is attesting that the information in the report is correct
17 to the best of the person's knowledge. The hospital or facility must
18 transmit the report to the department within fifteen days after the last day
19 of each reporting month.

20 C. Any report filed pursuant to this section shall be filed
21 electronically at an internet website that is designated by the department
22 unless the person required to file the report applies for a waiver from
23 electronic reporting by submitting a written request to the department.

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

26 36-2903.01. Additional powers and duties; report

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

33 B. The director shall:

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

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

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

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

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

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

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

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

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

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

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

34 (h) Recoup from the department all federal fiscal sanctions that
35 result from the department's inaccurate eligibility determinations. The

1 director may offset all or part of a sanction if the department submits a
2 corrective action plan and a strategy to remedy the error.

3 4. By rule establish a procedure and time frames for the intake of
4 grievances and requests for hearings, for the continuation of benefits and
5 services during the appeal process and for a grievance process at the
6 contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and
7 41-1092.05, the administration shall develop rules to establish the procedure
8 and time frame for the informal resolution of grievances and appeals. A
9 grievance that is not related to a claim for payment of system covered
10 services shall be filed in writing with and received by the administration or
11 the prepaid capitated provider or program contractor not later than sixty
12 days after the date of the adverse action, decision or policy implementation
13 being grieved. A grievance that is related to a claim for payment of system
14 covered services must be filed in writing and received by the administration
15 or the prepaid capitated provider or program contractor within twelve months
16 after the date of service, within twelve months after the date that
17 eligibility is posted or within sixty days after the date of the denial of a
18 timely claim submission, whichever is later. A grievance for the denial of a
19 claim for reimbursement of services may contest the validity of any adverse
20 action, decision, policy implementation or rule that related to or resulted
21 in the full or partial denial of the claim. A policy implementation may be
22 subject to a grievance procedure, but it may not be appealed for a hearing.
23 The administration is not required to participate in a mandatory settlement
24 conference if it is not a real party in interest. In any proceeding before
25 the administration, including a grievance or hearing, persons may represent
26 themselves or be represented by a duly authorized agent who is not charging a
27 fee. A legal entity may be represented by an officer, partner or employee
28 who is specifically authorized by the legal entity to represent it in the
29 particular proceeding.

30 5. Apply for and accept federal funds available under title XIX of the
31 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section
32 1396 (1980)) in support of the system. The application made by the director
33 pursuant to this paragraph shall be designed to qualify for federal funding
34 primarily on a prepaid capitated basis. Such funds may be used only for the
35 support of persons defined as eligible pursuant to title XIX of the social
36 security act or the approved section 1115 waiver.

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

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

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

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

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

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

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

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

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

5 4. Notwithstanding any other law, require persons eligible pursuant to
6 section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section
7 36-2981, paragraph 6 to be financially responsible for any cost sharing
8 requirements established in a state plan or a section 1115 waiver and
9 approved by the centers for medicare and medicaid services. Cost sharing
10 requirements may include copayments, coinsurance, deductibles, enrollment
11 fees and monthly premiums for enrolled members, including households with
12 children enrolled in the Arizona long-term care system.

13 E. The director shall adopt rules that further specify the medical
14 care and hospital services that are covered by the system pursuant to section
15 36-2907.

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

21 G. For inpatient hospital admissions and outpatient hospital services
22 on and after March 1, 1993, the administration shall adopt rules for the
23 reimbursement of hospitals according to the following procedures:

24 1. For inpatient hospital stays from March 1, 1993 through September
25 30, 2013, the administration shall use a prospective tiered per diem
26 methodology, using hospital peer groups if analysis shows that cost
27 differences can be attributed to independently definable features that
28 hospitals within a peer group share. In peer grouping the administration may
29 consider such factors as length of stay differences and labor market
30 variations. If there are no cost differences, the administration shall
31 implement a stop loss-stop gain or similar mechanism. Any stop loss-stop
32 gain or similar mechanism shall ensure that the tiered per diem rates
33 assigned to a hospital do not represent less than ninety per cent of its 1990
34 base year costs or more than one hundred ten per cent of its 1990 base year
35 costs, adjusted by an audit factor, during the period of March 1, 1993
36 through September 30, 1994. The tiered per diem rates set for hospitals

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

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

24 3. Through June 30, 2004, for outpatient hospital services, the
25 administration shall reimburse a hospital by applying a hospital specific
26 outpatient cost-to-charge ratio to the covered charges. Beginning on July 1,
27 2004 through June 30, 2005, the administration shall reimburse a hospital by
28 applying a hospital specific outpatient cost-to-charge ratio to covered
29 charges. If the hospital increases its charges for outpatient services filed
30 with the Arizona department of health services pursuant to chapter 4, article
31 3 of this title, by more than 4.7 per cent for dates of service effective on
32 or after July 1, 2004, the hospital specific cost-to-charge ratio will be
33 reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7
34 per cent, the effective date of the increased charges will be the effective
35 date of the adjusted Arizona health care cost containment system
36 cost-to-charge ratio. The administration shall develop the methodology for a

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

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

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

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

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

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

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

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

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

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

28 8. The prospective tiered per diem payment methodology for inpatient
29 hospital services shall include a mechanism for the prospective payment of
30 inpatient hospital capital related costs. The capital payment shall include
31 hospital specific and statewide average amounts. For tiered per diem rates
32 beginning on October 1, 1999, the capital related cost component is frozen at
33 the blended rate of forty per cent of the hospital specific capital cost and
34 sixty per cent of the statewide average capital cost in effect as of
35 January 1, 1999 and as further adjusted by the calculation of tier rates for
36 maternity and nursery as prescribed by law. Through September 30, 2011, the

1 administration shall adjust the capital related cost component by the data
2 resources incorporated market basket index for prospective payment system
3 hospitals.

4 9. For graduate medical education programs:

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

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

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

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

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

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

14 (ii) For a portion of additional indirect graduate medical education
15 costs for programs that are located in a county with a population of less
16 than five hundred thousand persons at the time the residency position was
17 created or for a residency position that includes a rotation in a county with
18 a population of less than five hundred thousand persons at the time the
19 residency position was established. These programs must be approved by the
20 administration.

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

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

32 (f) Local, county and tribal governments and any university under the
33 jurisdiction of the Arizona board of regents may provide monies in addition
34 to any state general fund monies appropriated for graduate medical education
35 in order to qualify for additional matching federal monies for providers,
36 programs or positions in a specific locality and costs incurred pursuant to a

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

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

21 10. Notwithstanding section 41-1005, subsection A, paragraph 9, the
22 administration shall adopt rules pursuant to title 41, chapter 6 establishing
23 the methodology for determining the prospective tiered per diem payments that
24 are in effect through September 30, 2013.

25 11. For inpatient hospital services rendered on or after October 1,
26 2011, the prospective tiered per diem payment rates are permanently reset to
27 the amounts payable for those services as of September 30, 2011 pursuant to
28 this subsection.

29 12. The administration shall obtain legislative approval before
30 adopting a hospital reimbursement methodology consistent with title XIX of
31 the social security act for inpatient dates of service on and after October
32 1, 2013.

33 H. The director may adopt rules that specify enrollment procedures,
34 including notice to contractors of enrollment. The rules may provide for
35 varying time limits for enrollment in different situations. The
36 administration shall specify in contract when a person who has been

1 determined eligible will be enrolled with that contractor and the date on
2 which the contractor will be financially responsible for health and medical
3 services to the person.

4 I. The administration may make direct payments to hospitals for
5 hospitalization and medical care provided to a member in accordance with this
6 article and rules. The director may adopt rules to establish the procedures
7 by which the administration shall pay hospitals pursuant to this subsection
8 if a contractor fails to make timely payment to a hospital. Such payment
9 shall be at a level determined pursuant to section 36-2904, subsection H
10 or I. The director may withhold payment due to a contractor in the amount of
11 any payment made directly to a hospital by the administration on behalf of a
12 contractor pursuant to this subsection.

13 J. The director shall establish a special unit within the
14 administration for the purpose of monitoring the third-party payment
15 collections required by contractors and noncontracting providers pursuant to
16 section 36-2903, subsection B, paragraph 10 and subsection F and section
17 36-2915, subsection E. The director shall determine by rule:

18 1. The type of third-party payments to be monitored pursuant to this
19 subsection.

20 2. The percentage of third-party payments that is collected by a
21 contractor or noncontracting provider and that the contractor or
22 noncontracting provider may keep and the percentage of such payments that the
23 contractor or noncontracting provider may be required to pay to the
24 administration. Contractors and noncontracting providers must pay to the
25 administration one hundred per cent of all third-party payments that are
26 collected and that duplicate administration fee-for-service payments. A
27 contractor that contracts with the administration pursuant to section
28 36-2904, subsection A may be entitled to retain a percentage of third-party
29 payments if the payments collected and retained by a contractor are reflected
30 in reduced capitation rates. A contractor may be required to pay the
31 administration a percentage of third-party payments that are collected by a
32 contractor and that are not reflected in reduced capitation rates.

33 K. The administration shall establish procedures to apply to the
34 following if a provider that has a contract with a contractor or
35 noncontracting provider seeks to collect from an individual or financially

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

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

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

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

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

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

23 3. If the administration determines that a provider that has a
24 contract with a contractor or noncontracting provider has billed a member for
25 charges that were paid or should have been paid by the administration, the
26 administration shall send written notification by certified mail or other
27 service with proof of delivery to the provider that has a contract with a
28 contractor or noncontracting provider stating that this billing is in
29 violation of federal and state law. If, twenty-one days or more after
30 receiving the notification, a provider that has a contract with a contractor
31 or noncontracting provider knowingly continues billing a member for charges
32 that were paid or should have been paid by the system, the administration may
33 assess a civil penalty in an amount equal to three times the amount of the
34 billing and reduce payment to the provider that has a contract with a
35 contractor or noncontracting provider accordingly. Receipt of delivery
36 signed by the addressee or the addressee's employee is prima facie evidence

1 of knowledge. Civil penalties collected pursuant to this subsection shall be
2 deposited in the state general fund. Section 36-2918, subsections C, D and
3 F, relating to the imposition, collection and enforcement of civil penalties,
4 apply to civil penalties imposed pursuant to this paragraph.

5 L. The administration may conduct postpayment review of all claims
6 paid by the administration and may recoup any monies erroneously paid. The
7 director may adopt rules that specify procedures for conducting postpayment
8 review. A contractor may conduct a postpayment review of all claims paid by
9 the contractor and may recoup monies that are erroneously paid.

10 M. Subject to title 41, chapter 4, article 4, the director or the
11 director's designee may employ and supervise personnel necessary to assist
12 the director in performing the functions of the administration.

13 N. The administration may contract with contractors for obstetrical
14 care who are eligible to provide services under title XIX of the social
15 security act.

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

1 private hospitals and state operated institutions for mental disease
2 qualifying for disproportionate share payments. For the purposes of this
3 subsection, "disproportionate share payment" means a payment to a hospital
4 that serves a disproportionate share of low-income patients as described by
5 42 United States Code section 1396r-4.

6 P. Notwithstanding any law to the contrary, the administration may
7 receive confidential adoption information to determine whether an adopted
8 child should be terminated from the system.

9 Q. The adoption agency or the adoption attorney shall notify the
10 administration within thirty days after an eligible person receiving services
11 has placed that person's child for adoption.

12 R. If the administration implements an electronic claims submission
13 system, it may adopt procedures pursuant to subsection G of this section
14 requiring documentation different than prescribed under subsection G,
15 paragraph 4 of this section.

16 S. In addition to any requirements adopted pursuant to subsection D,
17 paragraph 4 of this section, notwithstanding any other law, subject to
18 approval by the centers for medicare and medicaid services, beginning July 1,
19 2011, members eligible pursuant to section 36-2901, paragraph 6, subdivision
20 (a), section 36-2931 and section 36-2981, paragraph 6 shall pay the
21 following:

22 1. A monthly premium of fifteen dollars, except that the total monthly
23 premium for an entire household shall not exceed sixty dollars.

24 2. A copayment of five dollars for each physician office visit.

25 3. A copayment of ten dollars for each urgent care visit.

26 4. A copayment of thirty dollars for each emergency department visit.

27 T. THE ADMINISTRATION SHALL REQUIRE THAT ALL CONTRACTORS AND
28 NONCONTRACTING PROVIDERS NOT PERFORM NONFEDERALLY QUALIFIED ABORTIONS ON
29 CURRENTLY ENROLLED MEMBERS TO WHOM THEY PROVIDE OTHER SERVICES COVERED UNDER
30 THIS CHAPTER. THIS REQUIREMENT DOES NOT APPLY TO CONTRACTORS AND
31 NONCONTRACTING PROVIDERS THAT ONLY PERFORM ABORTIONS TO CURRENTLY ENROLLED
32 MEMBERS THROUGH AN AFFILIATED ENTITY THAT IS SEPARATE FROM THE ENTITY THAT
33 PROVIDES SERVICES PURSUANT TO THIS CHAPTER. FOR THE PURPOSES OF THIS
34 SUBSECTION, "NONFEDERALLY QUALIFIED ABORTION" MEANS AN ABORTION THAT DOES NOT
35 MEET THE REQUIREMENTS FOR FEDERAL REIMBURSEMENT UNDER TITLE XIX OF THE SOCIAL
36 SECURITY ACT.

1 Sec. 4. Title 36, chapter 29, article 1, Arizona Revised Statutes, is
2 amended by adding section 36-2903.08, to read:

3 36-2903.08. Abortions; public funding; prohibition; definition

4 A. EXCEPT AS REQUIRED BY FEDERAL LAW OR STATE LAW, MONIES EXPENDED
5 PURSUANT TO THIS CHAPTER SHALL NOT BE USED TO PERFORM, ASSIST WITH OR
6 ENCOURAGE AN ABORTION, TO DIRECTLY OR INDIRECTLY SUBSIDIZE ABORTION SERVICES
7 OR ADMINISTRATIVE EXPENSES RELATING TO ABORTIONS OR TO REFER FOR ABORTIONS.

8 B. SUBJECT TO THE AVAILABILITY OF MONIES, THE ADMINISTRATION SHALL
9 CONDUCT FINANCIAL AUDITS AS NECESSARY TO ENSURE COMPLIANCE WITH THIS SECTION.

10 C. NOTWITHSTANDING SUBSECTION A OF THIS SECTION, NONDIRECTIVE
11 COUNSELING RELATING TO PREGNANCY MAY BE PROVIDED.

12 D. THIS SECTION DOES NOT REQUIRE AN AGENCY RECEIVING FEDERAL MONIES
13 PURSUANT TO TITLE X OF THE PUBLIC HEALTH SERVICE ACT (42 UNITED STATES CODE
14 SECTIONS 300 THROUGH 300a-8) TO REFRAIN FROM PERFORMING ANY SERVICE REQUIRED
15 PURSUANT TO TITLE X, REGULATIONS ADOPTED PURSUANT TO TITLE X OR THE TITLE X
16 PROGRAM GUIDELINES FOR PROJECT GRANTS FOR FAMILY PLANNING SERVICES AS
17 PUBLISHED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES IN
18 ORDER TO REMAIN ELIGIBLE TO RECEIVE TITLE X MONIES.

19 E. FOR THE PURPOSES OF THIS SECTION, "ADMINISTRATIVE EXPENSES"
20 INCLUDES RENT, EMPLOYEE SALARIES, UTILITIES AND SIMILAR OVERHEAD COSTS.

21 Sec. 5. Legislative findings

22 A. Concerning section 36-449.02, Arizona Revised Statutes, as amended
23 by this act, the legislature finds that abortion clinics are closely
24 regulated health care entities. The legislature further finds that the
25 authority of the director of the department of health services to inspect
26 abortion clinics is essential for maintaining adequate health and safety
27 standards. The same public health considerations that apply to the
28 inspection of other health care institutions pursuant to section 36-424,
29 Arizona Revised Statutes, supported by a determination of reasonable cause,
30 also apply to abortion clinics.

31 B. Concerning section 36-2903.01, Arizona Revised Statutes, as amended
32 by this act, the legislature finds that this state has a significant interest
33 in ensuring that public monies are not used to facilitate a relationship with
34 a contractor or noncontracting provider that results in the provision of an
35 abortion procedure by the contractor or noncontracting provider that is not
36 otherwise covered under title 36, chapter 29, Arizona Revised Statutes. This

1 state interest is advanced by limiting the provision of such abortion
2 procedures to entities that are separate from any entity that provides
3 services under title 36, chapter 29, Arizona Revised Statutes. Rust v.
4 Sullivan, 500 U.S. 173 (1991); Planned Parenthood of Houston & Se. Tex. v.
5 Sanchez, 403 F.3d 324 (5th Cir. 2005); Planned Parenthood of Mid-Missouri &
6 E. Kansas, Inc. v. Dempsey, 167 F.3d 458 (8th Cir. 1999).

7 Sec. 6. Severability

8 If a provision of this act or its application to any person or
9 circumstance is held invalid, the invalidity does not affect other provisions
10 or applications of the act that can be given effect without the invalid
11 provision or application, and to this end the provisions of this act are
12 severable.

13 Sec. 7. Exemption from rule making

14 For the purposes of implementing the provisions of this act, the
15 department of health services is exempt from the rule making requirements of
16 title 41, chapter 6, Arizona Revised Statutes, for one year after the
17 effective date of this act."

18 Amend title to conform

and, as so amended, it do pass

JOHN KAVANAGH
Chairman

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