

REFERENCE TITLE: AHCCCS; hospital reimbursement methodology

State of Arizona
House of Representatives
Fifty-first Legislature
First Regular Session
2013

HB 2045

Introduced by
Representative Carter

AN ACT

AMENDING SECTION 36-2903.01, 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 36-2903.01, Arizona Revised Statutes, is amended to
3 read:

4 36-2903.01. Additional powers and duties; report

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

11 B. The director shall:

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

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

25 3. Enter into an intergovernmental agreement with the department to:
26 (a) Establish an expedited eligibility and enrollment process for all
27 persons who are hospitalized at the time of application.

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

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

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

34 (e) Require the department to adopt rules, consistent with the rules
35 adopted by the administration for a hearing process, that applicants or
36 members may use for appeals of eligibility determinations or
37 redeterminations.

38 (f) Establish the department's responsibility to place sufficient
39 eligibility workers at federally qualified health centers to screen for
40 eligibility and at hospital sites and level one trauma centers to ensure that
41 persons seeking hospital services are screened on a timely basis for
42 eligibility for the system, including a process to ensure that applications
43 for the system can be accepted on a twenty-four hour basis, seven days a
44 week.

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

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

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

35 5. Apply for and accept federal funds available under title XIX of the
36 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section
37 1396 (1980)) in support of the system. The application made by the director
38 pursuant to this paragraph shall be designed to qualify for federal funding
39 primarily on a prepaid capitated basis. Such funds may be used only for the
40 support of persons defined as eligible pursuant to title XIX of the social
41 security act or the approved section 1115 waiver.

42 6. At least thirty days before the implementation of a policy or a
43 change to an existing policy relating to reimbursement, provide notice to
44 interested parties. Parties interested in receiving notification of policy

1 changes shall submit a written request for notification to the
2 administration.

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

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

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

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

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

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

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

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

37 4. Notwithstanding any other law, require persons eligible pursuant to
38 section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section
39 36-2981, paragraph 6 to be financially responsible for any cost sharing
40 requirements established in a state plan or a section 1115 waiver and
41 approved by the centers for medicare and medicaid services. Cost sharing
42 requirements may include copayments, coinsurance, deductibles, enrollment
43 fees and monthly premiums for enrolled members, including households with
44 children enrolled in the Arizona long-term care system.

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

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

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

12 1. For inpatient hospital stays from March 1, 1993 through September
13 30, ~~2013~~ 2014, the administration shall use a prospective tiered per diem
14 methodology, using hospital peer groups if analysis shows that cost
15 differences can be attributed to independently definable features that
16 hospitals within a peer group share. In peer grouping the administration may
17 consider such factors as length of stay differences and labor market
18 variations. If there are no cost differences, the administration shall
19 implement a stop loss-stop gain or similar mechanism. Any stop loss-stop
20 gain or similar mechanism shall ensure that the tiered per diem rates
21 assigned to a hospital do not represent less than ninety per cent of its 1990
22 base year costs or more than one hundred ten per cent of its 1990 base year
23 costs, adjusted by an audit factor, during the period of March 1, 1993
24 through September 30, 1994. The tiered per diem rates set for hospitals
25 shall represent no less than eighty-seven and one-half per cent or more than
26 one hundred twelve and one-half per cent of its 1990 base year costs,
27 adjusted by an audit factor, from October 1, 1994 through September 30, 1995
28 and no less than eighty-five per cent or more than one hundred fifteen per
29 cent of its 1990 base year costs, adjusted by an audit factor, from October
30 1, 1995 through September 30, 1996. For the periods after September 30, 1996
31 no stop loss-stop gain or similar mechanisms shall be in effect. An
32 adjustment in the stop loss-stop gain percentage may be made to ensure that
33 total payments do not increase as a result of this provision. If peer groups
34 are used, the administration shall establish initial peer group designations
35 for each hospital before implementation of the per diem system. The
36 administration may also use a negotiated rate methodology. The tiered per
37 diem methodology may include separate consideration for specialty hospitals
38 that limit their provision of services to specific patient populations, such
39 as rehabilitative patients or children. The initial per diem rates shall be
40 based on hospital claims and encounter data for dates of service November 1,
41 1990 through October 31, 1991 and processed through May of 1992. **THE**
42 **ADMINISTRATION MAY ALSO ESTABLISH A SEPARATE REIMBURSEMENT METHODOLOGY FOR**
43 **CLAIMS WITH EXTRAORDINARILY HIGH COSTS PER DAY THAT EXCEED THRESHOLDS**
44 **ESTABLISHED BY THE ADMINISTRATION.**

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

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

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

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

43 Payment received by a hospital from the administration pursuant to this
 44 subsection or from a contractor either by contract or pursuant to section
 45 36-2904, subsection I is considered payment by the administration or the

1 contractor of the administration's or contractor's liability for the hospital
2 bill. A hospital may collect any unpaid portion of its bill from other
3 third-party payors or in situations covered by title 33, chapter 7,
4 article 3.

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

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

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

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

19 6. In developing the reimbursement methodology, if a review of the
20 reports filed by a hospital pursuant to section 36-125.04 indicates that
21 further investigation is considered necessary to verify the accuracy of the
22 information in the reports, the administration may examine the hospital's
23 records and accounts related to the reporting requirements of section
24 36-125.04. The administration shall bear the cost incurred in connection
25 with this examination unless the administration finds that the records
26 examined are significantly deficient or incorrect, in which case the
27 administration may charge the cost of the investigation to the hospital
28 examined.

29 7. Except for privileged medical information, the administration shall
30 make available for public inspection the cost and charge data and the
31 calculations used by the administration to determine payments under the
32 tiered per diem system, provided that individual hospitals are not identified
33 by name. The administration shall make the data and calculations available
34 for public inspection during regular business hours and shall provide copies
35 of the data and calculations to individuals requesting such copies within
36 thirty days of receipt of a written request. The administration may charge a
37 reasonable fee for the provision of the data or information.

38 8. The prospective tiered per diem payment methodology for inpatient
39 hospital services shall include a mechanism for the prospective payment of
40 inpatient hospital capital related costs. The capital payment shall include
41 hospital specific and statewide average amounts. For tiered per diem rates
42 beginning on October 1, 1999, the capital related cost component is frozen at
43 the blended rate of forty per cent of the hospital specific capital cost and
44 sixty per cent of the statewide average capital cost in effect as of
45 January 1, 1999 and as further adjusted by the calculation of tier rates for

1 maternity and nursery as prescribed by law. Through September 30, 2011, the
2 administration shall adjust the capital related cost component by the data
3 resources incorporated market basket index for prospective payment system
4 hospitals.

5 9. For graduate medical education programs:

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

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

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

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

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

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

7 (ii) For a portion of additional indirect graduate medical education
8 costs for programs that are located in a county with a population of less
9 than five hundred thousand persons at the time the residency position was
10 created or for a residency position that includes a rotation in a county with
11 a population of less than five hundred thousand persons at the time the
12 residency position was established. These programs must be approved by the
13 administration.

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

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

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

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

5 10. Notwithstanding section 41-1005, subsection A, paragraph 9, the
6 administration shall adopt rules pursuant to title 41, chapter 6 establishing
7 the methodology for determining the prospective tiered per diem payments that
8 are in effect through September 30, ~~2013~~ 2014.

9 11. For inpatient hospital services rendered on or after October 1,
10 2011, the prospective tiered per diem payment rates are permanently reset to
11 the amounts payable for those services as of ~~September 30~~ OCTOBER 1, 2011
12 pursuant to this subsection.

13 12. The administration shall ~~obtain legislative approval before~~
14 ~~adopting~~ ADOPT a hospital reimbursement methodology consistent with title XIX
15 of the social security act for inpatient dates of service on and after
16 October 1, ~~2013~~ 2014. THE ADMINISTRATION MAY MAKE ADDITIONAL ADJUSTMENTS TO
17 THE INPATIENT HOSPITAL RATES ESTABLISHED PURSUANT TO THIS SECTION FOR
18 HOSPITALS THAT ARE PUBLICLY OPERATED OR BASED ON OTHER FACTORS, INCLUDING THE
19 NUMBER OF BEDS IN THE HOSPITAL, THE SPECIALTY SERVICES AVAILABLE TO PATIENTS
20 AND THE GEOGRAPHIC LOCATION OF THE HOSPITAL. THE ADMINISTRATION MAY ALSO
21 PROVIDE ADDITIONAL REIMBURSEMENT FOR EXTRAORDINARILY HIGH COST CASES THAT
22 EXCEED A THRESHOLD ABOVE THE STANDARD PAYMENT.

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

30 I. The administration may make direct payments to hospitals for
31 hospitalization and medical care provided to a member in accordance with this
32 article and rules. The director may adopt rules to establish the procedures
33 by which the administration shall pay hospitals pursuant to this subsection
34 if a contractor fails to make timely payment to a hospital. Such payment
35 shall be at a level determined pursuant to section 36-2904, subsection H
36 or I. The director may withhold payment due to a contractor in the amount of
37 any payment made directly to a hospital by the administration on behalf of a
38 contractor pursuant to this subsection.

39 J. The director shall establish a special unit within the
40 administration for the purpose of monitoring the third-party payment
41 collections required by contractors and noncontracting providers pursuant to
42 section 36-2903, subsection B, paragraph 10 and subsection F and section
43 36-2915, subsection E. The director shall determine by rule:

44 1. The type of third-party payments to be monitored pursuant to this
45 subsection.

1 2. The percentage of third-party payments that is collected by a
2 contractor or noncontracting provider and that the contractor or
3 noncontracting provider may keep and the percentage of such payments that the
4 contractor or noncontracting provider may be required to pay to the
5 administration. Contractors and noncontracting providers must pay to the
6 administration one hundred per cent of all third-party payments that are
7 collected and that duplicate administration fee-for-service payments. A
8 contractor that contracts with the administration pursuant to section
9 36-2904, subsection A may be entitled to retain a percentage of third-party
10 payments if the payments collected and retained by a contractor are reflected
11 in reduced capitation rates. A contractor may be required to pay the
12 administration a percentage of third-party payments that are collected by a
13 contractor and that are not reflected in reduced capitation rates.

14 K. The administration shall establish procedures to apply to the
15 following if a provider that has a contract with a contractor or
16 noncontracting provider seeks to collect from an individual or financially
17 responsible relative or representative a claim that exceeds the amount that
18 is reimbursed or should be reimbursed by the system:

19 1. On written notice from the administration or oral or written notice
20 from a member that a claim for covered services may be in violation of this
21 section, the provider that has a contract with a contractor or noncontracting
22 provider shall investigate the inquiry and verify whether the person was
23 eligible for services at the time that covered services were provided. If
24 the claim was paid or should have been paid by the system, the provider that
25 has a contract with a contractor or noncontracting provider shall not
26 continue billing the member.

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

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

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

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

39 3. If the administration determines that a provider that has a
40 contract with a contractor or noncontracting provider has billed a member for
41 charges that were paid or should have been paid by the administration, the
42 administration shall send written notification by certified mail or other
43 service with proof of delivery to the provider that has a contract with a
44 contractor or noncontracting provider stating that this billing is in
45 violation of federal and state law. If, twenty-one days or more after

1 receiving the notification, a provider that has a contract with a contractor
 2 or noncontracting provider knowingly continues billing a member for charges
 3 that were paid or should have been paid by the system, the administration may
 4 assess a civil penalty in an amount equal to three times the amount of the
 5 billing and reduce payment to the provider that has a contract with a
 6 contractor or noncontracting provider accordingly. Receipt of delivery
 7 signed by the addressee or the addressee's employee is prima facie evidence
 8 of knowledge. Civil penalties collected pursuant to this subsection shall be
 9 deposited in the state general fund. Section 36-2918, subsections C, D and
 10 F, relating to the imposition, collection and enforcement of civil penalties,
 11 apply to civil penalties imposed pursuant to this paragraph.

12 L. The administration may conduct postpayment review of all claims
 13 paid by the administration and may recoup any monies erroneously paid. The
 14 director may adopt rules that specify procedures for conducting postpayment
 15 review. A contractor may conduct a postpayment review of all claims paid by
 16 the contractor and may recoup monies that are erroneously paid.

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

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

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

1 subsection, "disproportionate share payment" means a payment to a hospital
2 that serves a disproportionate share of low-income patients as described by
3 42 United States Code section 1396r-4.

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

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

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

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

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

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

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

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

25 Sec. 2. Reimbursement methodology; budget neutrality

26 It is the intent of the legislature that the reimbursement methodology
27 developed by the Arizona health care cost containment system administration
28 pursuant to this act be budget neutral in the aggregate. The administration
29 may consider the unique financial characteristics of particular hospitals,
30 including low patient volume of rural hospitals, when developing the payment
31 methodology.