

REFERENCE TITLE: 2013-2014; health; welfare; budget reconciliation

State of Arizona
Senate
Fifty-first Legislature
First Regular Session
2013

SB 1492

Introduced by
Senators McComish, Driggs, Shooter (with permission of Committee on Rules)

AN ACT

AMENDING SECTIONS 36-2903.01 AND 36-2907, ARIZONA REVISED STATUTES; AMENDING LAWS 2011, CHAPTER 234, SECTION 2; MAKING APPROPRIATIONS AND TRANSFERS; RELATING TO HEALTH AND WELFARE BUDGET RECONCILIATION.

(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, 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.

42 2. For rates effective on October 1, 1994, and annually through
43 September 30, 2011, the administration shall adjust tiered per diem payments
44 for inpatient hospital care by the data resources incorporated market basket
45 index for prospective payment system hospitals. For rates effective

1 beginning on October 1, 1999, the administration shall adjust payments to
2 reflect changes in length of stay for the maternity and nursery tiers.

3 3. Through June 30, 2004, for outpatient hospital services, the
4 administration shall reimburse a hospital by applying a hospital specific
5 outpatient cost-to-charge ratio to the covered charges. Beginning on July 1,
6 2004 through June 30, 2005, the administration shall reimburse a hospital by
7 applying a hospital specific outpatient cost-to-charge ratio to covered
8 charges. If the hospital increases its charges for outpatient services filed
9 with the Arizona department of health services pursuant to chapter 4, article
10 3 of this title, by more than 4.7 per cent for dates of service effective on
11 or after July 1, 2004, the hospital specific cost-to-charge ratio will be
12 reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7
13 per cent, the effective date of the increased charges will be the effective
14 date of the adjusted Arizona health care cost containment system
15 cost-to-charge ratio. The administration shall develop the methodology for a
16 capped fee-for-service schedule and a statewide cost-to-charge ratio. Any
17 covered outpatient service not included in the capped fee-for-service
18 schedule shall be reimbursed by applying the statewide cost-to-charge ratio
19 that is based on the services not included in the capped fee-for-service
20 schedule. Beginning on July 1, 2005, the administration shall reimburse
21 clean claims with dates of service on or after July 1, 2005, based on the
22 capped fee-for-service schedule or the statewide cost-to-charge ratio
23 established pursuant to this paragraph. The administration may make
24 additional adjustments to the outpatient hospital rates established pursuant
25 to this section based on other factors, including the number of beds in the
26 hospital, specialty services available to patients and the geographic
27 location of the hospital.

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

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

39 Payment received by a hospital from the administration pursuant to this
40 subsection or from a contractor either by contract or pursuant to section
41 36-2904, subsection I is considered payment by the administration or the
42 contractor of the administration's or contractor's liability for the hospital
43 bill. A hospital may collect any unpaid portion of its bill from other
44 third-party payors or in situations covered by title 33, chapter 7,
45 article 3.

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

4 (a) If the hospital's bill is paid within thirty days of the date the
5 bill was received, the administration shall pay ninety-nine per cent of the
6 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 administration shall pay one
9 hundred 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 administration shall pay one hundred per cent
12 of the rate plus a fee of one per cent per month for each month or portion of
13 a month following the sixtieth day of receipt of the bill until the date of
14 payment.

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

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

34 8. The prospective tiered per diem payment methodology for inpatient
35 hospital services shall include a mechanism for the prospective payment of
36 inpatient hospital capital related costs. The capital payment shall include
37 hospital specific and statewide average amounts. For tiered per diem rates
38 beginning on October 1, 1999, the capital related cost component is frozen at
39 the blended rate of forty per cent of the hospital specific capital cost and
40 sixty per cent of the statewide average capital cost in effect as of
41 January 1, 1999 and as further adjusted by the calculation of tier rates for
42 maternity and nursery as prescribed by law. Through September 30, 2011, the
43 administration shall adjust the capital related cost component by the data
44 resources incorporated market basket index for prospective payment system
45 hospitals.

1 9. For graduate medical education programs:

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

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

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

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

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

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

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

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

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

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

43 (g) Any funds appropriated but not allocated by the administration for
44 subdivision (b) or (c) of this paragraph may be reallocated if funding for

1 either subdivision is insufficient to cover appropriate graduate medical
2 education costs.

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

7 11. For inpatient hospital services rendered on or after October 1,
8 2011, the prospective tiered per diem payment rates are permanently reset to
9 the amounts payable for those services as of ~~September 30~~ OCTOBER 1, 2011
10 pursuant to this subsection.

11 12. The administration shall obtain legislative approval before
12 adopting a hospital reimbursement methodology consistent with title XIX of
13 the social security act for inpatient dates of service on and after October
14 1, 2013.

15 H. The director may adopt rules that specify enrollment procedures,
16 including notice to contractors of enrollment. The rules may provide for
17 varying time limits for enrollment in different situations. The
18 administration shall specify in contract when a person who has been
19 determined eligible will be enrolled with that contractor and the date on
20 which the contractor will be financially responsible for health and medical
21 services to the person.

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

31 J. The director shall establish a special unit within the
32 administration for the purpose of monitoring the third-party payment
33 collections required by contractors and noncontracting providers pursuant to
34 section 36-2903, subsection B, paragraph 10 and subsection F and section
35 36-2915, subsection E. The director shall determine by rule:

36 1. The type of third-party payments to be monitored pursuant to this
37 subsection.

38 2. The percentage of third-party payments that is collected by a
39 contractor or noncontracting provider and that the contractor or
40 noncontracting provider may keep and the percentage of such payments that the
41 contractor or noncontracting provider may be required to pay to the
42 administration. Contractors and noncontracting providers must pay to the
43 administration one hundred per cent of all third-party payments that are
44 collected and that duplicate administration fee-for-service payments. A
45 contractor that contracts with the administration pursuant to section

1 36-2904, subsection A may be entitled to retain a percentage of third-party
2 payments if the payments collected and retained by a contractor are reflected
3 in reduced capitation rates. A contractor may be required to pay the
4 administration a percentage of third-party payments that are collected by a
5 contractor and that are not reflected in reduced capitation rates.

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

11 1. On written notice from the administration or oral or written notice
12 from a member that a claim for covered services may be in violation of this
13 section, the provider that has a contract with a contractor or noncontracting
14 provider shall investigate the inquiry and verify whether the person was
15 eligible for services at the time that covered services were provided. If
16 the claim was paid or should have been paid by the system, the provider that
17 has a contract with a contractor or noncontracting provider shall not
18 continue billing the member.

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

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

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

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

31 3. If the administration determines that a provider that has a
32 contract with a contractor or noncontracting provider has billed a member for
33 charges that were paid or should have been paid by the administration, the
34 administration shall send written notification by certified mail or other
35 service with proof of delivery to the provider that has a contract with a
36 contractor or noncontracting provider stating that this billing is in
37 violation of federal and state law. If, twenty-one days or more after
38 receiving the notification, a provider that has a contract with a contractor
39 or noncontracting provider knowingly continues billing a member for charges
40 that were paid or should have been paid by the system, the administration may
41 assess a civil penalty in an amount equal to three times the amount of the
42 billing and reduce payment to the provider that has a contract with a
43 contractor or noncontracting provider accordingly. Receipt of delivery
44 signed by the addressee or the addressee's employee is prima facie evidence
45 of knowledge. Civil penalties collected pursuant to this subsection shall be

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

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

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

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

15 O. Notwithstanding any other law, on federal approval the
16 administration may make disproportionate share payments to private hospitals,
17 county operated hospitals, including hospitals owned or leased by a special
18 health care district, and state operated institutions for mental disease
19 beginning October 1, 1991 in accordance with federal law and subject to
20 legislative appropriation. If at any time the administration receives
21 written notification from federal authorities of any change or difference in
22 the actual or estimated amount of federal funds available for
23 disproportionate share payments from the amount reflected in the legislative
24 appropriation for such purposes, the administration shall provide written
25 notification of such change or difference to the president and the minority
26 leader of the senate, the speaker and the minority leader of the house of
27 representatives, the director of the joint legislative budget committee, the
28 legislative committee of reference and any hospital trade association within
29 this state, within three working days not including weekends after receipt of
30 the notice of the change or difference. In calculating disproportionate
31 share payments as prescribed in this section, the administration may use
32 either a methodology based on claims and encounter data that is submitted to
33 the administration from contractors or a methodology based on data that is
34 reported to the administration by private hospitals and state operated
35 institutions for mental disease. The selected methodology applies to all
36 private hospitals and state operated institutions for mental disease
37 qualifying for disproportionate share payments. For the purposes of this
38 subsection, "disproportionate share payment" means a payment to a hospital
39 that serves a disproportionate share of low-income patients as described by
40 42 United States Code section 1396r-4.

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

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

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

8 S. In addition to any requirements adopted pursuant to subsection D,
9 paragraph 4 of this section, notwithstanding any other law, subject to
10 approval by the centers for medicare and medicaid services, beginning July 1,
11 2011, members eligible pursuant to section 36-2901, paragraph 6, subdivision
12 (a), section 36-2931 and section 36-2981, paragraph 6 shall pay the
13 following:

- 14 1. A monthly premium of fifteen dollars, except that the total monthly
15 premium for an entire household shall not exceed sixty dollars.
- 16 2. A copayment of five dollars for each physician office visit.
- 17 3. A copayment of ten dollars for each urgent care visit.
- 18 4. A copayment of thirty dollars for each emergency department visit.

19 Sec. 2. Section 36-2907, Arizona Revised Statutes, is amended to read:

20 36-2907. Covered health and medical services; modifications;
21 related delivery of service requirements; definition

22 A. Subject to the limitations and exclusions specified in this
23 section, contractors shall provide the following medically necessary health
24 and medical services:

25 1. Inpatient hospital services that are ordinarily furnished by a
26 hospital for the care and treatment of inpatients and that are provided under
27 the direction of a physician or a primary care practitioner. For the
28 purposes of this section, inpatient hospital services exclude services in an
29 institution for tuberculosis or mental diseases unless authorized under an
30 approved section 1115 waiver.

31 2. Outpatient health services that are ordinarily provided in
32 hospitals, clinics, offices and other health care facilities by licensed
33 health care providers. Outpatient health services include services provided
34 by or under the direction of a physician or a primary care practitioner.

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

37 4. Medications that are ordered on prescription by a physician or a
38 dentist licensed pursuant to title 32, chapter 11. Persons who are dually
39 eligible for title XVIII and title XIX services must obtain available
40 medications through a medicare licensed or certified medicare advantage
41 prescription drug plan, a medicare prescription drug plan or any other entity
42 authorized by medicare to provide a medicare part D prescription drug
43 benefit.

44 5. Medical supplies, durable medical equipment and prosthetic devices
45 ordered by a physician or a primary care practitioner. Suppliers of durable

1 medical equipment shall provide the administration with complete information
2 about the identity of each person who has an ownership or controlling
3 interest in their business and shall comply with federal bonding requirements
4 in a manner prescribed by the administration.

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

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

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

19 9. Podiatry services ordered by a primary care physician or primary
20 care practitioner.

21 10. Nonexperimental transplants approved for title XIX reimbursement.

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

24 12. Hospice care.

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

27 1. Circumcision of newborn males is not a covered health and medical
28 service.

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

30 (a) Outpatient health services do not include occupational therapy or
31 speech therapy.

32 (b) Prosthetic devices do not include hearing aids, dentures, bone
33 anchored hearing aids or cochlear implants. Prosthetic devices, except
34 prosthetic implants, may be limited to twelve thousand five hundred dollars
35 per contract year.

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

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

39 (e) Podiatry services do not include services performed by a
40 podiatrist.

41 ~~(f) Nonexperimental transplants do not include the following:~~

42 ~~(i) Pancreas only transplants.~~

43 ~~(ii) Pancreas after kidney transplants.~~

44 ~~(iii) Lung transplants.~~

45 ~~(iv) Hemopoietic cell allogenic unrelated transplants.~~

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

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

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

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

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

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

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

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

41 G. The director shall adopt rules for the provision of transportation
42 services and rules providing for copayment by members for transportation for
43 other than emergency purposes. Subject to approval by the centers for
44 medicare and medicaid services, nonemergency medical transportation shall not
45 be provided except for stretcher vans and ambulance transportation. Prior

1 authorization is required for transportation by stretcher van and for
2 medically necessary ambulance transportation initiated pursuant to a
3 physician's direction. Prior authorization is not required for medically
4 necessary ambulance transportation services rendered to members or eligible
5 persons initiated by dialing telephone number 911 or other designated
6 emergency response systems.

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

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

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

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

31 1. Emergency services and specialty services provided pursuant to
32 section 36-2908.

33 2. That the director may permit the delivery of health and medical
34 services in other than the geographic service area in this state or in an
35 adjoining state if the director determines that medical practice patterns
36 justify the delivery of services or a net reduction in transportation costs
37 can reasonably be expected. Notwithstanding the definition of physician as
38 prescribed in section 36-2901, if services are procured from a physician or
39 primary care practitioner in an adjoining state, the physician or primary
40 care practitioner shall be licensed to practice in that state pursuant to
41 licensing statutes in that state similar to title 32, chapter 13, 15, 17 or
42 25 and shall complete a provider agreement for this state.

43 L. Covered outpatient services shall be subcontracted by a primary
44 care physician or primary care practitioner to other licensed health care
45 providers to the extent practicable for purposes including, but not limited

1 to, making health care services available to underserved areas, reducing
2 costs of providing medical care and reducing transportation costs.

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

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

9 Sec. 3. Laws 2011, chapter 234, section 2 is amended to read:

10 Sec. 2. AHCCCS; political subdivisions; coverage; definition;
11 delayed repeal

12 A. The Arizona health care cost containment system administration,
13 subject to the approval of the centers for medicare and medicaid services and
14 pursuant to section 36-2903, subsection B, paragraph 1, Arizona Revised
15 Statutes, may authorize any political subdivision of this state to provide
16 monies necessary to qualify for federal matching monies in order to provide
17 health care coverage to persons who would have been eligible pursuant to
18 section 36-2901.01, Arizona Revised Statutes, if additional general fund
19 monies were otherwise available. Health care coverage shall be offered only
20 through providers or health plans that are designated by the political
21 subdivision. A political subdivision may limit health care coverage provided
22 pursuant to this section.

23 B. For the purposes of this section, "political subdivision" means a
24 local, county or tribal government, a university under the jurisdiction of
25 the Arizona board of regents and any other governmental entity that is
26 legally qualified to participate in funding program expenditures pursuant to
27 title 36, chapter 29, Arizona Revised Statutes.

28 C. This section is repealed from and after ~~September 30~~ **DECEMBER 31,**
29 2013.

30 Sec. 4. ALTCs; county contributions; fiscal year 2013-2014

31 A. Notwithstanding section 11-292, Arizona Revised Statutes, county
32 contributions for the Arizona long-term care system for fiscal year 2013-2014
33 are as follows:

34	1. Apache	\$ 613,500
35	2. Cochise	\$ 5,179,900
36	3. Coconino	\$ 1,841,200
37	4. Gila	\$ 2,126,000
38	5. Graham	\$ 1,427,300
39	6. Greenlee	\$ 128,800
40	7. La Paz	\$ 691,300
41	8. Maricopa	\$149,698,100
42	9. Mohave	\$ 7,952,700
43	10. Navajo	\$ 2,538,600
44	11. Pima	\$ 39,129,200
45	12. Pinal	\$ 15,246,800

1	13. Santa Cruz	\$ 1,908,200
2	14. Yavapai	\$ 8,382,500
3	15. Yuma	\$ 7,832,000

4 B. If the overall cost for the Arizona long-term care system exceeds
 5 the amount specified in the general appropriations act for fiscal year
 6 2013-2014, the state treasurer shall collect from the counties the difference
 7 between the amount specified in subsection A of this section and the
 8 counties' share of the state's actual contribution. The counties' share of
 9 the state contribution shall be in compliance with any federal maintenance of
 10 effort requirements. The director of the Arizona health care cost
 11 containment system administration shall notify the state treasurer of the
 12 counties' share of the state's contribution and report the amount to the
 13 director of the joint legislative budget committee. The state treasurer
 14 shall withhold from any other monies payable to that county from whatever
 15 state funding source is available an amount necessary to fulfill that
 16 county's requirement specified in this subsection. The state treasurer shall
 17 not withhold distributions from the highway user revenue fund pursuant to
 18 title 28, chapter 18, article 2, Arizona Revised Statutes. The state
 19 treasurer shall deposit the amounts withheld pursuant to this subsection and
 20 amounts paid pursuant to subsection A of this section in the long-term care
 21 system fund established by section 36-2913, Arizona Revised Statutes.

22 Sec. 5. Sexually violent persons; county reimbursement; fiscal
 23 year 2013-2014; deposit; tax distribution withholding

24 A. Notwithstanding any other law, if this state pays the costs of a
 25 commitment of an individual determined to be sexually violent by the court,
 26 the county shall reimburse the department of health services for fifty per
 27 cent of these costs for fiscal year 2013-2014.

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

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

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

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

3 Sec. 6. Competency restoration treatment; city and county
4 reimbursement; fiscal year 2013-2014; deposit; tax
5 distribution withholding

6 A. Notwithstanding section 13-4512, Arizona Revised Statutes, if this
7 state pays the costs of a defendant's inpatient competency restoration
8 treatment pursuant to section 13-4512, Arizona Revised Statutes, the city or
9 county shall reimburse the department of health services for one hundred per
10 cent of these costs for fiscal year 2013-2014.

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

15 C. Each city and county shall make the reimbursements for these costs
16 as specified in subsection A of this section within thirty days after a
17 request by the department of health services. If the city or county does not
18 make the reimbursement, the superintendent of the Arizona state hospital
19 shall notify the state treasurer of the amount owed and the treasurer shall
20 withhold the amount, including any additional interest as provided in section
21 42-1123, Arizona Revised Statutes, from any transaction privilege tax
22 distributions to the city or county. The treasurer shall deposit the
23 withholdings, pursuant to sections 35-146 and 35-147, Arizona Revised
24 Statutes, in the Arizona state hospital fund established by section
25 36-545.08, Arizona Revised Statutes.

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

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

32 Sec. 7. AHCCCS; disproportionate share payments

33 A. Disproportionate share payments for fiscal year 2013-2014 made
34 pursuant to section 36-2903.01, subsection 0, Arizona Revised Statutes,
35 include:

36 1. \$89,877,700 for a qualifying nonstate operated public hospital:

37 (a) The Maricopa county special health care district shall provide a
38 certified public expense form for the amount of qualifying disproportionate
39 share hospital expenditures made on behalf of this state to the
40 administration on or before May 1, 2014 for all state plan years as required
41 by the Arizona health care cost containment system 1115 waiver standard terms
42 and conditions. The administration shall assist the district in determining
43 the amount of qualifying disproportionate share hospital expenditures. Once
44 the administration files a claim with the federal government and receives
45 federal funds participation based on the amount certified by the Maricopa

1 county special health care district, if the certification is equal to or
2 greater than \$89,877,700, and the administration determines that the revised
3 amount is correct pursuant to the methodology used by the administration
4 pursuant to section 36-2903.01, Arizona Revised Statutes, the administration
5 shall notify the governor, the president of the senate and the speaker of the
6 house of representatives, shall distribute \$4,202,300 to the Maricopa county
7 special health care district and shall deposit the balance of the federal
8 funds participation in the state general fund. If the certification provided
9 is for an amount greater than \$89,877,700 and the administration determines
10 that the revised amount is not correct pursuant to the methodology used by
11 the administration pursuant to section 36-2903.01, Arizona Revised Statutes,
12 the administration shall notify the governor, the president of the senate and
13 the speaker of the house of representatives and shall deposit the total
14 amount of the federal funds participation in the state general fund. Except
15 as provided in subdivision (b) of this paragraph, the disproportionate share
16 hospital payment attributed to the Maricopa county special health care
17 district shall not exceed \$89,877,700.

18 (b) To the extent there remains available qualifying disproportionate
19 share hospital payment authority after safety net care pool payments are
20 made, the Maricopa county special health care district shall provide a
21 certified public expense form for the amount and the administration shall
22 deposit the amount of the federal funds participation in excess of
23 \$89,877,700 in the state general fund.

24 2. \$26,724,700 for the Arizona state hospital. The Arizona state
25 hospital shall provide a certified public expense form for the amount of
26 qualifying disproportionate share hospital expenditures made on behalf of the
27 state to the administration on or before March 31, 2014. The administration
28 shall assist the Arizona state hospital in determining the amount of
29 qualifying disproportionate share hospital expenditures. Once the
30 administration files a claim with the federal government and receives federal
31 funds participation based on the amount certified by the Arizona state
32 hospital, the administration shall distribute the entire amount of federal
33 financial participation to the state general fund. If the certification
34 provided is for an amount less than \$26,724,700, the administration shall
35 notify the governor, the president of the senate and the speaker of the house
36 of representatives and shall distribute the entire amount of federal
37 financial participation to the state general fund. The certified public
38 expense form provided by the Arizona state hospital shall contain both the
39 total amount of qualifying disproportionate share hospital expenditures and
40 the amount limited by section 1923(g) of the social security act.

41 3. \$9,284,800 for private qualifying disproportionate share hospitals.
42 The Arizona health care cost containment system administration shall make
43 payments to hospitals consistent with this appropriation and the terms of the
44 section 1115 waiver, but payments shall be limited to those hospitals that
45 either:

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

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

5 B. Disproportionate share payments in fiscal year 2013-2014 made
 6 pursuant to section 36-2903.01, subsection 0, Arizona Revised Statutes,
 7 include amounts for disproportionate share hospitals designated by political
 8 subdivisions of this state, tribal governments and any university under the
 9 jurisdiction of the Arizona board of regents. Contingent on approval by the
 10 administration and the centers for medicare and medicaid services, any amount
 11 of federal funding allotted to this state pursuant to section 1923(f) of the
 12 social security act and not otherwise expended under subsection A, paragraph
 13 1, 2 or 3 of this section shall be made available for distribution pursuant
 14 to this subsection. Political subdivisions of this state, tribal governments
 15 and any university under the jurisdiction of the Arizona board of regents may
 16 designate hospitals eligible to receive disproportionate share funds in an
 17 amount up to the limit prescribed in section 1923(g) of the social security
 18 act if those political subdivisions, tribal governments or universities
 19 provide sufficient monies to qualify for the matching federal monies for the
 20 disproportionate share payments.

21 Sec. 8. AHCCCS transfer; counties; federal monies

22 On or before December 31, 2014, notwithstanding any other law, for
 23 fiscal year 2013-2014 the Arizona health care cost containment system
 24 administration shall transfer to the counties such portion, if any, as may be
 25 necessary to comply with section 10201(c)(6) of the patient protection and
 26 affordable care act (P.L. 111-148), regarding the counties' proportional
 27 share of the state's contribution.

28 Sec. 9. County acute care contribution; fiscal year 2013-2014

29 A. Notwithstanding section 11-292, Arizona Revised Statutes, for
 30 fiscal year 2013-2014 for the provision of hospitalization and medical care,
 31 the counties shall contribute the following amounts:

32	1. Apache	\$ 268,800
33	2. Cochise	\$ 2,214,800
34	3. Coconino	\$ 742,900
35	4. Gila	\$ 1,413,200
36	5. Graham	\$ 536,200
37	6. Greenlee	\$ 190,700
38	7. La Paz	\$ 212,100
39	8. Maricopa	\$19,820,700
40	9. Mohave	\$ 1,237,700
41	10. Navajo	\$ 310,800
42	11. Pima	\$14,951,800
43	12. Pinal	\$ 2,715,600

1	13. Santa Cruz	\$ 482,800
2	14. Yavapai	\$ 1,427,800
3	15. Yuma	\$ 1,325,100

4 B. If a county does not provide funding as specified in subsection A
5 of this section, the state treasurer shall subtract the amount owed by the
6 county to the Arizona health care cost containment system fund and the
7 long-term care system fund established by section 36-2913, Arizona Revised
8 Statutes, from any payments required to be made by the state treasurer to
9 that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona
10 Revised Statutes, plus interest on that amount pursuant to section 44-1201,
11 Arizona Revised Statutes, retroactive to the first day the funding was due.
12 If the monies the state treasurer withholds are insufficient to meet that
13 county's funding requirements as specified in subsection A of this section,
14 the state treasurer shall withhold from any other monies payable to that
15 county from whatever state funding source is available an amount necessary to
16 fulfill that county's requirement. The state treasurer shall not withhold
17 distributions from the highway user revenue fund pursuant to title 28,
18 chapter 18, article 2, Arizona Revised Statutes.

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

25 D. The state treasurer shall deposit the amounts paid pursuant to
26 subsection C of this section and amounts withheld pursuant to subsection B of
27 this section in the Arizona health care cost containment system fund and the
28 long-term care system fund established by section 36-2913, Arizona Revised
29 Statutes.

30 E. If payments made pursuant to subsection C of this section exceed
31 the amount required to meet the costs incurred by the Arizona health care
32 cost containment system for the hospitalization and medical care of those
33 persons defined as an eligible person pursuant to section 36-2901, paragraph
34 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of
35 the Arizona health care cost containment system administration may instruct
36 the state treasurer either to reduce remaining payments to be paid pursuant
37 to this section by a specified amount or to provide to the counties specified
38 amounts from the Arizona health care cost containment system fund and the
39 long-term care system fund.

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

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

4 Sec. 14. AHCCCS; ambulance services; reimbursement

5 For dates of service on and after October 1, 2013 through September 30,
6 2014, the Arizona health care cost containment system administration and its
7 contractors shall reimburse ambulance service providers in an amount equal to
8 68.59 per cent of the amounts prescribed by the department of health
9 services.

10 Sec. 15. AHCCCS; social security administration; medicare
11 liability waiver

12 The Arizona health care cost containment system may participate in any
13 special disability workload 1115 demonstration waiver offered by the centers
14 for medicare and medicaid services. Any credits provided by the 1115
15 demonstration waiver process are to be used in the fiscal year when those
16 credits are made available to fund the state share of any medical assistance
17 expenditures that qualify for federal financial participation under the
18 medicaid program. The Arizona health care cost containment system
19 administration shall report the receipt of any credits to the director of the
20 joint legislative budget committee on or before December 31, 2013 and June
21 30, 2014.

22 Sec. 16. Department of health services; health research
23 account; Alzheimer's disease research

24 Notwithstanding section 36-773, Arizona Revised Statutes, the
25 department of health services may use monies in the health research account
26 established by section 36-773, Arizona Revised Statutes, in an amount
27 specified in the general appropriations act for Alzheimer's disease research.

28 Sec. 17. Department of economic security; department of
29 administration; long-term care system fund; fiscal
30 year 2013-2014

31 Notwithstanding section 36-2953, Arizona Revised Statutes:

32 1. The department of economic security may use monies in the
33 department long-term care system fund established pursuant to section
34 36-2953, Arizona Revised Statutes, for any operational or programmatic
35 expenses in fiscal year 2013-2014.

36 2. The department of administration may use monies in the department
37 long-term care system fund established pursuant to section 36-2953, Arizona
38 Revised Statutes, for distribution to counties for operational expenses in
39 fiscal year 2013-2014.

40 Sec. 18. Transfer of monies; hearing and speech professionals
41 fund

42 All monies remaining in the hearing and speech professionals fund
43 established by section 36-1903, Arizona Revised Statutes, on the effective
44 date of this act are transferred to the health services licensing fund

1 established by section 36-414, Arizona Revised Statutes, as amended by Laws
2 2013, chapter 33, section 1.

3 Sec. 19. Child care assistance eligibility; notification

4 Notwithstanding section 46-803, Arizona Revised Statutes, for fiscal
5 year 2013-2014, the department of economic security may reduce maximum income
6 eligibility levels for child care assistance in order to manage within
7 appropriated and available monies. The department of economic security shall
8 notify the joint legislative budget committee of any change in maximum income
9 eligibility levels for child care within fifteen days after implementing the
10 change.

11 Sec. 20. Department of economic security; drug testing; TANF
12 cash benefits recipients

13 During fiscal year 2013-2014, the department of economic security shall
14 screen and test each adult recipient who is otherwise eligible for temporary
15 assistance for needy families cash benefits and who the department has
16 reasonable cause to believe engages in the illegal use of controlled
17 substances. Any recipient who is found to have tested positive for the use
18 of a controlled substance that was not prescribed for the recipient by a
19 licensed health care provider is ineligible to receive benefits for a period
20 of one year.

21 Sec. 21. AHCCCS; emergency department use; report

22 On or before December 1, 2013, the Arizona health care cost containment
23 system administration shall report to the directors of the joint legislative
24 budget committee and the governor's office of strategic planning and
25 budgeting on the use of emergency departments for nonemergency purposes by
26 Arizona health care cost containment system enrollees.

27 Sec. 22. Child welfare; report; accountability factors

28 On or before September 1, 2013, the director of the joint legislative
29 budget committee, the director of the governor's office of strategic planning
30 and budgeting and the director of the department of economic security shall
31 report to the governor, the president of the senate and the speaker of the
32 house of representatives recommendations for consolidating into one
33 comprehensive report the child welfare report required by section 8-526,
34 Arizona Revised Statutes, the financial and program accountability report for
35 child protective services required by section 8-818, Arizona Revised
36 Statutes, the monthly reports required by Laws 2013, chapter 1, section 1 and
37 other child welfare reports prepared by the department. The report shall
38 consider the frequency of reporting as part of the recommendations. The
39 joint legislative budget committee, the governor's office of strategic
40 planning and budgeting and the department of economic security may solicit
41 input from stakeholder groups for the report. The report shall also address
42 the merit of adding the following accountability factors:

1 1. The average duration of time from when a child enters emergency and
2 residential placement to the initial court case associated with that child.

3 2. The number of children moved from emergency and residential
4 placement to foster care, delineated by major age groupings.

5 3. The number of child protective services staff hired or leaving by
6 type, specifically the caseworkers' classification level from one through
7 four.

8 4. The number of new and closed foster care receiving homes, including
9 the total available placements by age groupings of infants, children who are
10 one through five years of age, children who are six through twelve years of
11 age and teen children who are twelve through eighteen years of age.

12 5. Cohort and behavioral health data.

13 Sec. 23. Auditor general; children support services reports

14 A. The auditor general shall provide to the governor, the speaker of
15 the house of representatives, the president of the senate and the directors
16 of the joint legislative budget committee and the governor's office of
17 strategic planning and budgeting the following reports on the expenditure of
18 monies for children support services in the department of economic security.
19 The reports shall address:

20 1. Expenditures for the recruitment, retention, training, licensing
21 and tracking of foster care families as part of children support services.
22 This report shall address whether the department of economic security's
23 current contract process of home recruitment study and supervision is the
24 most appropriate means to provide these services. The report also shall
25 address the best performance measures to evaluate the effectiveness of these
26 services.

27 2. Expenditures for transportation as part of children support
28 services. This report shall describe the types of funded services provided
29 along with cost details for those services. The report also shall address
30 the best performance measures to evaluate the effectiveness of these
31 services.

32 3. Expenditures in the emergency and residential placement special
33 line item. This report shall describe the reasons for the high usage of
34 emergency and residential placements, as opposed to foster homes. The report
35 also shall address possible methods to reduce the use of emergency and
36 residential placements in the future.

37 B. The first report shall be submitted on or before October 15, 2013,
38 the second report shall be submitted on or before March 15, 2014 and the
39 final report shall be submitted on or before October 15, 2014.

40 Sec. 24. Intent; implementation of program

41 It is the intent of the legislature that for fiscal year 2013-2014 the
42 Arizona health care cost containment system administration implement a
43 program within the available appropriation.

1 Sec. 25. Intent: false claims act: savings

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

6 Sec. 26. Intent: capitation rate increases

7 It is the intent of the legislature that the Arizona health care cost
8 containment system administration capitation rate increases not exceed three
9 per cent in fiscal years 2014-2015 and 2015-2016.