

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

# SENATE BILL 1492

## AN ACT

AMENDING SECTIONS 9-499.15 AND 32-1422, ARIZONA REVISED STATUTES; AMENDING TITLE 32, CHAPTER 32, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 32-3216; AMENDING SECTION 36-427, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 4, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-437; AMENDING SECTION 36-2901, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 36-2901.07, 36-2901.08 AND 36-2901.09; AMENDING SECTIONS 36-2903.01, 36-2907 AND 41-1005, ARIZONA REVISED STATUTES; AMENDING LAWS 2011, CHAPTER 234, SECTION 2; MAKING APPROPRIATIONS AND TRANSFERS; PROVIDING FOR THE DELAYED REPEAL OF SECTIONS 32-3216, 36-437, 36-2901.07 AND 36-2901.08, ARIZONA REVISED STATUTES, AS ADDED BY THIS ACT; 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 9-499.15, Arizona Revised Statutes, is amended to  
3 read:

4 9-499.15. Proposed municipal taxes and fees: notification  
5 required; exception

6 A. A municipality may not levy or assess any new taxes or fees or  
7 increase existing taxes or fees pursuant to statute on a business without  
8 complying with this section.

9 B. A municipality that proposes to levy or assess a tax or fee shall:

10 1. If the imposition of the proposed tax or fee is a new charge,  
11 provide written notice of the proposed charge on the home page of the  
12 municipality's website at least sixty days before the date the proposed new  
13 tax or fee is approved or disapproved by the governing body of the  
14 municipality.

15 2. If the municipality proposes to increase the rate of an existing  
16 tax or fee on a business, provide written notice of the proposed increase on  
17 the home page of the municipality's website at least sixty days before the  
18 date the proposed new rate is approved or disapproved by the governing body  
19 of the municipality.

20 C. A municipality shall demonstrate that the taxes or fees are imposed  
21 pursuant to statute.

22 D. This section does not apply to any fee adopted pursuant to section  
23 9-463.05.

24 E. IN ADDITION TO ANY OTHER LIMITATION THAT MAY BE IMPOSED BY LAW, A  
25 MUNICIPALITY SHALL NOT LEVY OR IMPOSE AN ASSESSMENT, FEE OR TAX ON HOSPITAL  
26 REVENUES, DISCHARGES, BEDS OR SERVICES FOR THE PURPOSE OF RECEIVING SERVICES  
27 OR PAYMENTS PURSUANT TO TITLE 36, CHAPTER 29.

28 Sec. 2. Section 32-1422, Arizona Revised Statutes, is amended to read:

29 32-1422. Basic requirements for granting a license to practice  
30 medicine

31 A. An applicant for a license to practice medicine in this state  
32 pursuant to this article shall meet each of the following basic requirements:

33 1. Graduate from an approved school of medicine or receive a medical  
34 education that the board deems to be of equivalent quality.

35 2. Successfully complete an approved twelve-month hospital internship,  
36 residency or clinical fellowship program.

37 3. Have the physical and mental capability to safely engage in the  
38 practice of medicine.

39 4. Have a professional record that indicates that the applicant has  
40 not committed any act or engaged in any conduct that would constitute grounds  
41 for disciplinary action against a licensee under this chapter.

42 5. Not have had a license to practice medicine revoked by a medical  
43 regulatory board in another jurisdiction in the United States for an act that  
44 occurred in that jurisdiction that constitutes unprofessional conduct  
45 pursuant to this chapter.

1           6. Not be currently under investigation, suspension or restriction by  
2 a medical regulatory board in another jurisdiction in the United States for  
3 an act that occurred in that jurisdiction AND that constitutes unprofessional  
4 conduct pursuant to this chapter. If the applicant is under investigation by  
5 a medical regulatory board in another jurisdiction, the board shall suspend  
6 the application process and may not issue or deny a license to the applicant  
7 until the investigation is resolved.

8           7. Not have surrendered a license to practice medicine in lieu of  
9 disciplinary action by a medical regulatory board in another jurisdiction in  
10 the United States for an act that occurred in that jurisdiction AND that  
11 constitutes unprofessional conduct pursuant to this chapter.

12           8. Pay all fees required by the board.

13           9. Complete the application as required by the board.

14           10. Complete a training unit as prescribed by the board relating to the  
15 requirements of this chapter and board rules. The applicant shall submit  
16 proof with the application form of having completed the training unit.

17           11. HAVE SUBMITTED DIRECTLY TO THE BOARD, ELECTRONICALLY OR BY HARD  
18 COPY, VERIFICATION OF THE FOLLOWING:

19           (a) LICENSURE FROM EVERY STATE IN WHICH THE APPLICANT HAS EVER HELD A  
20 MEDICAL LICENSE.

21           (b) ALL HOSPITAL AFFILIATIONS AND EMPLOYMENT FOR THE FIVE YEARS  
22 PRECEDING APPLICATION. EACH HOSPITAL MUST VERIFY AFFILIATIONS OR EMPLOYMENT  
23 ON THE HOSPITAL'S OFFICIAL LETTERHEAD OR THE ELECTRONIC EQUIVALENT.

24           B. The board may require the submission of credentials or other  
25 evidence, written and oral, and make any investigation it deems necessary to  
26 adequately inform itself with respect to an applicant's ability to meet the  
27 requirements prescribed by this section, including a requirement that the  
28 applicant for licensure undergo a physical examination, a mental evaluation  
29 and an oral competence examination and interview, or any combination thereof,  
30 as the board deems proper.

31           C. In determining if the requirements of subsection A, paragraph 4 OF  
32 THIS SECTION have been met, if the board finds that the applicant committed  
33 an act or engaged in conduct that would constitute grounds for disciplinary  
34 action, the board shall determine to its satisfaction that the conduct has  
35 been corrected, monitored and resolved. If the matter has not been resolved,  
36 the board shall determine to its satisfaction that mitigating circumstances  
37 exist that prevent its resolution.

38           D. In determining if the requirements of subsection A, paragraph 6 OF  
39 THIS SECTION have been met, if another jurisdiction has taken disciplinary  
40 action against an applicant, the board shall determine to its satisfaction  
41 that the cause for the action was corrected and the matter resolved. If the  
42 matter has not been resolved by that jurisdiction, the board shall determine  
43 to its satisfaction that mitigating circumstances exist that prevent its  
44 resolution.

1 E. The board may delegate authority to the executive director to deny  
2 licenses if applicants do not meet the requirements of this section.

3 Sec. 3. Title 32, chapter 32, article 1, Arizona Revised Statutes, is  
4 amended by adding section 32-3216, to read:

5 32-3216. Health care providers; charges; public availability;  
6 direct payment; notice; definitions

7 A. A HEALTH CARE PROVIDER MUST MAKE AVAILABLE ON REQUEST OR ONLINE THE  
8 DIRECT PAY PRICE FOR AT LEAST THE TWENTY-FIVE MOST COMMONLY PROVIDED  
9 SERVICES, IF APPLICABLE, THAT THE HEALTH CARE PROVIDER OFFERS. THE SERVICES  
10 MAY BE IDENTIFIED BY A COMMON PROCEDURAL TERMINOLOGY CODE OR BY A  
11 PLAIN-ENGLISH DESCRIPTION. THE DIRECT PAY PRICES MUST BE UPDATED AT LEAST  
12 ANNUALLY AND MUST BE BASED ON THE SERVICES FROM A TWELVE-MONTH PERIOD THAT  
13 OCCURRED WITHIN THE EIGHTEEN-MONTH PERIOD PRECEDING THE UPDATE. THE DIRECT  
14 PAY PRICE MUST BE FOR THE STANDARD TREATMENT PROVIDED FOR THE SERVICE AND MAY  
15 INCLUDE THE COST OF TREATMENT FOR COMPLICATIONS OR EXCEPTIONAL TREATMENT.  
16 HEALTH CARE PROVIDERS WHO ARE OWNERS OR EMPLOYEES OF A LEGAL ENTITY WITH  
17 FEWER THAN THREE LICENSED HEALTH CARE PROVIDERS ARE EXEMPT FROM THE  
18 REQUIREMENTS OF THIS SUBSECTION.

19 B. SUBSECTION A OF THIS SECTION DOES NOT APPLY TO EMERGENCY SERVICES.

20 C. THE HEALTH CARE SERVICES PROVIDED BY HEALTH CARE PROVIDERS IN  
21 VETERANS ADMINISTRATION FACILITIES, HEALTH FACILITIES ON MILITARY BASES,  
22 INDIAN HEALTH SERVICES HOSPITALS AND OTHER INDIAN HEALTH SERVICE FACILITIES,  
23 TRIBAL-OWNED CLINICS, THE ARIZONA STATE HOSPITAL AND ANY HEALTH CARE FACILITY  
24 THAT IS DETERMINED TO BE EXEMPT PURSUANT TO SECTION 36-437, SUBSECTION D ARE  
25 EXEMPT FROM THE REQUIREMENTS OF THIS SECTION.

26 D. SUBSECTION A OF THIS SECTION DOES NOT PREVENT A HEALTH CARE  
27 PROVIDER FROM OFFERING EITHER ADDITIONAL DISCOUNTS OR ADDITIONAL LAWFUL  
28 HEALTH CARE SERVICES FOR AN ADDITIONAL COST TO A PERSON OR AN EMPLOYER PAYING  
29 DIRECTLY.

30 E. A HEALTH CARE PROVIDER IS NOT REQUIRED TO REPORT THE DIRECT PAY  
31 PRICES TO A GOVERNMENT AGENCY OR DEPARTMENT OR TO A GOVERNMENT-AUTHORIZED OR  
32 GOVERNMENT-CREATED ENTITY FOR REVIEW OR FILING. A GOVERNMENT AGENCY OR  
33 DEPARTMENT OR GOVERNMENT-AUTHORIZED OR GOVERNMENT-CREATED ENTITY MAY NOT  
34 APPROVE, DISAPPROVE OR LIMIT EITHER:

35 1. A HEALTH CARE PROVIDER'S DIRECT PAY PRICE FOR SERVICES.

36 2. A HEALTH CARE PROVIDER'S ABILITY TO CHANGE THE PUBLISHED OR POSTED  
37 DIRECT PAY PRICE FOR SERVICES.

38 F. A HEALTH CARE SYSTEM MAY NOT PUNISH A PERSON OR EMPLOYER FOR PAYING  
39 DIRECTLY FOR LAWFUL HEALTH CARE SERVICES OR A HEALTH CARE PROVIDER FOR  
40 ACCEPTING DIRECT PAYMENT FROM A PERSON OR EMPLOYER FOR LAWFUL HEALTH CARE  
41 SERVICES.

42 G. EXCEPT AS PROVIDED IN SUBSECTION J OF THIS SECTION, A HEALTH CARE  
43 PROVIDER WHO RECEIVES DIRECT PAYMENT FROM A PERSON OR EMPLOYER FOR A LAWFUL  
44 HEALTH CARE SERVICE IS DEEMED PAID IN FULL IF THE ENTIRE FEE FOR THE SERVICE  
45 IS PAID AND SHALL NOT SUBMIT A CLAIM FOR PAYMENT OR REIMBURSEMENT FOR THE

1 SERVICE TO ANY HEALTH CARE SYSTEM. THIS SUBSECTION DOES NOT PREVENT A HEALTH  
2 CARE PROVIDER FROM PURSUING A HEALTH CARE LIEN FOR CUSTOMARY CHARGES PURSUANT  
3 TO TITLE 33. THIS SUBSECTION DOES NOT AFFECT THE ABILITY OF A HEALTH CARE  
4 PROVIDER TO SUBMIT CLAIMS FOR THE SAME SERVICE PROVIDED ON OTHER OCCASIONS TO  
5 THE SAME OR A DIFFERENT PERSON IF DIRECT PAYMENT DOES NOT OCCUR. THIS  
6 SUBSECTION DOES NOT REQUIRE A HEALTH CARE PROVIDER TO REFUND OR ADJUST ANY  
7 CAPITATED PAYMENT, BUNDLED PAYMENT OR OTHER FORM OF PREPAYMENT OR GLOBAL  
8 PAYMENT MADE BY A HEALTH CARE SYSTEM TO THE HEALTH CARE PROVIDER FOR LAWFUL  
9 HEALTH CARE SERVICES TO BE PROVIDED BY THE HEALTH CARE PROVIDER FOR THE  
10 PERSON WHO MAKES, OR ON WHOSE BEHALF AN EMPLOYER MAKES, DIRECT PAYMENT TO THE  
11 HEALTH CARE PROVIDER.

12 H. BEFORE A HEALTH CARE PROVIDER WHO IS CONTRACTED AS A NETWORK  
13 PROVIDER FOR A HEALTH CARE SYSTEM ACCEPTS DIRECT PAYMENT FROM A PERSON OR AN  
14 EMPLOYER, AND THE PERSON IS AN ENROLLEE OF THE SAME HEALTH CARE SYSTEM, THE  
15 HEALTH CARE PROVIDER SHALL OBTAIN THE PERSON'S OR EMPLOYER'S SIGNATURE ON A  
16 NOTICE IN A FORM THAT IS SUBSTANTIALLY SIMILAR TO THE FOLLOWING:

17 IMPORTANT NOTICE ABOUT DIRECT PAYMENT  
18 FOR YOUR HEALTH CARE SERVICES

19 THE ARIZONA CONSTITUTION PERMITS YOU TO PAY A HEALTH CARE  
20 PROVIDER DIRECTLY FOR HEALTH CARE SERVICES. BEFORE YOU MAKE ANY  
21 AGREEMENT TO DO SO, PLEASE READ THE FOLLOWING IMPORTANT  
22 INFORMATION:

23 IF YOU ARE AN ENROLLEE OF A HEALTH CARE SYSTEM (MORE  
24 COMMONLY REFERRED TO AS A HEALTH INSURANCE PLAN) AND YOUR HEALTH  
25 CARE PROVIDER IS CONTRACTED WITH THE HEALTH INSURANCE PLAN, THE  
26 FOLLOWING APPLY:

27 1. YOU MAY NOT BE REQUIRED TO PAY THE HEALTH CARE  
28 PROVIDER DIRECTLY FOR THE SERVICES COVERED BY YOUR PLAN, EXCEPT  
29 FOR COST SHARE AMOUNTS THAT YOU ARE OBLIGATED TO PAY UNDER YOUR  
30 PLAN, SUCH AS COPAYMENTS, COINSURANCE AND DEDUCTIBLE AMOUNTS.

31 2. YOUR PROVIDER'S AGREEMENT WITH THE HEALTH INSURANCE  
32 PLAN MAY PREVENT THE HEALTH CARE PROVIDER FROM BILLING YOU FOR  
33 THE DIFFERENCE BETWEEN THE PROVIDER'S BILLED CHARGES AND THE  
34 AMOUNT ALLOWED BY YOUR HEALTH INSURANCE PLAN FOR COVERED  
35 SERVICES.

36 3. IF YOU PAY DIRECTLY FOR A HEALTH CARE SERVICE, YOUR  
37 HEALTH CARE PROVIDER WILL NOT BE RESPONSIBLE FOR SUBMITTING  
38 CLAIM DOCUMENTATION TO YOUR HEALTH INSURANCE PLAN FOR THAT  
39 CLAIM. BEFORE PAYING YOUR CLAIM, YOUR HEALTH INSURANCE PLAN MAY  
40 REQUIRE YOU TO PROVIDE INFORMATION AND SUBMIT DOCUMENTATION  
41 NECESSARY TO DETERMINE WHETHER THE SERVICES ARE COVERED UNDER  
42 YOUR PLAN.

43 4. IF YOU DO NOT PAY DIRECTLY FOR A HEALTH CARE SERVICE,  
44 YOUR HEALTH CARE PROVIDER MAY BE RESPONSIBLE FOR SUBMITTING

1 CLAIM DOCUMENTATION TO YOUR HEALTH INSURANCE PLAN FOR THE HEALTH  
2 CARE SERVICE.

3 YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU RECEIVED THIS  
4 NOTICE BEFORE PAYING DIRECTLY FOR A HEALTH CARE SERVICE.

5 I. A HEALTH CARE PROVIDER WHO RECEIVES DIRECT PAYMENT FOR A LAWFUL  
6 HEALTH CARE SERVICE AND WHO COMPLIES WITH SUBSECTION H OF THIS SECTION IS NOT  
7 RESPONSIBLE FOR SUBMITTING DOCUMENTATION OF ANY KIND FOR PURPOSES OF  
8 REIMBURSEMENT TO ANY HEALTH CARE SYSTEM FOR THAT CLAIM IF THE FAILURE TO  
9 SUBMIT SUCH DOCUMENTATION DOES NOT CONFLICT WITH THE TERMS OF ANY FEDERAL OR  
10 STATE CONTRACTS TO WHICH THE HEALTH CARE SYSTEM IS A PARTY AND THE HEALTH  
11 CARE PROVIDER HAS AGREED TO SERVE PATIENTS UNDER OR WITH APPLICABLE STATE OR  
12 FEDERAL PROGRAMS IN WHICH A HEALTH CARE PROVIDER AND HEALTH CARE SYSTEM  
13 PARTICIPATE.

14 J. THIS SECTION DOES NOT IMPAIR THE PROVISIONS OF A HEALTH CARE  
15 SYSTEM'S PRIVATE HEALTH CARE NETWORK PROVIDER CONTRACT, EXCEPT THAT A HEALTH  
16 CARE PROVIDER MAY ACCEPT DIRECT PAYMENT FROM A PERSON OR EMPLOYER OR MAY  
17 DECLINE TO BILL THE HEALTH CARE SYSTEM DIRECTLY FOR SERVICES PAID DIRECTLY BY  
18 A PERSON OR EMPLOYER IF THE HEALTH CARE PROVIDER HAS COMPLIED WITH SUBSECTION  
19 H OF THIS SECTION AND THE HEALTH CARE PROVIDER'S RECEIPT OF DIRECT PAYMENT  
20 AND THE DECLINATION TO BILL THE HEALTH CARE SYSTEM DO NOT CONFLICT WITH THE  
21 TERMS OF ANY FEDERAL OR STATE CONTRACT TO WHICH THE HEALTH CARE SYSTEM IS A  
22 PARTY AND THE HEALTH CARE PROVIDER HAS AGREED TO SERVE PATIENTS UNDER OR WITH  
23 APPLICABLE STATE OR FEDERAL PROGRAMS IN WHICH BOTH A HEALTH CARE PROVIDER AND  
24 HEALTH CARE SYSTEM PARTICIPATE.

25 K. A HEALTH CARE PROVIDER WHO DOES NOT COMPLY WITH THE REQUIREMENTS OF  
26 THIS SECTION COMMITS UNPROFESSIONAL CONDUCT. ANY DISCIPLINARY ACTION TAKEN  
27 BY THE HEALTH CARE PROVIDER'S LICENSING BOARD MAY NOT INCLUDE REVOCATION OF  
28 THE HEALTH CARE PROVIDER'S LICENSE.

29 L. FOR THE PURPOSES OF THIS SECTION:

30 1. "DIRECT PAY PRICE" MEANS THE PRICE THAT WILL BE CHARGED BY A HEALTH  
31 CARE PROVIDER FOR A LAWFUL HEALTH CARE SERVICE, REGARDLESS OF THE PERSON'S  
32 HEALTH INSURANCE STATUS, IF THE ENTIRE FEE FOR THE SERVICE IS PAID IN FULL  
33 DIRECTLY TO THE HEALTH CARE PROVIDER BY THE PERSON, INCLUDING THE PERSON'S  
34 HEALTH SAVINGS ACCOUNT, OR BY THE PERSON'S EMPLOYER AND THAT DOES NOT  
35 PROHIBIT A PROVIDER FROM ESTABLISHING A PAYMENT PLAN WITH THE PERSON PAYING  
36 DIRECTLY FOR SERVICES.

37 2. "EMERGENCY SERVICES" MEANS LAWFUL HEALTH CARE SERVICES NEEDED TO  
38 EVALUATE AND STABILIZE AN EMERGENCY MEDICAL CONDITION AS DEFINED IN 42 UNITED  
39 STATES CODE SECTION 1396u-2(b)(2)(C).

40 3. "ENROLLEE" MEANS A PERSON WHO IS ENROLLED IN A HEALTH CARE PLAN  
41 PROVIDED BY A HEALTH CARE INSURER.

42 4. "HEALTH CARE INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY  
43 INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION,  
44 HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR HOSPITAL AND  
45 MEDICAL SERVICE CORPORATION AS PRESCRIBED IN TITLE 20.

1           5. "HEALTH CARE PLAN" MEANS A POLICY, CONTRACT OR EVIDENCE OF COVERAGE  
2 ISSUED TO AN ENROLLEE. HEALTH CARE PLAN DOES NOT INCLUDE LIMITED BENEFIT  
3 COVERAGE AS DEFINED IN SECTION 20-1137.

4           6. "HEALTH CARE PROVIDER" MEANS A PERSON WHO IS LICENSED PURSUANT TO  
5 CHAPTER 7, 8, 13, 16, 17, 19 OR 34 OF THIS TITLE.

6           7. "HEALTH CARE SYSTEM" OR "HEALTH INSURANCE PLAN" MEANS A PUBLIC OR  
7 PRIVATE ENTITY WHOSE FUNCTION OR PURPOSE IS THE MANAGEMENT, PROCESSING OR  
8 ENROLLMENT OF INDIVIDUALS OR THE PAYMENT, IN FULL OR IN PART, OF HEALTH CARE  
9 SERVICES.

10          8. "LAWFUL HEALTH CARE SERVICES" MEANS ANY HEALTH-RELATED SERVICE OR  
11 TREATMENT, TO THE EXTENT THAT THE SERVICE OR TREATMENT IS PERMITTED OR NOT  
12 PROHIBITED BY LAW OR REGULATION, THAT MAY BE PROVIDED BY PERSONS OR  
13 BUSINESSES OTHERWISE PERMITTED TO OFFER THE SERVICES OR TREATMENTS.

14          9. "PUNISH" MEANS TO IMPOSE ANY PENALTY, SURCHARGE OR NAMED FEE WITH A  
15 SIMILAR EFFECT THAT IS USED TO DISCOURAGE THE EXERCISE OF RIGHTS UNDER THIS  
16 SECTION.

17          Sec. 4. Section 36-427, Arizona Revised Statutes, is amended to read:  
18 36-427. Suspension or revocation; intermediate sanctions

19          A. The director ~~may~~, pursuant to title 41, chapter 6, article 10, **MAY**  
20 suspend or revoke, in whole or in part, the license of any health care  
21 institution if its owners, officers, agents or employees:

22           1. Violate this chapter or the rules of the department adopted  
23 pursuant to this chapter.

24           2. Knowingly aid, permit or abet the commission of any crime involving  
25 medical and health related services.

26           3. Have been, are or may continue to be in substantial violation of  
27 the requirements for licensure of the institution, as a result of which the  
28 health or safety of one or more patients or the general public is in  
29 immediate danger.

30           4. **FAIL TO COMPLY WITH SECTION 36-2901.08.**

31          B. If the licensee, the chief administrative officer or any other  
32 person in charge of the institution refuses to permit the department or its  
33 employees or agents the right to inspect its premises as provided in section  
34 36-424, such action shall be deemed reasonable cause to believe that a  
35 substantial violation under subsection A, paragraph 3 of this section exists.

36          C. If the director reasonably believes that a violation of subsection  
37 A, paragraph 3 of this section has occurred and that life or safety of  
38 patients will be immediately affected, the director, ~~upon~~ **ON** written notice  
39 to the licensee, may order the immediate restriction of admissions or  
40 readmissions, selected transfer of patients out of the facility, reduction of  
41 capacity and termination of specific services, procedures, practices or  
42 facilities.

43          D. The director may rescind, in whole or in part, sanctions imposed  
44 pursuant to this section upon correction of the violation or violations for  
45 which the sanctions were imposed.

1           Sec. 5. Title 36, chapter 4, article 3, Arizona Revised Statutes, is  
2 amended by adding section 36-437, to read:

3           36-437. Health care facilities; charges; public availability;  
4           direct payment; notice; definitions

5           A. A HEALTH CARE FACILITY WITH MORE THAN FIFTY INPATIENT BEDS MUST  
6 MAKE AVAILABLE ON REQUEST OR ONLINE THE DIRECT PAY PRICE FOR AT LEAST THE  
7 FIFTY MOST USED DIAGNOSIS-RELATED GROUP CODES, IF APPLICABLE, FOR THE  
8 FACILITY AND AT LEAST THE FIFTY MOST USED OUTPATIENT SERVICE CODES, IF  
9 APPLICABLE, FOR THE FACILITY. THE SERVICES MAY BE IDENTIFIED BY A COMMON  
10 PROCEDURAL TERMINOLOGY CODE OR BY A PLAIN-ENGLISH DESCRIPTION. THE HEALTH  
11 CARE FACILITY MUST UPDATE THE DIRECT PAY PRICES AT LEAST ANNUALLY BASED ON  
12 THE SERVICES FROM A TWELVE-MONTH PERIOD THAT OCCURRED WITHIN THE  
13 EIGHTEEN-MONTH PERIOD PRECEDING THE UPDATE. THE DIRECT PAY PRICE MUST BE FOR  
14 THE STANDARD TREATMENT PROVIDED FOR THE SERVICE AND MAY INCLUDE THE COST OF  
15 TREATMENT FOR COMPLICATIONS OR EXCEPTIONAL TREATMENT.

16           B. A HEALTH CARE FACILITY WITH FIFTY OR FEWER INPATIENT BEDS MUST MAKE  
17 AVAILABLE ON REQUEST OR ONLINE THE DIRECT PAY PRICE FOR AT LEAST THE  
18 THIRTY-FIVE MOST USED DIAGNOSIS-RELATED GROUP CODES, IF APPLICABLE, FOR THE  
19 FACILITY AND AT LEAST THE THIRTY-FIVE MOST USED OUTPATIENT SERVICE CODES, IF  
20 APPLICABLE, FOR THE FACILITY. THE SERVICES MAY BE IDENTIFIED BY A COMMON  
21 PROCEDURAL TERMINOLOGY CODE OR BY A PLAIN-ENGLISH DESCRIPTION. THE HEALTH  
22 CARE FACILITY MUST UPDATE THE DIRECT PAY PRICES AT LEAST ANNUALLY BASED ON  
23 THE SERVICES FROM A TWELVE-MONTH PERIOD THAT OCCURRED WITHIN THE  
24 EIGHTEEN-MONTH PERIOD PRECEDING THE UPDATE. THE DIRECT PAY PRICE MUST BE FOR  
25 THE STANDARD TREATMENT PROVIDED FOR THE SERVICE AND MAY INCLUDE THE COST OF  
26 TREATMENT FOR COMPLICATIONS OR EXCEPTIONAL TREATMENT.

27           C. SUBSECTIONS A AND B OF THIS SECTION DO NOT APPLY IF A DISCUSSION OF  
28 THE DIRECT PAY PRICE WOULD BE A VIOLATION OF THE FEDERAL EMERGENCY MEDICAL  
29 TREATMENT AND LABOR ACT.

30           D. VETERANS ADMINISTRATION FACILITIES, HEALTH FACILITIES ON MILITARY  
31 BASES, INDIAN HEALTH SERVICES HOSPITALS AND OTHER INDIAN HEALTH SERVICES  
32 FACILITIES, TRIBAL-OWNED CLINICS AND THE ARIZONA STATE HOSPITAL ARE EXEMPT  
33 FROM THE REQUIREMENTS OF THIS SECTION. IF THE DIRECTOR OF THE DEPARTMENT OF  
34 HEALTH SERVICES DETERMINES THAT A HEALTH CARE FACILITY DOES NOT SERVE THE  
35 GENERAL PUBLIC, THE HEALTH CARE FACILITY IS EXEMPT FROM THE REQUIREMENTS OF  
36 THIS SECTION.

37           E. SUBSECTIONS A AND B OF THIS SECTION DO NOT PREVENT A HEALTH CARE  
38 FACILITY FROM OFFERING EITHER ADDITIONAL DISCOUNTS OR ADDITIONAL LAWFUL  
39 HEALTH CARE SERVICES FOR AN ADDITIONAL COST TO A PERSON OR AN EMPLOYER PAYING  
40 DIRECTLY.

41           F. A HEALTH CARE FACILITY IS NOT REQUIRED TO REPORT THE DIRECT PAY  
42 PRICES TO A GOVERNMENT AGENCY OR DEPARTMENT OR TO A GOVERNMENT-AUTHORIZED OR  
43 GOVERNMENT-CREATED ENTITY FOR REVIEW. A GOVERNMENT AGENCY OR DEPARTMENT OR  
44 GOVERNMENT-AUTHORIZED OR GOVERNMENT-CREATED ENTITY MAY NOT APPROVE,  
45 DISAPPROVE OR LIMIT EITHER:

1           1. A HEALTH CARE FACILITY'S DIRECT PAY PRICE FOR SERVICES.

2           2. A HEALTH CARE FACILITY'S ABILITY TO CHANGE THE PUBLISHED OR POSTED  
3 DIRECT PAY PRICE FOR SERVICES.

4           G. A HEALTH CARE SYSTEM MAY NOT PUNISH A PERSON OR EMPLOYER FOR PAYING  
5 DIRECTLY FOR LAWFUL HEALTH CARE SERVICES OR A HEALTH CARE FACILITY FOR  
6 ACCEPTING DIRECT PAYMENT FROM A PERSON OR EMPLOYER FOR LAWFUL HEALTH CARE  
7 SERVICES.

8           H. EXCEPT AS PROVIDED IN SUBSECTION K OF THIS SECTION, A HEALTH CARE  
9 FACILITY THAT RECEIVES DIRECT PAYMENT FROM A PERSON OR EMPLOYER FOR A LAWFUL  
10 HEALTH CARE SERVICE IS DEEMED PAID IN FULL IF THE ENTIRE FEE FOR THE SERVICE  
11 IS PAID AND SHALL NOT SUBMIT A CLAIM FOR PAYMENT OR REIMBURSEMENT FOR THE  
12 SERVICE TO ANY HEALTH CARE SYSTEM. THIS SUBSECTION DOES NOT PREVENT A HEALTH  
13 CARE FACILITY FROM PURSUING A HEALTH CARE LIEN FOR CUSTOMARY CHARGES PURSUANT  
14 TO TITLE 33. THIS SUBSECTION DOES NOT AFFECT THE ABILITY OF A HEALTH CARE  
15 FACILITY TO SUBMIT CLAIMS FOR THE SAME SERVICE PROVIDED ON OTHER OCCASIONS TO  
16 THE SAME OR A DIFFERENT PERSON IF DIRECT PAYMENT DOES NOT OCCUR. THIS  
17 SUBSECTION DOES NOT REQUIRE A HEALTH CARE FACILITY TO REFUND OR ADJUST ANY  
18 CAPITATED PAYMENT, BUNDLED PAYMENT OR OTHER FORM OF PREPAYMENT OR GLOBAL  
19 PAYMENT MADE BY A HEALTH CARE SYSTEM TO THE HEALTH CARE FACILITY FOR LAWFUL  
20 HEALTH CARE SERVICES TO BE PROVIDED BY THE HEALTH CARE FACILITY FOR THE  
21 PERSON WHO MAKES, OR ON WHOSE BEHALF AN EMPLOYER MAKES, DIRECT PAYMENT TO THE  
22 HEALTH CARE FACILITY.

23           I. BEFORE A HEALTH CARE FACILITY THAT IS CONTRACTED AS A NETWORK  
24 PROVIDER FOR A HEALTH CARE SYSTEM ACCEPTS DIRECT PAYMENT FROM A PERSON OR AN  
25 EMPLOYER, AND THE PERSON IS AN ENROLLEE OF THE SAME HEALTH CARE SYSTEM, THE  
26 HEALTH CARE FACILITY SHALL OBTAIN THE PERSON'S OR EMPLOYER'S SIGNATURE ON A  
27 NOTICE IN A FORM THAT IS SUBSTANTIALLY SIMILAR TO THE FOLLOWING:

28                           IMPORTANT NOTICE ABOUT DIRECT PAYMENT  
29                           FOR YOUR HEALTH CARE SERVICES

30           THE ARIZONA CONSTITUTION PERMITS YOU TO PAY A HEALTH CARE  
31 FACILITY DIRECTLY FOR HEALTH CARE SERVICES. BEFORE YOU MAKE ANY  
32 AGREEMENT TO DO SO, PLEASE READ THE FOLLOWING IMPORTANT  
33 INFORMATION:

34           IF YOU ARE AN ENROLLEE OF A HEALTH CARE SYSTEM (MORE  
35 COMMONLY REFERRED TO AS A HEALTH INSURANCE PLAN) AND YOUR HEALTH  
36 CARE FACILITY IS CONTRACTED WITH THE HEALTH INSURANCE PLAN, THE  
37 FOLLOWING APPLY:

38           1. YOU MAY NOT BE REQUIRED TO PAY THE HEALTH CARE  
39 FACILITY DIRECTLY FOR THE SERVICES COVERED BY YOUR PLAN, EXCEPT  
40 FOR COST SHARE AMOUNTS THAT YOU ARE OBLIGATED TO PAY UNDER YOUR  
41 PLAN, SUCH AS COPAYMENTS, COINSURANCE AND DEDUCTIBLE AMOUNTS.

42           2. YOUR HEALTH CARE FACILITY'S AGREEMENT WITH THE HEALTH  
43 INSURANCE PLAN MAY PREVENT THE FACILITY FROM BILLING YOU FOR THE  
44 DIFFERENCE BETWEEN THE FACILITY'S BILLED CHARGES AND THE AMOUNT  
45 ALLOWED BY YOUR HEALTH INSURANCE PLAN FOR COVERED SERVICES.

1           3. IF YOU PAY DIRECTLY FOR A HEALTH CARE SERVICE, YOUR  
2 HEALTH CARE FACILITY WILL NOT BE RESPONSIBLE FOR SUBMITTING  
3 CLAIM DOCUMENTATION TO YOUR HEALTH INSURANCE PLAN FOR THAT  
4 CLAIM. BEFORE PAYING YOUR CLAIM, YOUR HEALTH INSURANCE PLAN MAY  
5 REQUIRE YOU TO PROVIDE INFORMATION AND SUBMIT DOCUMENTATION  
6 NECESSARY TO DETERMINE WHETHER THE SERVICES ARE COVERED UNDER  
7 YOUR PLAN.

8           4. IF YOU DO NOT PAY DIRECTLY FOR A HEALTH CARE SERVICE,  
9 YOUR HEALTH CARE FACILITY MAY BE RESPONSIBLE FOR SUBMITTING  
10 CLAIM DOCUMENTATION TO YOUR HEALTH INSURANCE PLAN FOR THE HEALTH  
11 CARE SERVICE.

12           YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU RECEIVED THIS  
13 NOTICE BEFORE PAYING DIRECTLY FOR A HEALTH CARE SERVICE.

14           J. A HEALTH CARE FACILITY THAT RECEIVES DIRECT PAYMENT FOR A LAWFUL  
15 HEALTH CARE SERVICE AND THAT COMPLIES WITH SUBSECTION I OF THIS SECTION IS  
16 NOT RESPONSIBLE FOR SUBMITTING DOCUMENTATION OF ANY KIND FOR PURPOSES OF  
17 REIMBURSEMENT TO ANY HEALTH CARE SYSTEM FOR THAT CLAIM IF THE FAILURE TO  
18 SUBMIT SUCH DOCUMENTATION DOES NOT CONFLICT WITH THE TERMS OF ANY FEDERAL OR  
19 STATE CONTRACTS TO WHICH THE HEALTH CARE SYSTEM IS A PARTY AND THE HEALTH  
20 CARE FACILITY HAS AGREED TO SERVE PATIENTS UNDER OR WITH APPLICABLE STATE OR  
21 FEDERAL PROGRAMS IN WHICH A HEALTH CARE FACILITY AND HEALTH CARE SYSTEM  
22 PARTICIPATE.

23           K. THIS SECTION DOES NOT IMPAIR THE PROVISIONS OF A HEALTH CARE  
24 SYSTEM'S PRIVATE HEALTH CARE NETWORK PROVIDER CONTRACT, EXCEPT THAT A HEALTH  
25 CARE FACILITY MAY ACCEPT DIRECT PAYMENT FROM A PERSON OR EMPLOYER OR MAY  
26 DECLINE TO BILL THE HEALTH CARE SYSTEM DIRECTLY FOR SERVICES PAID DIRECTLY BY  
27 A PERSON OR EMPLOYER IF THE HEALTH CARE FACILITY HAS COMPLIED WITH SUBSECTION  
28 I OF THIS SECTION AND THE HEALTH CARE FACILITY'S RECEIPT OF DIRECT PAYMENT  
29 AND THE DECLINATION TO BILL THE HEALTH CARE SYSTEM DO NOT CONFLICT WITH THE  
30 TERMS OF ANY FEDERAL OR STATE CONTRACT TO WHICH THE HEALTH CARE SYSTEM IS A  
31 PARTY AND THE HEALTH CARE FACILITY HAS AGREED TO SERVE PATIENTS UNDER OR WITH  
32 APPLICABLE STATE OR FEDERAL PROGRAMS IN WHICH A HEALTH CARE FACILITY AND  
33 HEALTH CARE SYSTEM PARTICIPATE.

34           L. THIS SECTION DOES NOT PREVENT THE DEPARTMENT OF HEALTH SERVICES  
35 FROM PERFORMING AN INVESTIGATION OF A HEALTH CARE FACILITY UNDER THE  
36 DEPARTMENT'S POWERS AND DUTIES AS PRESCRIBED IN THIS TITLE. IF A HEALTH CARE  
37 FACILITY FAILS TO COMPLY WITH THIS SECTION, THE PENALTY SHALL NOT INCLUDE THE  
38 REVOCATION OF THE LICENSE TO DELIVER HEALTH CARE SERVICES.

39           M. FOR THE PURPOSES OF THIS SECTION:

40           1. "DIRECT PAY PRICE" MEANS THE ENTIRE PRICE THAT WILL BE CHARGED BY A  
41 HEALTH CARE FACILITY FOR A LAWFUL HEALTH CARE SERVICE, REGARDLESS OF THE  
42 PERSON'S HEALTH INSURANCE STATUS, IF THE ENTIRE FEE FOR THE SERVICE IS PAID  
43 IN FULL DIRECTLY TO THE HEALTH CARE FACILITY BY THE PERSON, INCLUDING THE  
44 PERSON'S HEALTH SAVINGS ACCOUNT, OR BY THE PERSON'S EMPLOYER AND THAT DOES

1 NOT PROHIBIT A FACILITY FROM ESTABLISHING A PAYMENT PLAN WITH THE PERSON  
2 PAYING DIRECTLY FOR SERVICES.

3 2. "ENROLLEE" MEANS A PERSON WHO IS ENROLLED IN A HEALTH CARE PLAN  
4 PROVIDED BY A HEALTH CARE INSURER.

5 3. "HEALTH CARE FACILITY" MEANS A HOSPITAL, OUTPATIENT SURGICAL  
6 CENTER, HEALTH CARE LABORATORY, DIAGNOSTIC IMAGING CENTER OR URGENT CARE  
7 CENTER.

8 4. "HEALTH CARE INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY  
9 INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION,  
10 HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR HOSPITAL AND  
11 MEDICAL SERVICE CORPORATION AS PRESCRIBED IN TITLE 20.

12 5. "HEALTH CARE PLAN" MEANS A POLICY, CONTRACT OR EVIDENCE OF COVERAGE  
13 ISSUED TO AN ENROLLEE. HEALTH CARE PLAN DOES NOT INCLUDE LIMITED BENEFIT  
14 COVERAGE AS DEFINED IN SECTION 20-1137.

15 6. "HEALTH CARE SYSTEM" OR "HEALTH INSURANCE PLAN" MEANS A PUBLIC OR  
16 PRIVATE ENTITY WHOSE FUNCTION OR PURPOSE IS THE MANAGEMENT, PROCESSING OR  
17 ENROLLMENT OF INDIVIDUALS OR THE PAYMENT, IN FULL OR IN PART, OF HEALTH CARE  
18 SERVICES.

19 7. "LAWFUL HEALTH CARE SERVICES" MEANS ANY HEALTH-RELATED SERVICE OR  
20 TREATMENT, TO THE EXTENT THAT THE SERVICE OR TREATMENT IS PERMITTED OR NOT  
21 PROHIBITED BY LAW OR REGULATION, THAT MAY BE PROVIDED BY PERSONS OR  
22 BUSINESSES OTHERWISE PERMITTED TO OFFER THE SERVICES OR TREATMENTS.

23 8. "PUNISH" MEANS TO IMPOSE ANY PENALTY, SURCHARGE OR NAMED FEE WITH A  
24 SIMILAR EFFECT THAT IS USED TO DISCOURAGE THE EXERCISE OF RIGHTS UNDER THIS  
25 SECTION.

26 Sec. 6. Section 36-2901, Arizona Revised Statutes, is amended to read:  
27 36-2901. Definitions

28 In this article, unless the context otherwise requires:

29 1. "Administration" means the Arizona health care cost containment  
30 system administration.

31 2. "Administrator" means the administrator of the Arizona health care  
32 cost containment system.

33 3. "Contractor" means a person or entity that has a prepaid capitated  
34 contract with the administration pursuant to section 36-2904 to provide  
35 health care to members under this article either directly or through  
36 subcontracts with providers.

37 4. "Department" means the department of economic security.

38 5. "Director" means the director of the Arizona health care cost  
39 containment system administration.

40 6. "Eligible person" means any person who is:

41 (a) Any of the following:

42 (i) Defined as mandatorily or optionally eligible pursuant to title  
43 XIX of the social security act as authorized by the state plan.

44 (ii) Defined in title XIX of the social security act as an eligible  
45 pregnant woman with a family income that does not exceed one hundred fifty

1 per cent of the federal poverty guidelines, as a child under the age of six  
2 years and whose family income does not exceed one hundred thirty-three per  
3 cent of the federal poverty guidelines or as children who have not attained  
4 nineteen years of age and whose family income does not exceed one hundred per  
5 cent of the federal poverty guidelines.

6 (iii) Under twenty-one years of age and who was in the custody of the  
7 department of economic security pursuant to title 8, chapter 5 or 10 when the  
8 person became eighteen years of age.

9 (iv) Defined as eligible pursuant to section 36-2901.01.

10 (v) Defined as eligible pursuant to section 36-2901.04.

11 (vi) **DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901.07.**

12 (b) A full-time officer or employee of this state or of a city, town  
13 or school district of this state or other person who is eligible for  
14 hospitalization and medical care under title 38, chapter 4, article 4.

15 (c) A full-time officer or employee of any county in this state or  
16 other persons authorized by the county to participate in county medical care  
17 and hospitalization programs if the county in which such officer or employee  
18 is employed has authorized participation in the system by resolution of the  
19 county board of supervisors.

20 (d) An employee of a business within this state.

21 (e) A dependent of an officer or employee who is participating in the  
22 system.

23 (f) Not enrolled in the Arizona long-term care system pursuant to  
24 article 2 of this chapter.

25 (g) Defined as eligible pursuant to section 1902(a)(10)(A)(ii)(XV) and  
26 (XVI) of title XIX of the social security act and who meets the income  
27 requirements of section 36-2929.

28 7. "Graduate medical education" means a program, including an approved  
29 fellowship, that prepares a physician for the independent practice of  
30 medicine by providing didactic and clinical education in a medical discipline  
31 to a medical student who has completed a recognized undergraduate medical  
32 education program.

33 8. "Malice" means evil intent and outrageous, oppressive or  
34 intolerable conduct that creates a substantial risk of tremendous harm to  
35 others.

36 9. "Member" means an eligible person who enrolls in the system.

37 10. **"MODIFIED ADJUSTED GROSS INCOME" HAS THE SAME MEANING PRESCRIBED IN**  
38 **42 UNITED STATES CODE SECTION 1396a(e)(14).**

39 ~~10-~~ 11. "Noncontracting provider" means a person who provides health  
40 care to members pursuant to this article but not pursuant to a subcontract  
41 with a contractor.

42 ~~11-~~ 12. "Physician" means a person licensed pursuant to title 32,  
43 chapter 13 or 17.

44 ~~12-~~ 13. "Prepaid capitated" means a mode of payment by which a health  
45 care contractor directly delivers health care services for the duration of a

1 contract to a maximum specified number of members based on a fixed rate per  
2 member notwithstanding:

3 (a) The actual number of members who receive care from the contractor.

4 (b) The amount of health care services provided to any member.

5 ~~13-~~ 14. "Primary care physician" means a physician who is a family  
6 practitioner, general practitioner, pediatrician, general internist, or  
7 obstetrician or gynecologist.

8 ~~14-~~ 15. "Primary care practitioner" means a nurse practitioner  
9 certified pursuant to title 32, chapter 15 or a physician assistant certified  
10 pursuant to title 32, chapter 25. This paragraph does not expand the scope  
11 of practice for nurse practitioners as defined pursuant to title 32, chapter  
12 15, or for physician assistants as defined pursuant to title 32, chapter 25.

13 ~~15-~~ 16. "Section 1115 waiver" means the research and demonstration  
14 waiver granted by the United States department of health and human services.

15 ~~16-~~ 17. "Special health care district" means a special health care  
16 district organized pursuant to title 48, chapter 31.

17 ~~17-~~ 18. "State plan" has the same meaning prescribed in section  
18 36-2931.

19 ~~18-~~ 19. "System" means the Arizona health care cost containment system  
20 established by this article.

21 Sec. 7. Title 36, chapter 29, article 1, Arizona Revised Statutes, is  
22 amended by adding sections 36-2901.07, 36-2901.08 and 36-2901.09, to read:

23 36-2901.07. Definition of eligible person; conditional  
24 eligibility

25 A. BEGINNING JANUARY 1, 2014, FOR THE PURPOSES OF SECTION 36-2901,  
26 "ELIGIBLE PERSON" INCLUDES A PERSON WHO IS ELIGIBLE PURSUANT TO 42 UNITED  
27 STATES CODE SECTION 1396a(a)(10)(A)(i)(VIII) AND WHOSE HOUSEHOLD'S MODIFIED  
28 ADJUSTED GROSS INCOME IS MORE THAN ONE HUNDRED PER CENT BUT EQUAL TO OR LESS  
29 THAN ONE HUNDRED THIRTY-THREE PER CENT OF THE FEDERAL POVERTY GUIDELINES.

30 B. THE ADMINISTRATION SHALL DISCONTINUE ELIGIBILITY FOR A PERSON WHO  
31 IS ELIGIBLE PURSUANT TO SUBSECTION A OF THIS SECTION IF THE FEDERAL MEDICAL  
32 ASSISTANCE PERCENTAGE ESTABLISHED PURSUANT TO 42 UNITED STATES CODE SECTION  
33 1396d(y) OR 1396d(z) IS LESS THAN EIGHTY PER CENT.

34 C. THE ADMINISTRATION SHALL DISCONTINUE ELIGIBILITY FOR PERSONS WHO  
35 ARE ELIGIBLE PURSUANT TO SUBSECTION A OF THIS SECTION IF THE MAXIMUM AMOUNT  
36 THAT CAN BE ASSESSED UNDER SECTION 36-2901.08 WITHOUT CAUSING A REDUCTION IN  
37 FEDERAL FINANCIAL PARTICIPATION, IN COMBINATION WITH THE MONIES SPECIFIED IN  
38 SECTION 36-2901.09 AND ANY OTHER MONIES APPROPRIATED FOR THE COSTS OF THIS  
39 SECTION AND SECTION 36-2901.01, IS INSUFFICIENT TO COVER THOSE COSTS.

40 36-2901.08. Hospital assessment

41 A. THE DIRECTOR SHALL ESTABLISH, ADMINISTER AND COLLECT AN ASSESSMENT  
42 ON HOSPITAL REVENUES OR BED DAYS FOR THE PURPOSE OF FUNDING THE NONFEDERAL  
43 SHARE OF THE COSTS THAT ARE INCURRED BEGINNING JANUARY 1, 2014 OF ELIGIBILITY  
44 FOR PERSONS WHO ARE DEFINED AS ELIGIBLE PURSUANT TO SECTIONS 36-2901.01 AND  
45 36-2901.07.

1 B. THE DIRECTOR SHALL ADOPT RULES REGARDING THE METHOD FOR DETERMINING  
2 THE ASSESSMENT, THE AMOUNT OR RATE OF THE ASSESSMENT, AND MODIFICATIONS OR  
3 EXEMPTIONS FROM THE ASSESSMENT. THE ASSESSMENT IS SUBJECT TO APPROVAL BY THE  
4 FEDERAL GOVERNMENT TO ENSURE THAT THE ASSESSMENT IS NOT ESTABLISHED OR  
5 ADMINISTERED IN A MANNER THAT CAUSES A REDUCTION IN FEDERAL FINANCIAL  
6 PARTICIPATION.

7 C. THE DIRECTOR MAY ESTABLISH MODIFICATIONS OR EXEMPTIONS TO THE  
8 ASSESSMENT. IN DETERMINING THE MODIFICATIONS OR EXEMPTIONS, THE DIRECTOR MAY  
9 CONSIDER FACTORS INCLUDING THE SIZE OF THE HOSPITAL, THE SPECIALTY SERVICES  
10 AVAILABLE TO PATIENTS AND THE GEOGRAPHIC LOCATION OF THE HOSPITAL.

11 D. BEFORE IMPLEMENTING THE ASSESSMENT, AND ANNUALLY THEREAFTER IF THE  
12 METHODOLOGY IS MODIFIED, THE DIRECTOR SHALL PRESENT THE METHODOLOGY TO THE  
13 JOINT LEGISLATIVE BUDGET COMMITTEE FOR REVIEW.

14 E. THE ADMINISTRATION SHALL NOT COLLECT AN ASSESSMENT FOR COSTS  
15 ASSOCIATED WITH SERVICE AFTER THE EFFECTIVE DATE OF ANY REDUCTION OF THE  
16 FEDERAL MEDICAL ASSISTANCE PERCENTAGE ESTABLISHED BY 42 UNITED STATES CODE  
17 SECTION 1396d(y) OR 1396d(z) TO LESS THAN EIGHTY PER CENT.

18 F. THE ADMINISTRATION SHALL DEPOSIT THE REVENUES COLLECTED PURSUANT TO  
19 THIS SECTION IN THE HOSPITAL ASSESSMENT FUND ESTABLISHED BY SECTION  
20 36-2901.09.

21 G. A HOSPITAL SHALL NOT PASS THE COST OF THE ASSESSMENT ON TO PATIENTS  
22 OR THIRD-PARTY PAYORS THAT ARE LIABLE TO PAY FOR CARE ON A PATIENT'S BEHALF.  
23 AS PART OF ITS FINANCIAL STATEMENT SUBMISSIONS PURSUANT TO SECTION 36-125.04,  
24 A HOSPITAL SHALL SUBMIT TO THE DEPARTMENT OF HEALTH SERVICES AN ATTESTATION  
25 THAT IT HAS NOT PASSED ON THE COST OF THE ASSESSMENT TO PATIENTS OR  
26 THIRD-PARTY PAYORS.

27 H. IF A HOSPITAL DOES NOT COMPLY WITH THIS SECTION AS PRESCRIBED BY  
28 THE DIRECTOR, THE DIRECTOR MAY SUSPEND OR REVOKE THE HOSPITAL'S ARIZONA  
29 HEALTH CARE COST CONTAINMENT SYSTEM PROVIDER AGREEMENT REGISTRATION. IF THE  
30 HOSPITAL DOES NOT COMPLY WITHIN ONE HUNDRED EIGHTY DAYS AFTER THE DIRECTOR  
31 SUSPENDS OR REVOKES THE HOSPITAL'S PROVIDER AGREEMENT, THE DIRECTOR SHALL  
32 NOTIFY THE DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES, WHO SHALL SUSPEND  
33 OR REVOKE THE HOSPITAL'S LICENSE PURSUANT TO SECTION 36-427.

34 36-2901.09. Hospital assessment fund

35 A. THE HOSPITAL ASSESSMENT FUND IS ESTABLISHED CONSISTING OF MONIES  
36 COLLECTED PURSUANT TO SECTION 36-2901.08. THE DIRECTOR SHALL ADMINISTER THE  
37 FUND.

38 B. THE DIRECTOR SHALL USE FUND MONIES ONLY AS NECESSARY TO SUPPLEMENT  
39 MONIES IN THE PROPOSITION 204 PROTECTION ACCOUNT ESTABLISHED BY SECTION  
40 36-778 AND THE ARIZONA TOBACCO LITIGATION SETTLEMENT FUND ESTABLISHED BY  
41 SECTION 36-2901.02.

42 C. MONIES IN THE FUND:

- 43 1. DO NOT REVERT TO THE STATE GENERAL FUND.

1           2. ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190 RELATING TO  
2 LAPSING OF APPROPRIATIONS.

3           3. ARE CONTINUOUSLY APPROPRIATED.

4           Sec. 8. Section 36-2903.01, Arizona Revised Statutes, is amended to  
5 read:

6           36-2903.01. Additional powers and duties: report

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

13           B. The director shall:

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

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

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

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

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

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

34           (d) Establish eligibility quality control reviews by the  
35 administration.

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

40           (f) Establish the department's responsibility to place sufficient  
41 eligibility workers at federally qualified health centers to screen for  
42 eligibility and at hospital sites and level one trauma centers to ensure that  
43 persons seeking hospital services are screened on a timely basis for  
44 eligibility for the system, including a process to ensure that applications

1 for the system can be accepted on a twenty-four hour basis, seven days a  
2 week.

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

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

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

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

44 6. At least thirty days before the implementation of a policy or a  
45 change to an existing policy relating to reimbursement, provide notice to

1 interested parties. Parties interested in receiving notification of policy  
2 changes shall submit a written request for notification to the  
3 administration.

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

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

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

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

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

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

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

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

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

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

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

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

6 (h) Well exams are not a covered health and medical service, except  
7 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. 10. Section 41-1005, Arizona Revised Statutes, is amended to  
10 read:

11 41-1005. Exemptions

12 A. This chapter does not apply to any:

13 1. Rule that relates to the use of public works, including streets and  
14 highways, under the jurisdiction of an agency if the effect of the order is  
15 indicated to the public by means of signs or signals.

16 2. Order of the Arizona game and fish commission that opens, closes or  
17 alters seasons or establishes bag or possession limits for wildlife.

18 3. Rule relating to section 28-641 or to any rule regulating motor  
19 vehicle operation that relates to speed, parking, standing, stopping or  
20 passing enacted pursuant to title 28, chapter 3.

21 4. Rule concerning only the internal management of an agency that does  
22 not directly and substantially affect the procedural or substantive rights or  
23 duties of any segment of the public.

24 5. Rule that only establishes specific prices to be charged for  
25 particular goods or services sold by an agency.

26 6. Rule concerning only the physical servicing, maintenance or care of  
27 agency owned or operated facilities or property.

28 7. Rule or substantive policy statement concerning inmates or  
29 committed youths of a correctional or detention facility in secure custody or  
30 patients admitted to a hospital, if made by the state department of  
31 corrections, the department of juvenile corrections, the board of executive  
32 clemency or the department of health services or a facility or hospital under  
33 the jurisdiction of the state department of corrections, the department of  
34 juvenile corrections or the department of health services.

35 8. Form whose contents or substantive requirements are prescribed by  
36 rule or statute, and instructions for the execution or use of the form.

37 9. Capped fee-for-service schedule adopted by the Arizona health care  
38 cost containment system administration pursuant to title 36, chapter 29.

39 10. Fees prescribed by section 6-125.

40 11. Order of the director of water resources adopting or modifying a  
41 management plan pursuant to title 45, chapter 2, article 9.

42 12. Fees established under section 3-1086.

43 13. Fee-for-service schedule adopted by the department of economic  
44 security pursuant to section 8-512.

45 14. Fees established under sections 41-2144 and 41-2189.

- 1 15. Rule or other matter relating to agency contracts.
- 2 16. Fees established under section 32-2067 or 32-2132.
- 3 17. Rules made pursuant to section 5-111, subsection A.
- 4 18. Rules made by the Arizona state parks board concerning the  
5 operation of the Tonto natural bridge state park, the facilities located in  
6 the Tonto natural bridge state park and the entrance fees to the Tonto  
7 natural bridge state park.
- 8 19. Fees or charges established under section 41-511.05.
- 9 20. Emergency medical services protocols except as provided in section  
10 36-2205, subsection B.
- 11 21. Fee schedules established pursuant to section 36-3409.
- 12 22. Procedures of the state transportation board as prescribed in  
13 section 28-7048.
- 14 23. Rules made by the state department of corrections.
- 15 24. Fees prescribed pursuant to section 32-1527.
- 16 25. Rules made by the department of economic security pursuant to  
17 section 46-805.
- 18 26. Schedule of fees prescribed by section 23-908.
- 19 27. Procedure that is established pursuant to title 23, chapter 6,  
20 article ~~5~~ or 6.
- 21 28. Rules, administrative policies, procedures and guidelines adopted  
22 for any purpose by the Arizona commerce authority pursuant to chapter 10 of  
23 this title if the authority provides, as appropriate under the circumstances,  
24 for notice of an opportunity for comment on the proposed rules,  
25 administrative policies, procedures and guidelines.
- 26 29. Rules made by a marketing commission or marketing committee  
27 pursuant to section 3-414.
- 28 30. Administration of public assistance program monies authorized for  
29 liabilities that are incurred for disasters declared pursuant to sections  
30 26-303 and 35-192.
- 31 31. User charges, tolls, fares, rents, advertising and sponsorship  
32 charges, services charges or similar charges established pursuant to section  
33 28-7705.
- 34 32. ADMINISTRATION AND IMPLEMENTATION OF THE HOSPITAL ASSESSMENT  
35 PURSUANT TO SECTION 36-2901.08, EXCEPT THAT THE ARIZONA HEALTH CARE COST  
36 CONTAINMENT SYSTEM ADMINISTRATION MUST PROVIDE NOTICE AND AN OPPORTUNITY FOR  
37 PUBLIC COMMENT AT LEAST THIRTY DAYS BEFORE ESTABLISHING OR IMPLEMENTING THE  
38 ADMINISTRATION OF THE ASSESSMENT.
- 39 B. Notwithstanding subsection A, paragraph 22 of this section, at such  
40 time as the federal highway administration authorizes the privatization of  
41 rest areas, the state transportation board shall make rules governing the  
42 lease or license by the department of transportation to a private entity for  
43 the purposes of privatization of a rest area.
- 44 C. Coincident with the making of a final rule pursuant to an exemption  
45 from the applicability of this chapter under this section, another statute or

1 session law, the agency shall file a copy of the rule with the secretary of  
2 state for publication pursuant to section 41-1012 and provide a copy to the  
3 council.

4 D. Unless otherwise required by law, articles 2, 3, 4 and 5 of this  
5 chapter do not apply to the Arizona board of regents and the institutions  
6 under its jurisdiction, except that the Arizona board of regents shall make  
7 policies or rules for the board and the institutions under its jurisdiction  
8 that provide, as appropriate under the circumstances, for notice of and  
9 opportunity for comment on the policies or rules proposed.

10 E. Unless otherwise required by law, articles 2, 3, 4 and 5 of this  
11 chapter do not apply to the Arizona state schools for the deaf and the blind,  
12 except that the board of directors of all the state schools for the deaf and  
13 the blind shall adopt policies for the board and the schools under its  
14 jurisdiction that provide, as appropriate under the circumstances, for notice  
15 of and opportunity for comment on the policies proposed for adoption.

16 F. Unless otherwise required by law, articles 2, 3, 4 and 5 of this  
17 chapter do not apply to the state board of education, except that the state  
18 board of education shall adopt policies or rules for the board and the  
19 institutions under its jurisdiction that provide, as appropriate under the  
20 circumstances, for notice of and opportunity for comment on the policies or  
21 rules proposed for adoption. In order to implement or change any rule, the  
22 state board of education shall provide at least two opportunities for public  
23 comment.

24 Sec. 11. Laws 2011, chapter 234, section 2 is amended to read:

25 Sec. 2. AHCCCS; political subdivisions; coverage; definition;  
26 delayed repeal

27 A. The Arizona health care cost containment system administration,  
28 subject to the approval of the centers for medicare and medicaid services and  
29 pursuant to section 36-2903, subsection B, paragraph 1, Arizona Revised  
30 Statutes, may authorize any political subdivision of this state to provide  
31 monies necessary to qualify for federal matching monies in order to provide  
32 health care coverage to persons who would have been eligible pursuant to  
33 section 36-2901.01, Arizona Revised Statutes, if additional general fund  
34 monies were otherwise available. Health care coverage shall be offered only  
35 through providers or health plans that are designated by the political  
36 subdivision. A political subdivision may limit health care coverage provided  
37 pursuant to this section.

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

43 C. This section is repealed from and after ~~September 30~~ DECEMBER 31,  
44 2013.

1           Sec. 12. ALTCs; county contributions; fiscal year 2013-2014

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

5	1. Apache	\$ 613,500
6	2. Cochise	\$ 5,179,900
7	3. Coconino	\$ 1,841,200
8	4. Gila	\$ 2,126,000
9	5. Graham	\$ 1,427,300
10	6. Greenlee	\$ 128,800
11	7. La Paz	\$ 691,300
12	8. Maricopa	\$149,698,100
13	9. Mohave	\$ 7,952,700
14	10. Navajo	\$ 2,538,600
15	11. Pima	\$ 39,129,200
16	12. Pinal	\$ 15,246,800
17	13. Santa Cruz	\$ 1,908,200
18	14. Yavapai	\$ 8,382,500
19	15. Yuma	\$ 7,832,000

20           B. If the overall cost for the Arizona long-term care system exceeds  
21 the amount specified in the general appropriations act for fiscal year  
22 2013-2014, the state treasurer shall collect from the counties the difference  
23 between the amount specified in subsection A of this section and the  
24 counties' share of the state's actual contribution. The counties' share of  
25 the state contribution shall be in compliance with any federal maintenance of  
26 effort requirements. The director of the Arizona health care cost  
27 containment system administration shall notify the state treasurer of the  
28 counties' share of the state's contribution and report the amount to the  
29 director of the joint legislative budget committee. The state treasurer  
30 shall withhold from any other monies payable to that county from whatever  
31 state funding source is available an amount necessary to fulfill that  
32 county's requirement specified in this subsection. The state treasurer shall  
33 not withhold distributions from the highway user revenue fund pursuant to  
34 title 28, chapter 18, article 2, Arizona Revised Statutes. The state  
35 treasurer shall deposit the amounts withheld pursuant to this subsection and  
36 amounts paid pursuant to subsection A of this section in the long-term care  
37 system fund established by section 36-2913, Arizona Revised Statutes.

38           Sec. 13. Sexually violent persons; county reimbursement; fiscal  
39 year 2013-2014; deposit; tax distribution  
40 withholding

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

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

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

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

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

21 Sec. 14. Competency restoration treatment; city and county  
22 reimbursement; fiscal year 2013-2014; deposit; tax  
23 distribution withholding

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

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

33 C. Each city and county shall make the reimbursements for these costs  
34 as specified in subsection A of this section within thirty days after a  
35 request by the department of health services. If the city or county does not  
36 make the reimbursement, the superintendent of the Arizona state hospital  
37 shall notify the state treasurer of the amount owed and the treasurer shall  
38 withhold the amount, including any additional interest as provided in section  
39 42-1123, Arizona Revised Statutes, from any transaction privilege tax  
40 distributions to the city or county. The treasurer shall deposit the  
41 withholdings, pursuant to sections 35-146 and 35-147, Arizona Revised  
42 Statutes, in the Arizona state hospital fund established by section  
43 36-545.08, Arizona Revised Statutes.

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

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

7 Sec. 15. AHCCCS; disproportionate share payments

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

11 1. \$89,877,700 for a qualifying nonstate operated public hospital:

12 (a) The Maricopa county special health care district shall provide a  
13 certified public expense form for the amount of qualifying disproportionate  
14 share hospital expenditures made on behalf of this state to the  
15 administration on or before May 1, 2014 for all state plan years as required  
16 by the Arizona health care cost containment system 1115 waiver standard terms  
17 and conditions. The administration shall assist the district in determining  
18 the amount of qualifying disproportionate share hospital expenditures. Once  
19 the administration files a claim with the federal government and receives  
20 federal funds participation based on the amount certified by the Maricopa  
21 county special health care district, if the certification is equal to or  
22 greater than \$89,877,700, and the administration determines that the revised  
23 amount is correct pursuant to the methodology used by the administration  
24 pursuant to section 36-2903.01, Arizona Revised Statutes, the administration  
25 shall notify the governor, the president of the senate and the speaker of the  
26 house of representatives, shall distribute \$4,202,300 to the Maricopa county  
27 special health care district and shall deposit the balance of the federal  
28 funds participation in the state general fund. If the certification provided  
29 is for an amount greater than \$89,877,700 and the administration determines  
30 that the revised amount is not correct pursuant to the methodology used by  
31 the administration pursuant to section 36-2903.01, Arizona Revised Statutes,  
32 the administration shall notify the governor, the president of the senate and  
33 the speaker of the house of representatives and shall deposit the total  
34 amount of the federal funds participation in the state general fund. Except  
35 as provided in subdivision (b) of this paragraph, the disproportionate share  
36 hospital payment attributed to the Maricopa county special health care  
37 district shall not exceed \$89,877,700.

38 (b) To the extent there remains available qualifying disproportionate  
39 share hospital payment authority after safety net care pool payments are  
40 made, the Maricopa county special health care district shall provide a  
41 certified public expense form for the amount and the administration shall  
42 deposit the amount of the federal funds participation in excess of  
43 \$89,877,700 in the state general fund.

44 2. \$26,724,700 for the Arizona state hospital. The Arizona state  
45 hospital shall provide a certified public expense form for the amount of

1 qualifying disproportionate share hospital expenditures made on behalf of the  
2 state to the administration on or before March 31, 2014. The administration  
3 shall assist the Arizona state hospital in determining the amount of  
4 qualifying disproportionate share hospital expenditures. Once the  
5 administration files a claim with the federal government and receives federal  
6 funds participation based on the amount certified by the Arizona state  
7 hospital, the administration shall distribute the entire amount of federal  
8 financial participation to the state general fund. If the certification  
9 provided is for an amount less than \$26,724,700, the administration shall  
10 notify the governor, the president of the senate and the speaker of the house  
11 of representatives and shall distribute the entire amount of federal  
12 financial participation to the state general fund. The certified public  
13 expense form provided by the Arizona state hospital shall contain both the  
14 total amount of qualifying disproportionate share hospital expenditures and  
15 the amount limited by section 1923(g) of the social security act.

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

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

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

25 B. Disproportionate share payments in fiscal year 2013-2014 made  
26 pursuant to section 36-2903.01, subsection 0, Arizona Revised Statutes,  
27 include amounts for disproportionate share hospitals designated by political  
28 subdivisions of this state, tribal governments and any university under the  
29 jurisdiction of the Arizona board of regents. Contingent on approval by the  
30 administration and the centers for medicare and medicaid services, any amount  
31 of federal funding allotted to this state pursuant to section 1923(f) of the  
32 social security act and not otherwise expended under subsection A, paragraph  
33 1, 2 or 3 of this section shall be made available for distribution pursuant  
34 to this subsection. Political subdivisions of this state, tribal governments  
35 and any university under the jurisdiction of the Arizona board of regents may  
36 designate hospitals eligible to receive disproportionate share funds in an  
37 amount up to the limit prescribed in section 1923(g) of the social security  
38 act if those political subdivisions, tribal governments or universities  
39 provide sufficient monies to qualify for the matching federal monies for the  
40 disproportionate share payments.

41 Sec. 16. AHCCCS transfer; counties; federal monies

42 On or before December 31, 2014, notwithstanding any other law, for  
43 fiscal year 2013-2014 the Arizona health care cost containment system  
44 administration shall transfer to the counties such portion, if any, as may be  
45 necessary to comply with section 10201(c)(6) of the patient protection and

1 affordable care act (P.L. 111-148), regarding the counties' proportional  
2 share of the state's contribution.

3 Sec. 17. County acute care contribution: fiscal year 2013-2014

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

7	1. Apache	\$ 268,800
8	2. Cochise	\$ 2,214,800
9	3. Coconino	\$ 742,900
10	4. Gila	\$ 1,413,200
11	5. Graham	\$ 536,200
12	6. Greenlee	\$ 190,700
13	7. La Paz	\$ 212,100
14	8. Maricopa	\$19,820,700
15	9. Mohave	\$ 1,237,700
16	10. Navajo	\$ 310,800
17	11. Pima	\$14,951,800
18	12. Pinal	\$ 2,715,600
19	13. Santa Cruz	\$ 482,800
20	14. Yavapai	\$ 1,427,800
21	15. Yuma	\$ 1,325,100

22 B. If a county does not provide funding as specified in subsection A  
23 of this section, the state treasurer shall subtract the amount owed by the  
24 county to the Arizona health care cost containment system fund and the  
25 long-term care system fund established by section 36-2913, Arizona Revised  
26 Statutes, from any payments required to be made by the state treasurer to  
27 that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona  
28 Revised Statutes, plus interest on that amount pursuant to section 44-1201,  
29 Arizona Revised Statutes, retroactive to the first day the funding was due.  
30 If the monies the state treasurer withholds are insufficient to meet that  
31 county's funding requirements as specified in subsection A of this section,  
32 the state treasurer shall withhold from any other monies payable to that  
33 county from whatever state funding source is available an amount necessary to  
34 fulfill that county's requirement. The state treasurer shall not withhold  
35 distributions from the highway user revenue fund pursuant to title 28,  
36 chapter 18, article 2, Arizona Revised Statutes.

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

43 D. The state treasurer shall deposit the amounts paid pursuant to  
44 subsection C of this section and amounts withheld pursuant to subsection B of  
45 this section in the Arizona health care cost containment system fund and the

1 long-term care system fund established by section 36-2913, Arizona Revised  
2 Statutes.

3 E. If payments made pursuant to subsection C of this section exceed  
4 the amount required to meet the costs incurred by the Arizona health care  
5 cost containment system for the hospitalization and medical care of those  
6 persons defined as an eligible person pursuant to section 36-2901, paragraph  
7 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of  
8 the Arizona health care cost containment system administration may instruct  
9 the state treasurer either to reduce remaining payments to be paid pursuant  
10 to this section by a specified amount or to provide to the counties specified  
11 amounts from the Arizona health care cost containment system fund and the  
12 long-term care system fund.

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

18 Sec. 18. Hospitalization and medical care contribution; fiscal  
19 year 2013-2014

20 A. Notwithstanding any other law, for fiscal year 2013-2014, beginning  
21 with the second monthly distribution of transaction privilege tax revenues,  
22 the state treasurer shall withhold one-eleventh of the following amounts from  
23 state transaction privilege tax revenues otherwise distributable, after any  
24 amounts withheld for the county long-term care contribution or the county  
25 administration contribution pursuant to section 11-292, subsection 0, Arizona  
26 Revised Statutes, for deposit in the Arizona health care cost containment  
27 system fund established by section 36-2913, Arizona Revised Statutes, for the  
28 provision of hospitalization and medical care:

29	1. Apache	\$ 87,300
30	2. Cochise	\$ 162,700
31	3. Coconino	\$ 160,500
32	4. Gila	\$ 65,900
33	5. Graham	\$ 46,800
34	6. Greenlee	\$ 12,000
35	7. La Paz	\$ 24,900
36	8. Mohave	\$ 187,400
37	9. Navajo	\$ 122,800
38	10. Pima	\$1,115,900
39	11. Pinal	\$ 218,300
40	12. Santa Cruz	\$ 51,600
41	13. Yavapai	\$ 206,200
42	14. Yuma	\$ 183,900

43 B. If the monies the state treasurer withholds are insufficient to  
44 meet that county's funding requirement as specified in subsection A of this  
45 section, the state treasurer shall withhold from any other monies payable to

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

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

8 D. In fiscal year 2013-2014, the sum of \$2,646,200 withheld pursuant  
9 to subsection A of this section is allocated for the county acute care  
10 contribution for the provision of hospitalization and medical care services  
11 administered by the Arizona health care cost containment system  
12 administration.

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

15 Sec. 19. Proposition 204 administration; county expenditure  
16 limitation

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

21 Sec. 20. AHCCCS; risk contingency rate setting

22 Notwithstanding any other law, for the contract year beginning  
23 October 1, 2013 and ending September 30, 2014, the Arizona health care cost  
24 containment system administration may continue the risk contingency rate  
25 setting for all managed care organizations and the funding for all managed  
26 care organizations administrative funding levels that was imposed for the  
27 contract year beginning October 1, 2010 and ending September 30, 2011.

28 Sec. 21. AHCCCS; ambulance services; reimbursement

29 For dates of service on and after October 1, 2013 through September 30,  
30 2014, the Arizona health care cost containment system administration and its  
31 contractors shall reimburse ambulance service providers in an amount equal to  
32 68.59 per cent of the amounts prescribed by the department of health  
33 services.

34 Sec. 22. AHCCCS; social security administration; medicare  
35 liability waiver

36 The Arizona health care cost containment system may participate in any  
37 special disability workload 1115 demonstration waiver offered by the centers  
38 for medicare and medicaid services. Any credits provided by the 1115  
39 demonstration waiver process are to be used in the fiscal year when those  
40 credits are made available to fund the state share of any medical assistance  
41 expenditures that qualify for federal financial participation under the  
42 medicaid program. The Arizona health care cost containment system  
43 administration shall report the receipt of any credits to the director of the  
44 joint legislative budget committee on or before December 31, 2013 and June  
45 30, 2014.



1           Sec. 28. AHCCCS; emergency department use; report

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

7           Sec. 29. Child welfare; report; accountability factors

8           On or before September 1, 2013, the director of the joint legislative  
9 budget committee, the director of the governor's office of strategic planning  
10 and budgeting and the director of the department of economic security shall  
11 report to the governor, the president of the senate and the speaker of the  
12 house of representatives recommendations for consolidating into one  
13 comprehensive report the child welfare report required by section 8-526,  
14 Arizona Revised Statutes, the financial and program accountability report for  
15 child protective services required by section 8-818, Arizona Revised  
16 Statutes, the monthly reports required by Laws 2013, chapter 1, section 1 and  
17 other child welfare reports prepared by the department. The report shall  
18 consider the frequency of reporting as part of the recommendations. The  
19 joint legislative budget committee, the governor's office of strategic  
20 planning and budgeting and the department of economic security may solicit  
21 input from stakeholder groups for the report. The report shall also address  
22 the merit of adding the following accountability factors:

- 23           1. The average duration of time from when a child enters emergency and  
24 residential placement to the initial court case associated with that child.
- 25           2. The number of children moved from emergency and residential  
26 placement to foster care, delineated by major age groupings.
- 27           3. The number of child protective services staff hired or leaving by  
28 type, specifically the caseworkers' classification level from one through  
29 four.
- 30           4. The number of new and closed foster care receiving homes, including  
31 the total available placements by age groupings of infants, children who are  
32 one through five years of age, children who are six through twelve years of  
33 age and teen children who are twelve through eighteen years of age.
- 34           5. Cohort and behavioral health data.

35           Sec. 30. Auditor general; children support services reports

36           A. The auditor general shall provide to the governor, the speaker of  
37 the house of representatives, the president of the senate and the directors  
38 of the joint legislative budget committee and the governor's office of  
39 strategic planning and budgeting the following reports on the expenditure of  
40 monies for children support services in the department of economic security.  
41 The reports shall address:

- 42           1. Expenditures for the recruitment, retention, training, licensing  
43 and tracking of foster care families as part of children support services.  
44 This report shall address whether the department of economic security's  
45 current contract process of home recruitment study and supervision is the

1 most appropriate means to provide these services. The report also shall  
2 address the best performance measures to evaluate the effectiveness of these  
3 services.

4 2. Expenditures for transportation as part of children support  
5 services. This report shall describe the types of funded services provided  
6 along with cost details for those services. The report also shall address  
7 the best performance measures to evaluate the effectiveness of these  
8 services.

9 3. Expenditures in the emergency and residential placement special  
10 line item. This report shall describe the reasons for the high usage of  
11 emergency and residential placements, as opposed to foster homes. The report  
12 also shall address possible methods to reduce the use of emergency and  
13 residential placements in the future.

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

17 Sec. 31. Arizona health care cost containment system; hospital  
18 work groups

19 The Arizona health care cost containment system administration shall  
20 establish work groups to study and provide input on the development of the  
21 hospital assessment established pursuant to this act. The work groups shall  
22 include, at a minimum, representatives from the urban, rural and critical  
23 access hospital communities.

24 Sec. 32. Arizona health care cost containment system; cost  
25 sharing; exemption from rule making

26 A. The Arizona health care cost containment system administration  
27 shall pursue cost sharing requirements for members to the maximum extent  
28 allowed under federal law.

29 B. For the purposes of implementing cost sharing pursuant to  
30 subsection A of this section, the Arizona health care cost containment system  
31 administration is exempt from the rule making requirements of title 41,  
32 chapter 6, Arizona Revised Statutes, for one year after the effective date of  
33 this act.

34 Sec. 33. Hospital transparency; report

35 On or before January 1, 2014, the director of the Arizona health care  
36 cost containment system administration and the director of the department of  
37 health services shall submit a joint report on hospital charge master  
38 transparency to the governor, speaker of the house of representatives and the  
39 president of the senate and shall provide a copy to the secretary of state.  
40 The report shall provide a summary of the current charge master reporting  
41 process, a summary of hospital billed charges compared to costs and examples  
42 of how charge masters or hospital prices are reported and used in other  
43 states. The report shall include recommendations to improve the state's use  
44 of hospital charge master information, including reporting and oversight  
45 changes.



1 (c) Health care providers.

2 C. On or before October 1, 2014, the committee shall submit to the  
3 governor, the president of the senate and the speaker of the house of  
4 representatives a report of its findings and recommendations to address each  
5 of the impacts described in subsection B of this section. The committee  
6 shall provide a copy of its report to the secretary of state.

7 D. This section is repealed from and after December 31, 2014.

8 Sec. 36. AHCCCS uncompensated care; provider assessment;  
9 reports; delayed repeal

10 A. On or before October 1, 2013, and annually thereafter, the Arizona  
11 health care cost containment system administration shall report to the  
12 speaker of the house of representatives, the president of the senate and the  
13 directors of the joint legislative budget committee and governor's office of  
14 strategic planning and budgeting on the change in uncompensated hospital  
15 costs experienced by Arizona hospitals during the previous fiscal year.

16 B. On or before August 1, 2014, and annually thereafter, the Arizona  
17 health care cost containment system administration shall report to the  
18 speaker of the house of representatives, the president of the senate and the  
19 directors of the joint legislative budget committee and governor's office of  
20 strategic planning and budgeting the amount each hospital contributed for the  
21 provider assessment authorized pursuant to section 36-2901.08, Arizona  
22 Revised Statutes, as added by this act, in the previous fiscal year.

23 C. This section is repealed from and after January 1, 2018.

24 Sec. 37. Exemption from rule making

25 For the purposes of implementing the provisions of this act, the  
26 department of health services is exempt from the rule making requirements of  
27 title 41, chapter 6, Arizona Revised Statutes, for one year after the  
28 effective date of this act.

29 Sec. 38. Intent; hospital assessment

30 It is the intent of the legislature that:

31 1. The requirement that the hospital assessment established pursuant  
32 to section 36-2901.08, Arizona Revised Statutes, as added by this act, be  
33 subject to approval by the federal government does not adopt federal law by  
34 reference.

35 2. The requirement that the director of the Arizona health care cost  
36 containment system administration establish a hospital assessment pursuant to  
37 section 36-2901.08, Arizona Revised Statutes, as added by this act, does not  
38 delegate legislative taxing authority to the administration, and the director  
39 must impose the assessment in accordance with clear guidance as provided in  
40 this act.

41 Sec. 39. Intent; implementation of program

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

1           Sec. 40. 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. 41. 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.

10          Sec. 42. AHCCCS; department of health services; expenditure  
11                   authority; fiscal year 2013-2014

12          A. In addition to any other appropriations made in fiscal year  
13 2013-2014 to the Arizona health care cost containment system, sufficient  
14 monies from expenditure authority are appropriated to the Arizona health care  
15 cost containment system for the purposes of implementing section 36-2901.01,  
16 Arizona Revised Statutes, and section 36-2901.07, Arizona Revised Statutes,  
17 as added by this act.

18          B. In addition to any other appropriations made in fiscal year  
19 2013-2014 to the department of health services, sufficient monies from  
20 expenditure authority are appropriated to the department of health services  
21 for the purposes of implementing section 36-2901.01, Arizona Revised  
22 Statutes, and section 36-2901.07, Arizona Revised Statutes, as added by this  
23 act.

24          Sec. 43. Effective date

25          Section 9-499.15, Arizona Revised Statutes, as amended by this act, is  
26 effective from and after December 31, 2013.

27          Sec. 44. Delayed repeal

28          Sections 36-2901.07 and 36-2901.08, Arizona Revised Statutes, as added  
29 by this act, are repealed from and after December 31, 2016.

30          Sec. 45. Severability

31          If any provision or clause of sections 32-3216 and 36-437, Arizona  
32 Revised Statutes, as added by this act, or the application of these sections  
33 to any person or circumstance is held invalid, the invalidity does not affect  
34 other provisions or applications of sections 32-3216 and 36-437, Arizona  
35 Revised Statutes, as added by this act, that can be given effect without the  
36 invalid provision or application, and to this end the provisions of this act  
37 are severable.

38          Sec. 46. Delayed effective date

39          Sections 32-3216 and 36-437, Arizona Revised Statutes, as added by this  
40 act, are effective from and after December 31, 2013.

41          Sec. 47. Delayed repeal

42          Sections 32-3216 and 36-437, Arizona Revised Statutes, as added by this  
43 act, are repealed from and after December 31, 2021.