

State of Arizona  
House of Representatives  
Fifty-first Legislature  
Second Regular Session  
2014

# HOUSE BILL 2705

AN ACT

AMENDING TITLE 36, CHAPTER 1, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-108.01; AMENDING SECTION 36-2903.01, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-2903.08; AMENDING SECTIONS 36-2907, 36-2953 AND 36-3415, ARIZONA REVISED STATUTES; AMENDING LAWS 2013, FIRST SPECIAL SESSION, CHAPTER 10, SECTION 19; REPEALING LAWS 2013, FIRST SPECIAL SESSION, CHAPTER 10, SECTION 41; MAKING A TRANSFER; 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. Title 36, chapter 1, article 1, Arizona Revised Statutes,  
3 is amended by adding section 36-108.01, to read:

4 36-108.01. Department of health services intergovernmental  
5 agreement/county contributions fund; annual report

6 ON OR BEFORE OCTOBER 1, 2014, THE DIRECTORS OF THE JOINT LEGISLATIVE  
7 BUDGET COMMITTEE AND THE GOVERNOR'S OFFICE OF STRATEGIC PLANNING AND  
8 BUDGETING SHALL AGREE TO THE CONTENT AND FORMAT OF A REVENUE AND EXPENDITURE  
9 REPORT OF THE DEPARTMENT OF HEALTH SERVICES INTERGOVERNMENTAL  
10 AGREEMENT/COUNTY CONTRIBUTIONS FUND. BEGINNING NOVEMBER 1, 2014, THE  
11 DEPARTMENT OF HEALTH SERVICES SHALL REPORT ANNUALLY TO THE JOINT LEGISLATIVE  
12 BUDGET COMMITTEE ON THE REVENUES, EXPENDITURES AND ENDING BALANCES FROM THE  
13 PREVIOUS, CURRENT AND SUBSEQUENT FISCAL YEARS.

14 Sec. 2. Section 36-2903.01, Arizona Revised Statutes, is amended to  
15 read:

16 36-2903.01. Additional powers and duties; report; definition

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

23 B. The director shall:

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

30 2. Enter into an interagency agreement with the department to  
31 establish a streamlined eligibility process to determine the eligibility of  
32 all persons defined pursuant to section 36-2901, paragraph 6,  
33 subdivision (a). At the administration's option, the interagency agreement  
34 may allow the administration to determine the eligibility of certain persons,  
35 including those defined pursuant to section 36-2901, paragraph 6,  
36 subdivision (a).

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

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

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

41 (c) Establish the process for management evaluation reviews that the  
42 administration shall perform to evaluate the eligibility determination  
43 functions performed by the department.

44 (d) Establish eligibility quality control reviews by the  
45 administration.

1 (e) Require the department to adopt rules, consistent with the rules  
2 adopted by the administration for a hearing process, that applicants or  
3 members may use for appeals of eligibility determinations or  
4 redeterminations.

5 (f) Establish the department's responsibility to place sufficient  
6 eligibility workers at federally qualified health centers to screen for  
7 eligibility and at hospital sites and level one trauma centers to ensure that  
8 persons seeking hospital services are screened on a timely basis for  
9 eligibility for the system, including a process to ensure that applications  
10 for the system can be accepted on a twenty-four hour basis, seven days a  
11 week.

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

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

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

1           5. Apply for and accept federal funds available under title XIX of the  
2 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section  
3 1396 (1980)) in support of the system. The application made by the director  
4 pursuant to this paragraph shall be designed to qualify for federal funding  
5 primarily on a prepaid capitated basis. Such funds may be used only for the  
6 support of persons defined as eligible pursuant to title XIX of the social  
7 security act or the approved section 1115 waiver.

8           6. At least thirty days before the implementation of a policy or a  
9 change to an existing policy relating to reimbursement, provide notice to  
10 interested parties. Parties interested in receiving notification of policy  
11 changes shall submit a written request for notification to the  
12 administration.

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

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

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

22           C. The director is authorized to apply for any federal funds available  
23 for the support of programs to investigate and prosecute violations arising  
24 from the administration and operation of the system. Available state funds  
25 appropriated for the administration and operation of the system may be used  
26 as matching funds to secure federal funds pursuant to this subsection.

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

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

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

43           3. Deputize, in writing, any qualified officer or employee in the  
44 administration to perform any act that the director by law is empowered to do

1 or charged with the responsibility of doing, including the authority to issue  
2 final administrative decisions pursuant to section 41-1092.08.

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

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

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

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

22 1. For inpatient hospital stays from March 1, 1993 through September  
23 30, 2014, the administration shall use a prospective tiered per diem  
24 methodology, using hospital peer groups if analysis shows that cost  
25 differences can be attributed to independently definable features that  
26 hospitals within a peer group share. In peer grouping the administration may  
27 consider such factors as length of stay differences and labor market  
28 variations. If there are no cost differences, the administration shall  
29 implement a stop loss-stop gain or similar mechanism. Any stop loss-stop  
30 gain or similar mechanism shall ensure that the tiered per diem rates  
31 assigned to a hospital do not represent less than ninety per cent of its 1990  
32 base year costs or more than one hundred ten per cent of its 1990 base year  
33 costs, adjusted by an audit factor, during the period of March 1, 1993  
34 through September 30, 1994. The tiered per diem rates set for hospitals  
35 shall represent no less than eighty-seven and one-half per cent or more than  
36 one hundred twelve and one-half per cent of its 1990 base year costs,  
37 adjusted by an audit factor, from October 1, 1994 through September 30, 1995  
38 and no less than eighty-five per cent or more than one hundred fifteen per  
39 cent of its 1990 base year costs, adjusted by an audit factor, from October  
40 1, 1995 through September 30, 1996. For the periods after September 30, 1996  
41 no stop loss-stop gain or similar mechanisms shall be in effect. An  
42 adjustment in the stop loss-stop gain percentage may be made to ensure that  
43 total payments do not increase as a result of this provision. If peer groups  
44 are used, the administration shall establish initial peer group designations  
45 for each hospital before implementation of the per diem system. The

1 administration may also use a negotiated rate methodology. The tiered per  
2 diem methodology may include separate consideration for specialty hospitals  
3 that limit their provision of services to specific patient populations, such  
4 as rehabilitative patients or children. The initial per diem rates shall be  
5 based on hospital claims and encounter data for dates of service November 1,  
6 1990 through October 31, 1991 and processed through May of 1992. The  
7 administration may also establish a separate reimbursement methodology for  
8 claims with extraordinarily high costs per day that exceed thresholds  
9 established by the administration.

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

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

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

- 1 (a) An admission face sheet.
- 2 (b) An itemized statement.
- 3 (c) An admission history and physical.
- 4 (d) A discharge summary or an interim summary if the claim is split.
- 5 (e) An emergency record, if admission was through the emergency room.
- 6 (f) Operative reports, if applicable.
- 7 (g) A labor and delivery room report, if applicable.

8 Payment received by a hospital from the administration pursuant to this  
9 subsection or from a contractor either by contract or pursuant to section  
10 36-2904, subsection I is considered payment by the administration or the  
11 contractor of the administration's or contractor's liability for the hospital  
12 bill. A hospital may collect any unpaid portion of its bill from other  
13 third-party payors or in situations covered by title 33, chapter 7,  
14 article 3.

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

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

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

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

29 6. In developing the reimbursement methodology, if a review of the  
30 reports filed by a hospital pursuant to section 36-125.04 indicates that  
31 further investigation is considered necessary to verify the accuracy of the  
32 information in the reports, the administration may examine the hospital's  
33 records and accounts related to the reporting requirements of section  
34 36-125.04. The administration shall bear the cost incurred in connection  
35 with this examination unless the administration finds that the records  
36 examined are significantly deficient or incorrect, in which case the  
37 administration may charge the cost of the investigation to the hospital  
38 examined.

39 7. Except for privileged medical information, the administration shall  
40 make available for public inspection the cost and charge data and the  
41 calculations used by the administration to determine payments under the  
42 tiered per diem system, provided that individual hospitals are not identified  
43 by name. The administration shall make the data and calculations available  
44 for public inspection during regular business hours and shall provide copies  
45 of the data and calculations to individuals requesting such copies within

1 thirty days of receipt of a written request. The administration may charge a  
2 reasonable fee for the provision of the data or information.

3 8. The prospective tiered per diem payment methodology for inpatient  
4 hospital services shall include a mechanism for the prospective payment of  
5 inpatient hospital capital related costs. The capital payment shall include  
6 hospital specific and statewide average amounts. For tiered per diem rates  
7 beginning on October 1, 1999, the capital related cost component is frozen at  
8 the blended rate of forty per cent of the hospital specific capital cost and  
9 sixty per cent of the statewide average capital cost in effect as of  
10 January 1, 1999 and as further adjusted by the calculation of tier rates for  
11 maternity and nursery as prescribed by law. Through September 30, 2011, the  
12 administration shall adjust the capital related cost component by the data  
13 resources incorporated market basket index for prospective payment system  
14 hospitals.

15 9. For graduate medical education programs:

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

38 (b) The monies available for graduate medical education programs  
39 pursuant to this subdivision shall not exceed the fiscal year 2006-2007  
40 appropriation adjusted annually by the increase or decrease in the index  
41 published by the global insight hospital market basket index for prospective  
42 hospital reimbursement. Graduate medical education programs eligible for  
43 such reimbursement are not precluded from receiving reimbursement for funding  
44 under subdivision (c) of this paragraph. Beginning July 1, 2006, the  
45 administration shall distribute any monies appropriated for graduate medical

1 education above the amount prescribed in subdivision (a) of this paragraph in  
2 the following order or priority:

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

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

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

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

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

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

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

34 (f) Local, county and tribal governments and any university under the  
35 jurisdiction of the Arizona board of regents may provide monies in addition  
36 to any state general fund monies appropriated for graduate medical education  
37 in order to qualify for additional matching federal monies for providers,  
38 programs or positions in a specific locality and costs incurred pursuant to a  
39 specific contract between the administration and providers or other entities  
40 to provide graduate medical education services as an administrative activity.  
41 Payments by the administration pursuant to this subdivision may be limited to  
42 those providers designated by the funding entity and may be based on any  
43 methodology deemed appropriate by the administration, including replacing any  
44 payments that might otherwise have been paid pursuant to subdivision (a), (b)  
45 or (c) of this paragraph had sufficient state general fund monies or other

1 monies been appropriated to fully fund those payments. These programs,  
2 positions, payment methodologies and administrative graduate medical  
3 education services must be approved by the administration and the centers for  
4 medicare and medicaid services. The administration shall report to the  
5 president of the senate, the speaker of the house of representatives and the  
6 director of the joint legislative budget committee on or before July 1 of  
7 each year on the amount of money contributed and number of residency  
8 positions funded by local, county and tribal governments, including the  
9 amount of federal matching monies used.

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

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

18 11. For inpatient hospital services rendered on or after October 1,  
19 2011, the prospective tiered per diem payment rates are permanently reset to  
20 the amounts payable for those services as of October 1, 2011 pursuant to this  
21 subsection.

22 12. The administration shall adopt a diagnosis-related group based  
23 hospital reimbursement methodology consistent with title XIX of the social  
24 security act for inpatient dates of service on and after October 1, 2014.  
25 The administration may make additional adjustments to the inpatient hospital  
26 rates established pursuant to this section for hospitals that are publicly  
27 operated or based on other factors, including the number of beds in the  
28 hospital, the specialty services available to patients, the geographic  
29 location and diagnosis-related group codes that are made publicly available  
30 by the hospital pursuant to section 36-437. The administration may also  
31 provide additional reimbursement for extraordinarily high cost cases that  
32 exceed a threshold above the standard payment. The administration may also  
33 establish a separate payment methodology for specific services or hospitals  
34 serving unique populations.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17 P. DISPROPORTIONATE SHARE PAYMENTS MADE PURSUANT TO SUBSECTION O OF  
18 THIS SECTION INCLUDE AMOUNTS FOR DISPROPORTIONATE SHARE HOSPITALS DESIGNATED  
19 BY POLITICAL SUBDIVISIONS OF THIS STATE, TRIBAL GOVERNMENTS AND UNIVERSITIES  
20 UNDER THE JURISDICTION OF THE ARIZONA BOARD OF REGENTS. SUBJECT TO THE  
21 APPROVAL OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, ANY AMOUNT OF  
22 FEDERAL FUNDING ALLOTTED TO THIS STATE PURSUANT TO SECTION 1923(f) OF THE  
23 SOCIAL SECURITY ACT AND NOT OTHERWISE SPENT UNDER SUBSECTION O OF THIS  
24 SECTION SHALL BE MADE AVAILABLE FOR DISTRIBUTION PURSUANT TO THIS SUBSECTION.  
25 POLITICAL SUBDIVISIONS OF THIS STATE, TRIBAL GOVERNMENTS AND UNIVERSITIES  
26 UNDER THE JURISDICTION OF THE ARIZONA BOARD OF REGENTS MAY DESIGNATE  
27 HOSPITALS ELIGIBLE TO RECEIVE DISPROPORTIONATE SHARE PAYMENTS IN AN AMOUNT UP  
28 TO THE LIMIT PRESCRIBED IN SECTION 1923(g) OF THE SOCIAL SECURITY ACT IF  
29 THOSE POLITICAL SUBDIVISIONS, TRIBAL GOVERNMENTS OR UNIVERSITIES PROVIDE  
30 SUFFICIENT MONIES TO QUALIFY FOR THE MATCHING FEDERAL MONIES FOR THE  
31 DISPROPORTIONATE SHARE PAYMENTS.

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

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

38 ~~R.~~ S. If the administration implements an electronic claims  
39 submission system, it may adopt procedures pursuant to subsection G of this  
40 section requiring documentation different than prescribed under subsection G,  
41 paragraph 4 of this section.

42 ~~S.~~ T. In addition to any requirements adopted pursuant to subsection  
43 D, paragraph 4 of this section, notwithstanding any other law, subject to  
44 approval by the centers for medicare and medicaid services, beginning July 1,  
45 2011, members eligible pursuant to section 36-2901, paragraph 6, subdivision

1 (a), section 36-2931 and section 36-2981, paragraph 6 shall pay the  
2 following:

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

8 U. FOR THE PURPOSES OF THIS SECTION, "DISPROPORTIONATE SHARE PAYMENT"  
9 MEANS A PAYMENT TO A HOSPITAL THAT SERVES A DISPROPORTIONATE SHARE OF  
10 LOW-INCOME PATIENTS AS DESCRIBED BY 42 UNITED STATES CODE SECTION 1396r-4.

11 Sec. 3. Title 36, chapter 29, article 1, Arizona Revised Statutes, is  
12 amended by adding section 36-2903.08, to read:

13 36-2903.08. AHCCCS uncompensated care; hospital assessment;  
14 reports

15 A. ON OR BEFORE OCTOBER 1, 2014, AND ANNUALLY THEREAFTER, THE ARIZONA  
16 HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION SHALL REPORT TO THE  
17 SPEAKER OF THE HOUSE OF REPRESENTATIVES, THE PRESIDENT OF THE SENATE AND THE  
18 DIRECTORS OF THE JOINT LEGISLATIVE BUDGET COMMITTEE AND THE GOVERNOR'S OFFICE  
19 OF STRATEGIC PLANNING AND BUDGETING ON THE CHANGE IN UNCOMPENSATED HOSPITAL  
20 COSTS EXPERIENCED BY HOSPITALS IN THIS STATE AND HOSPITAL PROFITABILITY  
21 DURING THE PREVIOUS FISCAL YEAR.

22 B. ON OR BEFORE AUGUST 1, 2014, AND ANNUALLY THEREAFTER, THE ARIZONA  
23 HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION SHALL REPORT TO THE  
24 SPEAKER OF THE HOUSE OF REPRESENTATIVES, THE PRESIDENT OF THE SENATE AND THE  
25 DIRECTORS OF THE JOINT LEGISLATIVE BUDGET COMMITTEE AND THE GOVERNOR'S OFFICE  
26 OF STRATEGIC PLANNING AND BUDGETING THE FOLLOWING:

- 27 1. THE AMOUNT EACH HOSPITAL CONTRIBUTED FOR THE HOSPITAL ASSESSMENT  
28 AUTHORIZED PURSUANT TO SECTION 36-2901.08 IN THE PREVIOUS FISCAL YEAR.  
29 2. THE AMOUNT OF ESTIMATED PAYMENTS EACH HOSPITAL RECEIVED FROM THE  
30 COVERAGE FUNDED BY THE ASSESSMENT.

31 Sec. 4. Section 36-2907, Arizona Revised Statutes, is amended to read:

32 36-2907. Covered health and medical services; modifications;  
33 related delivery of service requirements; definition

34 A. Subject to the limitations and exclusions specified in this  
35 section, contractors shall provide the following medically necessary health  
36 and medical services:

37 1. Inpatient hospital services that are ordinarily furnished by a  
38 hospital for the care and treatment of inpatients and that are provided under  
39 the direction of a physician or a primary care practitioner. For the  
40 purposes of this section, inpatient hospital services exclude services in an  
41 institution for tuberculosis or mental diseases unless authorized under an  
42 approved section 1115 waiver.

43 2. Outpatient health services that are ordinarily provided in  
44 hospitals, clinics, offices and other health care facilities by licensed

1 health care providers. Outpatient health services include services provided  
2 by or under the direction of a physician or a primary care practitioner.

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

5 4. Medications that are ordered on prescription by a physician or a  
6 dentist licensed pursuant to title 32, chapter 11. Persons who are dually  
7 eligible for title XVIII and title XIX services must obtain available  
8 medications through a medicare licensed or certified medicare advantage  
9 prescription drug plan, a medicare prescription drug plan or any other entity  
10 authorized by medicare to provide a medicare part D prescription drug  
11 benefit.

12 5. Medical supplies, durable medical equipment, **INSULIN PUMPS** and  
13 prosthetic devices ordered by a physician or a primary care practitioner.  
14 Suppliers of durable medical equipment shall provide the administration with  
15 complete information about the identity of each person who has an ownership  
16 or controlling interest in their business and shall comply with federal  
17 bonding requirements in a manner prescribed by the administration.

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

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

24 8. Family planning services that do not include abortion or abortion  
25 counseling. If a contractor elects not to provide family planning services,  
26 this election does not disqualify the contractor from delivering all other  
27 covered health and medical services under this chapter. In that event, the  
28 administration may contract directly with another contractor, including an  
29 outpatient surgical center or a noncontracting provider, to deliver family  
30 planning services to a member who is enrolled with the contractor that elects  
31 not to provide family planning services.

32 9. Podiatry services ordered by a primary care physician or primary  
33 care practitioner.

34 10. Nonexperimental transplants approved for title XIX reimbursement.

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

37 12. Hospice care.

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

40 1. Circumcision of newborn males is not a covered health and medical  
41 service.

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

43 (a) Outpatient health services do not include occupational therapy or  
44 speech therapy.

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

5 (c) ~~Insulin pumps~~, Percussive vests and orthotics are not covered  
6 health and medical services.

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

8 (e) Podiatry services do not include services performed by a  
9 podiatrist.

10 (f) Nonexperimental transplants do not include pancreas only  
11 transplants.

12 (g) Bariatric surgery procedures, including laparoscopic and open  
13 gastric bypass and restrictive procedures, are not covered health and medical  
14 services.

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

18 D. The director shall adopt rules necessary to limit, to the extent  
19 possible, the scope, duration and amount of services, including maximum  
20 limitations for inpatient services that are consistent with federal  
21 regulations under title XIX of the social security act (P.L. 89-97; 79 Stat.  
22 344; 42 United States Code section 1396 (1980)). To the extent possible and  
23 practicable, these rules shall provide for the prior approval of medically  
24 necessary services provided pursuant to this chapter.

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

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

1 to the appropriate agency responsible for making the final eligibility  
2 determination.

3 G. The director shall adopt rules for the provision of transportation  
4 services and rules providing for copayment by members for transportation for  
5 other than emergency purposes. Subject to approval by the centers for  
6 medicare and medicaid services, nonemergency medical transportation shall not  
7 be provided except for stretcher vans and ambulance transportation. Prior  
8 authorization is required for transportation by stretcher van and for  
9 medically necessary ambulance transportation initiated pursuant to a  
10 physician's direction. Prior authorization is not required for medically  
11 necessary ambulance transportation services rendered to members or eligible  
12 persons initiated by dialing telephone number 911 or other designated  
13 emergency response systems.

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

19 I. If the director does not receive bids within the amounts budgeted  
20 or if at any time the amount remaining in the Arizona health care cost  
21 containment system fund is insufficient to pay for full contract services for  
22 the remainder of the contract term, the administration, on notification to  
23 system contractors at least thirty days in advance, may modify the list of  
24 services required under subsection A of this section for persons defined as  
25 eligible other than those persons defined pursuant to section 36-2901,  
26 paragraph 6, subdivision (a). The director may also suspend services or may  
27 limit categories of expense for services defined as optional pursuant to  
28 title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United  
29 States Code section 1396 (1980)) for persons defined pursuant to section  
30 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not  
31 apply to the continuity of care for persons already receiving these services.

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

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

38 1. Emergency services and specialty services provided pursuant to  
39 section 36-2908.

40 2. That the director may permit the delivery of health and medical  
41 services in other than the geographic service area in this state or in an  
42 adjoining state if the director determines that medical practice patterns  
43 justify the delivery of services or a net reduction in transportation costs  
44 can reasonably be expected. Notwithstanding the definition of physician as  
45 prescribed in section 36-2901, if services are procured from a physician or

1 primary care practitioner in an adjoining state, the physician or primary  
2 care practitioner shall be licensed to practice in that state pursuant to  
3 licensing statutes in that state similar to title 32, chapter 13, 15, 17 or  
4 25 and shall complete a provider agreement for this state.

5 L. Covered outpatient services shall be subcontracted by a primary  
6 care physician or primary care practitioner to other licensed health care  
7 providers to the extent practicable for purposes including, but not limited  
8 to, making health care services available to underserved areas, reducing  
9 costs of providing medical care and reducing transportation costs.

10 M. The director shall adopt rules that prescribe the coordination of  
11 medical care for persons who are eligible for system services. The rules  
12 shall include provisions for the transfer of patients, the transfer of  
13 medical records and the initiation of medical care.

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

16 Sec. 5. Section 36-2953, Arizona Revised Statutes, is amended to read:  
17 36-2953. Department long-term care system fund; uniform  
18 accounting

19 A. The department shall establish and maintain a department long-term  
20 care system fund which is a separate fund to distinguish its revenues and its  
21 expenditures pursuant to this article from other programs funded or  
22 administered by the department. Subject to legislative appropriation, the  
23 fund shall be used to pay administrative and program costs associated with  
24 the operation of the system. The department long-term care system fund shall  
25 be divided as follows:

26 1. An account for eligibility determination pursuant to section  
27 36-2933, if the administration enters into an interagency agreement with the  
28 department pursuant to section 36-2933, subsection E.

29 2. An account for the provision of long-term care services as  
30 prescribed in section 36-2939, subsections A and B.

31 B. The department long-term care system fund shall be comprised of:

32 1. Monies paid by the administration pursuant to the contract.

33 2. Amounts paid by third party payors.

34 3. Gifts, donations and grants from any source.

35 4. State appropriations for the department long-term care system  
36 pursuant to this article.

37 5. Interest on monies deposited in the long-term care system fund.

38 C. The department shall submit a prospective long-term care budget as  
39 prescribed by the administration.

40 D. The administration shall prescribe a uniform accounting system for  
41 the fund established pursuant to subsection A of this section. Technical  
42 assistance shall be provided by the administration to the department in order  
43 to facilitate the implementation of the uniform accounting system.

1 E. The department shall submit an annual audited financial and  
2 programmatic report for the preceding fiscal year as required by the  
3 administration. The report shall include beginning and ending fund balances,  
4 revenues and expenditures including specific identification of administrative  
5 costs for the system. The report shall include the number of members served  
6 by the system and the cost incurred for various types of services provided to  
7 members in a format prescribed by the director.

8 F. The department shall submit additional utilization and financial  
9 reports as required by the director.

10 G. The director shall make at least an annual review of the  
11 department's records and accounts.

12 H. ALL MONIES IN THE DEPARTMENT LONG-TERM CARE SYSTEM FUND THAT ARE  
13 UNEXPENDED AND UNENCUMBERED AT THE END OF THE FISCAL YEAR REVERT TO THE STATE  
14 GENERAL FUND ON OR BEFORE JUNE 30 OF THAT FISCAL YEAR. THE TRANSFER AMOUNT  
15 MAY BE ADJUSTED FOR REPORTED BUT UNPAID CLAIMS AND ESTIMATED INCURRED BUT  
16 UNREPORTED CLAIMS, SUBJECT TO APPROVAL BY THE ADMINISTRATION.

17 Sec. 6. Section 36-3415, Arizona Revised Statutes, is amended to read:  
18 36-3415. Behavioral health expenditures; annual report

19 ~~On or before August 1, 2012, the directors of the joint legislative~~  
20 ~~budget committee and the governor's office of strategic planning and~~  
21 ~~budgeting shall agree to the content of the report on medicaid and~~  
22 ~~nonmedicaid behavioral health expenditures.~~ Beginning October 1, 2013, the  
23 department of health services shall report annually to the joint legislative  
24 budget committee on each fiscal year's medicaid and nonmedicaid behavioral  
25 health expenditures, including behavioral health demographics, **INCLUDING**  
26 **CLIENT INCOME**, utilization and expenditures, medical necessity oversight  
27 practices, tracking of high cost beneficiaries, mortality trends, placement  
28 trends, program integrity and access to services.

29 Sec. 7. Laws 2013, first special session, chapter 10, section 19 is  
30 amended to read:

31 Sec. 19. AHCCCS; disproportionate share payments

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

35 1. \$89,877,700 for a qualifying nonstate operated public hospital:

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

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

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

23 2. ~~\$26,724,700~~ \$28,474,900 for the Arizona state hospital. The  
24 Arizona state hospital shall provide a certified public expense form for the  
25 amount of qualifying disproportionate share hospital expenditures made on  
26 behalf of the state to the administration on or before March 31, 2014. The  
27 administration shall assist the Arizona state hospital in determining the  
28 amount of qualifying disproportionate share hospital expenditures. Once the  
29 administration files a claim with the federal government and receives federal  
30 funds participation based on the amount certified by the Arizona state  
31 hospital, the administration shall distribute the entire amount of federal  
32 financial participation to the state general fund. If the certification  
33 provided is for an amount less than ~~\$26,724,700~~ \$28,474,900, the  
34 administration shall notify the governor, the president of the senate and the  
35 speaker of the house of representatives and shall distribute the entire  
36 amount of federal financial participation to the state general fund. The  
37 certified public expense form provided by the Arizona state hospital shall  
38 contain both the total amount of qualifying disproportionate share hospital  
39 expenditures and the amount limited by section 1923(g) of the social security  
40 act.

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

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

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

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

21 Sec. 8. Repeal

22 Laws 2013, first special session, chapter 10, section 41 is repealed.

23 Sec. 9. ALTCS; county contributions; fiscal year 2014-2015

24 A. Notwithstanding section 11-292, Arizona Revised Statutes, county  
25 contributions for the Arizona long-term care system for fiscal year 2014-2015  
26 are as follows:

27	1. Apache	\$ 616,900
28	2. Cochise	\$ 5,138,300
29	3. Coconino	\$ 1,851,400
30	4. Gila	\$ 2,107,400
31	5. Graham	\$ 1,442,600
32	6. Greenlee	\$ 76,200
33	7. La Paz	\$ 712,200
34	8. Maricopa	\$150,220,100
35	9. Mohave	\$ 7,972,700
36	10. Navajo	\$ 2,552,500
37	11. Pima	\$ 38,919,400
38	12. Pinal	\$ 15,294,300
39	13. Santa Cruz	\$ 1,914,800
40	14. Yavapai	\$ 8,314,700
41	15. Yuma	\$ 8,062,700

42 B. If the overall cost for the Arizona long-term care system exceeds  
43 the amount specified in the general appropriations act for fiscal year  
44 2014-2015, the state treasurer shall collect from the counties the difference  
45 between the amount specified in subsection A of this section and the

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

16 Sec. 10. Sexually violent persons; county reimbursement; fiscal  
17 year 2014-2015; deposit; tax distribution  
18 withholding

19 A. Notwithstanding any other law, if this state pays the costs of a  
20 commitment of an individual who is determined by the court to be sexually  
21 violent, the department of health services may determine the percentage of  
22 the costs to be reimbursed by the county. It is the intent of the  
23 legislature that the department of health services not increase the  
24 percentage rate of the county share of costs in fiscal year 2014-2015,  
25 relative to fiscal year 2013-2014.

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

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

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

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



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

16 2. \$28,474,900 for the Arizona state hospital. The Arizona state  
17 hospital shall provide a certified public expense form for the amount of  
18 qualifying disproportionate share hospital expenditures made on behalf of the  
19 state to the administration on or before March 31, 2015. The administration  
20 shall assist the Arizona state hospital in determining the amount of  
21 qualifying disproportionate share hospital expenditures. Once the  
22 administration files a claim with the federal government and receives federal  
23 funds participation based on the amount certified by the Arizona state  
24 hospital, the administration shall distribute the entire amount of federal  
25 financial participation to the state general fund. If the certification  
26 provided is for an amount less than \$28,474,900, the administration shall  
27 notify the governor, the president of the senate and the speaker of the house  
28 of representatives and shall distribute the entire amount of federal  
29 financial participation to the state general fund. The certified public  
30 expense form provided by the Arizona state hospital must contain both the  
31 total amount of qualifying disproportionate share hospital expenditures and  
32 the amount limited by section 1923(g) of the social security act.

33 3. \$9,284,800 for private qualifying disproportionate share hospitals.  
34 The Arizona health care cost containment system administration shall make  
35 payments to hospitals consistent with this appropriation and the terms of the  
36 section 1115 waiver, but payments are limited to those hospitals that either:

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

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

41 Sec. 13. AHCCCS transfer; counties; federal monies

42 On or before December 31, 2015, notwithstanding any other law, for  
43 fiscal year 2014-2015 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. 14. County acute care contribution: fiscal year 2014-2015

4 A. Notwithstanding section 11-292, Arizona Revised Statutes, for  
5 fiscal year 2014-2015 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	\$19,523,400
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, as amended by this act, from any payments required to be made by  
27 the state treasurer to that county pursuant to section 42-5029, subsection D,  
28 paragraph 2, Arizona Revised Statutes, plus interest on that amount pursuant  
29 to section 44-1201, Arizona Revised Statutes, retroactive to the first day  
30 the funding was due. If the monies the state treasurer withholds are  
31 insufficient to meet that county's funding requirements as specified in  
32 subsection A of this section, the state treasurer shall withhold from any  
33 other monies payable to that county from whatever state funding source is  
34 available an amount necessary to fulfill that county's requirement. The  
35 state treasurer shall not withhold distributions from the Arizona highway  
36 user revenue fund pursuant to title 28, chapter 18, article 2, Arizona  
37 Revised Statutes.

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

1 D. The state treasurer shall deposit the amounts paid pursuant to  
2 subsection C of this section and amounts withheld pursuant to subsection B of  
3 this section in the Arizona health care cost containment system fund and the  
4 long-term care system fund established by section 36-2913, Arizona Revised  
5 Statutes, as amended by this act.

6 E. If payments made pursuant to subsection C of this section exceed  
7 the amount required to meet the costs incurred by the Arizona health care  
8 cost containment system for the hospitalization and medical care of those  
9 persons defined as an eligible person pursuant to section 36-2901, paragraph  
10 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of  
11 the Arizona health care cost containment system administration may instruct  
12 the state treasurer either to reduce remaining payments to be paid pursuant  
13 to this section by a specified amount or to provide to the counties specified  
14 amounts from the Arizona health care cost containment system fund and the  
15 long-term care system fund established by section 36-2913, Arizona Revised  
16 Statutes, as amended by this act.

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

22 Sec. 15. Hospitalization and medical care contribution; fiscal  
23 year 2014-2015

24 A. Notwithstanding any other law, for fiscal year 2014-2015, beginning  
25 with the second monthly distribution of transaction privilege tax revenues,  
26 the state treasurer shall withhold one-eleventh of the following amounts from  
27 state transaction privilege tax revenues otherwise distributable, after any  
28 amounts withheld for the county long-term care contribution or the county  
29 administration contribution pursuant to section 11-292, subsection 0, Arizona  
30 Revised Statutes, for deposit in the Arizona health care cost containment  
31 system fund established by section 36-2913, Arizona Revised Statutes, as  
32 amended by this act, for the provision of hospitalization and medical care:

33	1. Apache	\$ 87,300
34	2. Cochise	\$ 162,700
35	3. Coconino	\$ 160,500
36	4. Gila	\$ 65,900
37	5. Graham	\$ 46,800
38	6. Greenlee	\$ 12,000
39	7. La Paz	\$ 24,900
40	8. Mohave	\$ 187,400
41	9. Navajo	\$ 122,800
42	10. Pima	\$1,115,900
43	11. Pinal	\$ 218,300

1	12. Santa Cruz	\$ 51,600
2	13. Yavapai	\$ 206,200
3	14. Yuma	\$ 183,900

4 B. If the monies the state treasurer withholds are insufficient to  
5 meet a county's funding requirement as specified in subsection A of this  
6 section, the state treasurer shall withhold from any other monies payable to  
7 that county from whatever state funding source is available an amount  
8 necessary to fulfill that county's requirement. The state treasurer shall  
9 not withhold distributions from the Arizona highway user revenue fund  
10 pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes.

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

14 D. In fiscal year 2014-2015, the sum of \$2,646,200 withheld pursuant  
15 to subsection A of this section is allocated for the county acute care  
16 contribution for the provision of hospitalization and medical care services  
17 administered by the Arizona health care cost containment system  
18 administration.

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

21 Sec. 16. Proposition 204 administration; county expenditure  
22 limitation

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

27 Sec. 17. AHCCCS; risk contingency rate setting

28 Notwithstanding any other law, for the contract year beginning  
29 October 1, 2014 and ending September 30, 2015, the Arizona health care cost  
30 containment system administration may continue the risk contingency rate  
31 setting for all managed care organizations and the funding for all managed  
32 care organizations administrative funding levels that was imposed for the  
33 contract year beginning October 1, 2010 and ending September 30, 2011.

34 Sec. 18. 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, 2014 and June  
45 30, 2015.





1           Sec. 29. Intent: department of health services: behavioral  
2                                   health service provider rates

3           It is the intent of the legislature that the department of health  
4 services may increase behavioral health service provider rates by up to two  
5 per cent above the September 30, 2014 rates beginning on October 1, 2014.

6           Sec. 30. Retroactivity

7           Laws 2013, first special session, chapter 10, section 19, as amended by  
8 this act, applies retroactively to from and after June 30, 2013.