House Engrossed

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; 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)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Title 36, chapter 1, article 1, Arizona Revised Statutes, is amended by adding section 36-108.01, to read:

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

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

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

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

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

B. The director shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9. For graduate medical education programs:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. THE AMOUNT EACH HOSPITAL CONTRIBUTED FOR THE HOSPITAL ASSESSMENT AUTHORIZED PURSUANT TO SECTION 36-2901.08 IN THE PREVIOUS FISCAL YEAR.

2. THE AMOUNT OF ESTIMATED PAYMENTS EACH HOSPITAL RECEIVED FROM THE COVERAGE FUNDED BY THE ASSESSMENT.

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

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

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

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

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

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

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

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

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

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

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

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

9. Podiatry services THAT ARE ALL OF THE FOLLOWING:

(a) PERFORMED BY A PODIATRIST AND ordered by a primary care physician or primary care practitioner.

(b) MEDICALLY RECOGNIZED AS THE PREFERRED TREATMENT OPTION CONSISTENT WITH MEDICARE GUIDELINES.

(c) LESS EXPENSIVE THAN ALL OTHER TREATMENT OPTIONS OR SURGICAL PROCEDURES TO TREAT THE SAME DIAGNOSED CONDITION.

10. Nonexperimental transplants approved for title XIX reimbursement.

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

12. Hospice care.

13. BEGINNING OCTOBER 1, 2014, MEDICALLY NECESSARY CHIROPRACTIC SERVICES AS DESCRIBED IN SECTION 32-925 THAT ARE ORDERED BY A PRIMARY CARE PHYSICIAN PURSUANT TO RULES ADOPTED BY THE ADMINISTRATION.

14. EMERGENCY DENTAL CARE AND EXTRACTIONS FOR PERSONS WHO ARE AT LEAST TWENTY-ONE YEARS OF AGE IF THE SERVICE IS BOTH:

(a) MEDICALLY RECOGNIZED AS THE PREFERRED TREATMENT OPTION CONSISTENT WITH MEDICARE GUIDELINES.

(b) LESS EXPENSIVE THAN ALL OTHER TREATMENT OPTIONS OR SURGICAL PROCEDURES TO TREAT THE SAME DIAGNOSED CONDITION.

15. ORTHOTIC DEVICES IF THE DEVICE MEETS ALL OF THE FOLLOWING:

(a) IS ORDERED BY A PHYSICIAN.

(b) IS MEDICALLY RECOGNIZED AS THE PREFERRED TREATMENT OPTION CONSISTENT WITH MEDICARE GUIDELINES.

(c) IS LESS EXPENSIVE THAN ALL OTHER TREATMENT OPTIONS OR SURGICAL PROCEDURES TO TREAT THE SAME DIAGNOSED CONDITION.

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

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

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

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

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

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

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

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

~~(f)~~ (e) Nonexperimental transplants do not include pancreas only transplants.

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

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

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

E. The director shall make available home health services in lieu of hospitalization pursuant to contracts awarded under this article. For the

purposes of this subsection, "home health services" means the provision of nursing services, home health aide services or medical supplies, equipment and appliances that are provided on a part-time or intermittent basis by a licensed home health agency within a member's residence based on the orders of a physician or a primary care practitioner. Home health agencies shall comply with the federal bonding requirements in a manner prescribed by the administration.

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

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

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

I. If the director does not receive bids within the amounts budgeted or if at any time the amount remaining in the Arizona health care cost containment system fund is insufficient to pay for full contract services for the remainder of the contract term, the administration, on notification to system contractors at least thirty days in advance, may modify the list of services required under subsection A of this section for persons defined as eligible other than those persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). The director may also suspend services or may

limit categories of expense for services defined as optional pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) for persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not apply to the continuity of care for persons already receiving these services.

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

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

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

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

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

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

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

Sec. 5. Section 36-2953, Arizona Revised Statutes, is amended to read:

36-2953. Department long-term care system fund; uniform accounting

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

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

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

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

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

2. Amounts paid by third party payors.

3. Gifts, donations and grants from any source.

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

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

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

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

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

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

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

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

Sec. 6. Section 36-3415, Arizona Revised Statutes, is amended to read:

36-3415. Behavioral health expenditures; annual report

~~On or before August 1, 2012, the directors of the joint legislative budget committee and the governor's office of strategic planning and budgeting shall agree to the content of the report on medicaid and nonmedicaid behavioral health expenditures.~~ Beginning October 1, 2013, the department of health services shall report annually to the joint legislative budget committee on each fiscal year's medicaid and nonmedicaid behavioral health expenditures, including behavioral health demographics~~,~~ INCLUDING CLIENT INCOME, utilization and expenditures, medical necessity oversight

practices, tracking of high cost beneficiaries, mortality trends, placement trends, program integrity and access to services.

Sec. 7. Repeal

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

Sec. 8. AHCCCS; chiropractic services; expenditure limitation

Notwithstanding section 36-2907, Arizona Revised Statutes, as amended by this act, for fiscal year 2014-2015, the Arizona health care cost containment system administration shall provide medically necessary chiropractic services as described in section 32-925, Arizona Revised Statutes, but shall limit the general fund costs associated with these services to not more than $1,000,000 in that fiscal year.

Sec. 9. AHCCCS; coverage of adult emergency dental care services and orthotic devices; fiscal year 2014-2015; expenditure limitations

A. For fiscal year 2014-2015, the Arizona health care cost containment system administration shall provide emergency dental care and extractions for persons who are at least twenty-one years of age as prescribed in title 36, chapter 29, Arizona Revised Statutes, but, notwithstanding section 36-2907, Arizona Revised Statutes, as amended by this act, shall limit the state general fund costs associated with these services to not more than $1,100,000 in that fiscal year.

B. For fiscal year 2014-2015, the Arizona health care cost containment system administration shall provide orthotic devices as prescribed in title 36, chapter 29, Arizona Revised Statutes, but, notwithstanding section 36-2907, Arizona Revised Statutes, as amended by this act, shall limit the state general fund costs associated with these services to not more than $1,000,000 in that fiscal year.

Sec. 10. ALTCS; county contributions; fiscal year 2014-2015

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

1.	Apache	$ 616,900
2.	Cochise	$ 5,138,300
3.	Coconino	$ 1,851,400
4.	Gila	$ 2,107,400
5.	Graham	$ 1,442,600
6.	Greenlee	$ 76,200
7.	La Paz	$ 712,200
8.	Maricopa	$150,220,100
9.	Mohave	$ 7,972,700
10.	Navajo	$ 2,552,500
11.	Pima	$ 38,919,400
12.	Pinal	$ 15,294,300
13.	Santa Cruz	$ 1,914,800

14. Yavapai $ 8,314,700
15. Yuma $ 8,062,700

B. If the overall cost for the Arizona long-term care system exceeds the amount specified in the general appropriations act for fiscal year 2014-2015, the state treasurer shall collect from the counties the difference between the amount specified in subsection A of this section and the counties' share of the state's actual contribution. The counties' share of the state contribution must be in compliance with any federal maintenance of effort requirements. The director of the Arizona health care cost containment system administration shall notify the state treasurer of the counties' share of the state's contribution and report the amount to the director of the joint legislative budget committee. The state treasurer shall withhold from any other monies payable to a county from whatever state funding source is available an amount necessary to fulfill that county's requirement specified in this subsection. The state treasurer shall not withhold distributions from the Arizona highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes. The state treasurer shall deposit the amounts withheld pursuant to this subsection and amounts paid pursuant to subsection A of this section in the long-term care system fund established by section 36-2913, Arizona Revised Statutes, as amended by this act.

Sec. 11. Sexually violent persons; county reimbursement; fiscal year 2014-2015; deposit; tax distribution withholding

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

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

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

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

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

Sec. 12. Competency restoration treatment; city and county reimbursement; fiscal year 2014-2015; deposit; tax distribution withholding

A. Notwithstanding section 13-4512, Arizona Revised Statutes, if this state pays the costs of a defendant's inpatient, in custody competency restoration treatment pursuant to section 13-4512, Arizona Revised Statutes, the city or county shall reimburse the department of health services for one hundred per cent of these costs for fiscal year 2014-2015.

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

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

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

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

Sec. 13. AHCCCS; disproportionate share payments

Disproportionate share payments for fiscal year 2014-2015 made pursuant to section 36-2903.01, subsection O, Arizona Revised Statutes, include:

1. $89,877,700 for a qualifying nonstate operated public hospital. The Maricopa county special health care district shall provide a certified public expense form for the amount of qualifying disproportionate share hospital expenditures made on behalf of this state to the Arizona health care cost containment system administration on or before May 1, 2015 for all state plan years as required by the Arizona health care cost containment system 1115 waiver standard terms and conditions. The administration shall assist

the district in determining the amount of qualifying disproportionate share hospital expenditures. Once the administration files a claim with the federal government and receives federal funds participation based on the amount certified by the Maricopa county special health care district, if the certification is equal to or less than $89,877,700 and the administration determines that the revised amount is correct pursuant to the methodology used by the administration pursuant to section 36-2903.01, Arizona Revised Statutes, as amended by this act, the administration shall notify the governor, the president of the senate and the speaker of the house of representatives, shall distribute $4,202,300 to the Maricopa county special health care district and shall deposit the balance of the federal funds participation in the state general fund. If the certification provided is for an amount less than $89,877,700 and the administration determines that the revised amount is not correct pursuant to the methodology used by the administration pursuant to section 36-2903.01, Arizona Revised Statutes, as amended by this act, the administration shall notify the governor, the president of the senate and the speaker of the house of representatives and shall deposit the total amount of the federal funds participation in the state general fund. The disproportionate share hospital payment attributed to the Maricopa county special health care district may not exceed $89,877,700.

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

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

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

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

Sec. 14. AHCCCS transfer; counties; federal monies

On or before December 31, 2015, notwithstanding any other law, for fiscal year 2014-2015 the Arizona health care cost containment system administration shall transfer to the counties such portion, if any, as may be necessary to comply with section 10201(c)(6) of the patient protection and affordable care act (P.L. 111-148), regarding the counties' proportional share of the state's contribution.

Sec. 15. County acute care contribution; fiscal year 2014-2015

A. Notwithstanding section 11-292, Arizona Revised Statutes, for fiscal year 2014-2015 for the provision of hospitalization and medical care, the counties shall contribute the following amounts:

1.	Apache	$ 268,800
2.	Cochise	$ 2,214,800
3.	Coconino	$ 742,900
4.	Gila	$ 1,413,200
5.	Graham	$ 536,200
6.	Greenlee	$ 190,700
7.	La Paz	$ 212,100
8.	Maricopa	$19,523,400
9.	Mohave	$ 1,237,700
10.	Navajo	$ 310,800
11.	Pima	$14,951,800
12.	Pinal	$ 2,715,600
13.	Santa Cruz	$ 482,800
14.	Yavapai	$ 1,427,800
15.	Yuma	$ 1,325,100

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

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

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

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

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

Sec. 16. Hospitalization and medical care contribution; fiscal year 2014-2015

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

1.	Apache	$ 87,300
2.	Cochise	$ 162,700
3.	Coconino	$ 160,500
4.	Gila	$ 65,900
5.	Graham	$ 46,800
6.	Greenlee	$ 12,000
7.	La Paz	$ 24,900

8.	Mohave	$ 187,400
9.	Navajo	$ 122,800
10.	Pima	$1,115,900
11.	Pinal	$ 218,300
12.	Santa Cruz	$ 51,600
13.	Yavapai	$ 206,200
14.	Yuma	$ 183,900

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

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

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

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

Sec. 17. Proposition 204 administration; county expenditure limitation

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

Sec. 18. AHCCCS; risk contingency rate setting

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

Sec. 19. AHCCCS; social security administration; medicare liability waiver

The Arizona health care cost containment system may participate in any special disability workload 1115 demonstration waiver offered by the centers for medicare and medicaid services. Any credits provided by the 1115 demonstration waiver process are to be used in the fiscal year when those credits are made available to fund the state share of any medical assistance expenditures that qualify for federal financial participation under the

medicaid program. The Arizona health care cost containment system administration shall report the receipt of any credits to the director of the joint legislative budget committee on or before December 31, 2014 and June 30, 2015.

Sec. 20. Department of health services; health research account; Alzheimer's disease research

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

Sec. 21. Child care assistance eligibility; notification

Notwithstanding section 46-803, Arizona Revised Statutes, for fiscal year 2014-2015, the department of economic security may reduce maximum income eligibility levels for child care assistance in order to manage within appropriated and available monies. The department of economic security shall notify the joint legislative budget committee of any change in maximum income eligibility levels for child care assistance within fifteen days after implementing the change.

Sec. 22. AHCCCS; emergency department use; report

On or before December 1, 2014, the Arizona health care cost containment system administration shall report to the directors of the joint legislative budget committee and the governor's office of strategic planning and budgeting on the use of emergency departments for nonemergency purposes by Arizona health care cost containment system enrollees.

Sec. 23. Hospital transparency; joint report

On or before January 1, 2015, the director of the Arizona health care cost containment system administration and the director of the department of health services shall submit a joint report on hospital charge master transparency to the governor, the speaker of the house of representatives and the president of the senate and shall provide a copy to the secretary of state. The report must provide a summary of the current charge master reporting process, a summary of hospital billed charges compared to costs and examples of how charge masters or hospital prices are reported and used in other states. The report must include recommendations to improve the state's use of hospital charge master information, including reporting and oversight changes.

Sec. 24. Department of economic security; drug testing; TANF cash benefits recipients

During fiscal year 2014-2015, the department of economic security shall screen and test each adult recipient who is otherwise eligible for temporary assistance for needy families cash benefits and who the department has reasonable cause to believe engages in the illegal use of controlled substances. Any recipient who is found to have tested positive for the use of a controlled substance that was not prescribed for the recipient by a

licensed health care provider is ineligible to receive benefits for a period of one year.

Sec. 25. Auditor general; report; child safety and family services

On or before March 15, 2015, the auditor general shall provide to the governor, the speaker of the house of representatives, the president of the senate and the directors of the joint legislative budget committee and the governor's office of strategic planning and budgeting a report containing the following information on child safety and family services in the department of economic security:

1. The rate of substantiated cases of child abuse or neglect for other states compared to Arizona's rate of substantiated cases of child abuse or neglect, based on the ratio of the total number of children in each state to the substantiated cases of child abuse or neglect.

2. The average number of reports of child abuse or neglect for other states over the past five years compared to Arizona's number of reports of child abuse or neglect over the same time period.

3. The number of states with a child safety organization similar to the office of child welfare investigations, including a description of how other states with state-level child safety law enforcement organizations avoid redundancies among child safety caseworkers, child safety law enforcement and local law enforcement when investigating allegations of criminal abuse.

Sec. 26. Child welfare; joint report

The early childhood development and health board and the department of economic security shall jointly report to the joint legislative budget committee on their collaborative efforts to address child welfare issues of common concern. The report must include information about the level of coordination among the department of economic security, the early childhood development and health board and community groups to promote the well-being of children and families that are identified in reports of abuse or neglect. The joint report must be submitted on or before February 1, 2015 for the prior year.

Sec. 27. Intent; implementation of program

It is the intent of the legislature that for fiscal year 2014-2015 the Arizona health care cost containment system administration implement a program within the available appropriation.

Sec. 28. Intent; false claims act; savings

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

1 Sec. 29. Intent; capitation rate increases
2 It is the intent of the legislature that the Arizona health care cost
3 containment system administration capitation rate increases not exceed three
4 per cent in fiscal years 2014-2015, 2015-2016 and 2016-2017.
5 Sec. 30. Intent; department of health services; behavioral
6 health service provider rates
7 It is the intent of the legislature that the department of health
8 services may increase behavioral health service provider rates by up to two
9 per cent above the September 30, 2014 rates beginning on October 1, 2014.