START\_STATUTE36-2904.  Prepaid capitation coverage; requirements; long‑term care; dispute resolution; award of contracts; notification; report

A.  The administration may expend public funds appropriated for the purposes of this article and shall execute prepaid capitated health services contracts, pursuant to section 36‑2906, with group disability insurers, hospital and medical service corporations, health care services organizations and any other appropriate public or private persons, including county‑owned and operated facilities, for health and medical services to be provided under contract with contractors. The administration may assign liability for eligible persons and members through contractual agreements with contractors. If there is an insufficient number of qualified bids for prepaid capitated health services contracts for the provision of hospitalization and medical care within a county, the director may:

1.  Execute discount advance payment contracts, pursuant to section 36‑2906 and subject to section 36‑2903.01, for hospital services.

2.  Execute capped fee‑for‑service contracts for health and medical services, other than hospital services. Any capped fee‑for‑service contract shall provide for reimbursement at a level of not to exceed a capped fee‑for‑service schedule adopted by the administration.

B.  During any period in which services are needed and no contract exists, the director may do either of the following:

1.  Pay noncontracting providers for health and medical services, other than hospital services, on a capped fee‑for‑service basis for members and persons who are determined eligible. However, the state shall not pay any amount for services that exceeds a maximum amount set forth in a capped fee‑for‑service schedule adopted by the administration.

2.  Pay a hospital subject to the reimbursement level limitation prescribed in section 36‑2903.01.

If health and medical services are provided in the absence of a contract, the director shall continue to attempt to procure by the bid process as provided in section 36‑2906 contracts for such services as specified in this subsection.

C.  Payments to contractors shall be made monthly or quarterly and may be subject to contract provisions requiring the retention of a specified percentage of the payment by the director, a reserve fund or other contract provisions by which adjustments to the payments are made based on utilization efficiency, including incentives for maintaining quality care and minimizing unnecessary inpatient services. Reserve funds withheld from contractors shall be distributed to contractors who meet performance standards established by the director. Any reserve fund established pursuant to this subsection shall be established as a separate account within the Arizona health care cost containment system fund.

D.  Except as prescribed in subsection E of this section, a member defined as eligible pursuant to section 36‑2901, paragraph 6, subdivision (a) may select, to the extent practicable as determined by the administration, from among the available contractors of hospitalization and medical care and may select a primary care physician or primary care practitioner from among the primary care physicians and primary care practitioners participating in the contract in which the member is enrolled. The administration shall provide reimbursement only to entities that have a provider agreement with the administration and that have agreed to the contractual requirements of that agreement. Except as provided in sections 36‑2908 and 36‑2909, the system shall only provide reimbursement for any health or medical services or costs of related services provided by or under referral from the primary care physician or primary care practitioner participating in the contract in which the member is enrolled. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors in the system.

E.  For a member defined as eligible pursuant to section 36‑2901, paragraph 6, subdivision (a), item (v) the director shall enroll the member with an available contractor located in the geographic area of the member's residence. The member may select a primary care physician or primary care practitioner from among the primary care physicians or primary care practitioners participating in the contract in which the member is enrolled. The system shall only provide reimbursement for health or medical services or costs of related services provided by or under referral from a primary care physician or primary care practitioner participating in the contract in which the member is enrolled. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors in the system.

F.  If a person who has been determined eligible but who has not yet enrolled in the system receives emergency services, the director shall provide by rule for the enrollment of the person on a priority basis. If a person requires system covered services on or after the date the person is determined eligible for the system but before the date of enrollment, the person is entitled to receive these services in accordance with rules adopted by the director, and the administration shall pay for the services pursuant to section 36‑2903.01 or, as specified in contract, with the contractor pursuant to the subcontracted rate or this section.

G.  The administration shall not pay claims for system covered services that are initially submitted more than six months after the date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later, or that are submitted as clean claims more than twelve months after the date of service for which payment is claimed or after the date that eligibility is posted, whichever date is later, except for claims submitted for reinsurance pursuant to section 36‑2906, subsection C, paragraph 6. The administration shall not pay claims for system covered services that are submitted by contractors for reinsurance after the time period specified in the contract. The director may adopt rules or require contractual provisions that prescribe requirements and time limits for submittal of and payment for those claims. Notwithstanding any other provision of this article, if a claim that gives rise to a contractor's claim for reinsurance or deferred liability is the subject of an administrative grievance or appeal proceeding or other legal action, the contractor shall have at least sixty days after an ultimate decision is rendered to submit a claim for reinsurance or deferred liability.  Contractors that contract with the administration pursuant to subsection A of this section shall not pay claims for system covered services that are initially submitted more than six months after the date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later, or that are submitted as clean claims more than twelve months after the date of the service for which payment is claimed or after the date that eligibility is posted, whichever date is later. For the purposes of this subsection:

1.  "Clean claims" means claims that may be processed without obtaining additional information from the subcontracted provider of care, from a noncontracting provider or from a third party but does not include claims under investigation for fraud or abuse or claims under review for medical necessity.

2.  "Date of service" for a hospital inpatient means the date of discharge of the patient.

3.  "Submitted" means the date the claim is received by the administration or the prepaid capitated provider, whichever is applicable, as established by the date stamp on the face of the document or other record of receipt.

H.  In any county having a population of five hundred thousand or fewer persons, a hospital that executes a subcontract other than a capitation contract with a contractor for the provision of hospital and medical services pursuant to this article shall offer a subcontract to any other contractor providing services to that portion of the county and to any other person that plans to become a contractor in that portion of the county. If such a hospital executes a subcontract other than a capitation contract with a contractor for the provision of hospital and medical services pursuant to this article, the hospital shall adopt uniform criteria to govern the reimbursement levels paid by all contractors with whom the hospital executes such a subcontract. Reimbursement levels offered by hospitals to contractors pursuant to this subsection may vary among contractors only as a result of the number of bed days purchased by the contractors, the amount of financial deposit required by the hospital, if any, or the schedule of performance discounts offered by the hospital to the contractor for timely payment of claims.

I.  This subsection applies to inpatient hospital admissions and to outpatient hospital services on and after March 1, 1993. The director may negotiate at any time with a hospital on behalf of a contractor for services provided pursuant to this article. If a contractor negotiates with a hospital for services provided pursuant to this article, the following procedures apply:

1.  The director shall require any contractor to reimburse hospitals for services provided under this article based on reimbursement levels that do not in the aggregate exceed those established pursuant to section 36‑2903.01 and under terms on which the contractor and the hospital agree. However, a hospital and a contractor may agree on a different payment methodology than the methodology prescribed by the director pursuant to section 36‑2903.01. The director by rule shall prescribe:

(a)  The time limits for any negotiation between the contractor and the hospital.

(b)  The ability of the director to review and approve or disapprove the reimbursement levels and terms agreed on by the contractor and the hospital.

(c)  That if a contractor and a hospital do not agree on reimbursement levels and terms as required by this subsection, the reimbursement levels established pursuant to section 36‑2903.01 apply.

(d)  That, except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of subdivision (f) on initial receipt of the legible, error‑free claim form by the contractor if the claim includes the following error‑free documentation in legible form:

(i)  An admission face sheet.

(ii)  An itemized statement.

(iii)  An admission history and physical.

(iv)  A discharge summary or an interim summary if the claim is split.

(v)  An emergency record, if admission was through the emergency room.

(vi)  Operative reports, if applicable.

(vii)  A labor and delivery room report, if applicable.

(e)  That payment received by a hospital from a contractor is considered payment by the contractor of the 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.

(f)  That a contractor shall pay for services rendered on and after October 1, 1997 under any reimbursement level according to paragraph 1 of this subsection subject to the following:

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

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

(iii)  If the hospital's bill is paid any time after sixty days of the date the bill was received, the contractor 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.

2.  In any county having a population of five hundred thousand or fewer persons, a hospital that executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services pursuant to this article shall offer a subcontract to any other provider providing services to that portion of the county and to any other person that plans to become a provider in that portion of the county.  If a hospital executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services pursuant to this article, the hospital shall adopt uniform criteria to govern the reimbursement levels paid by all providers with whom the hospital executes a subcontract.

J.  If there is an insufficient number of, or an inadequate member capacity in, contracts awarded to contractors, the director, in order to deliver covered services to members enrolled or expected to be enrolled in the system within a county, may negotiate and award, without bid, a contract with a health care services organization holding a certificate of authority pursuant to title 20, chapter 4, article 9.  The director shall require a health care services organization contracting under this subsection to comply with section 36‑2906.01.  The term of the contract shall not extend beyond the next bid and contract award process as provided in section 36‑2906 and shall be no greater than capitation rates paid to contractors in the same county or counties pursuant to section 36‑2906. Contracts awarded pursuant to this subsection are exempt from the requirements of title 41, chapter 23.

K.  A contractor may require that a subcontracting or noncontracting provider shall be paid for covered services, other than hospital services, according to the capped fee‑for‑service schedule adopted by the director pursuant to subsection A, paragraph 2 of this section or subsection B, paragraph 1 of this section or at lower rates as may be negotiated by the contractor.

L.  The director shall require any contractor to have a plan to notify members of reproductive age either directly or through the parent or legal guardian, whichever is most appropriate, of the specific covered family planning services available to them and a plan to deliver those services to members who request them. The director shall ensure that these plans include provisions for written notification, other than the member handbook, and verbal notification during a member's visit with the member's primary care physician or primary care practitioner.

M.  The director shall adopt a plan to notify members of reproductive age who receive care from a contractor who elects not to provide family planning services of the specific covered family planning services available to them and to provide for the delivery of those services to members who request them.  Notification may be directly to the member, or through the parent or legal guardian, whichever is most appropriate. The director shall ensure that the plan includes provisions for written notification, other than the member handbook, and verbal notification during a member's visit with the member's primary care physician or primary care practitioner.

N.  The director shall prepare a report that represents a statistically valid sample and that indicates the number of children age two by contractor who received the immunizations recommended by the national centers for disease control and prevention while enrolled as members. The report shall indicate each type of immunization and the number and percentage of enrolled children in the sample age two who received each type of immunization. The report shall be done by contract year and shall be delivered to the governor, the president of the senate and the speaker of the house of representatives no later than April 1, 2004 and every second year thereafter.

O.  If the administration implements an electronic claims submission system it may adopt procedures pursuant to subsection I, paragraph 1 of this section requiring documentation different than prescribed under subsection I, paragraph 1, subdivision (d) of this section.END\_STATUTE