State of Arizona
House of Representatives
Fiftieth Legislature
Second Regular Session
2012

CHAPTER 122

HOUSE BILL 2534

AN ACT

AMENDING SECTIONS 8-142.01, 8-245, 8-512, 31-165, 36-210, 36-717, 36-2903.01, 36-2905.01, 36-2905.02, 36-2909, 36-2912, 36-2932, 36-2986, 36-2987, 36-3411, 41-1608, 41-1954, 41-2807, 48-5501 AND 48-5561.01, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 8-142.01, Arizona Revised Statutes, is amended to read:

8-142.01. Adoption subsidy program; hospital reimbursement

A. Notwithstanding section 8-144, subsection B, for inpatient hospital admissions and outpatient hospital services on or after March 1, 1993, the department shall reimburse a hospital according to the ~~tiered per diem~~ rates ~~and outpatient cost-to-charge ratios~~ established by the Arizona health care cost containment system pursuant to section 36-2903.01, subsection ~~H~~ G.

B. The department shall use the Arizona health care cost containment system rates as identified in subsection A of this section for any child enrolled in the adoption subsidy program. This requirement shall not be construed to expand the liability of the adoption subsidy program beyond eligible preexisting conditions on an adoption subsidy agreement entered into between the department and the adoptive parent.

C. A hospital bill is considered received for purposes of subsection E of this section ~~upon~~ ON initial receipt of the legible, error-free claim form by the department if the claim includes the following error-free documentation in legible form:

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

D. The department shall require that the hospital pursue other third party payors before submitting a claim to the department. Payment received by a hospital from the department pursuant to this section is considered payment by the department of the department'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.

E. For inpatient hospital admissions and outpatient hospital services rendered on and after October 1, 1997, if the department receives the claim directly from the hospital for services rendered, the department shall pay a hospital's rate established according to this section subject to the following:

1. If the hospital's bill is paid within thirty days of the date the bill was received, the department shall pay ninety-nine per cent of the rate.
2. If the hospital's bill is paid after thirty days but within sixty days of the date the bill was received, the department shall pay one hundred per cent of the rate.
3. If the hospital's bill is paid any time after sixty days of the date the bill was received, the department 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.

F. For medical services other than those for which a rate has been established pursuant to section 36-2903.01, subsection ~~H~~ G, the department shall pay according to the Arizona health care cost containment system capped fee-for-service schedule adopted pursuant to section 36-2904, subsection K.

G. For any hospital or medical claims not covered under subsection A or F of this section, the department shall establish and adopt a schedule setting out maximum allowable fees that the department deems reasonable for such services after appropriate study and analysis of usual and customary fees charged by providers.

Sec. 2. Section 8-245, Arizona Revised Statutes, is amended to read:

8-245. Physical and mental care

A. When a child under the jurisdiction of the juvenile court appears to be in need of medical or surgical care, the juvenile court may order the parent, guardian or custodian to provide treatment for the child in a hospital or otherwise. If the parent, guardian or custodian fails to provide the care as ordered, the juvenile court may enter an order therefor, and the expense, when approved by the juvenile court, shall be a county charge. The juvenile court may adjudge that the person required by law to support the child pay part or all of the expenses of treatment in accordance with section 8-243.

B. A county with a population of more than one million persons shall pay claims approved by the county from a facility or provider for medical or surgical care to a child that is a county charge pursuant to subsection A of this section, unless otherwise provided by an intergovernmental agreement, as follows:

1. For inpatient and outpatient hospital services, the county shall reimburse at a level that does not exceed the reimbursement methodology established pursuant to section 36-2903.01, subsection ~~H~~ G.

2. For health and medical services, the county shall reimburse at a level that does not exceed the capped fee-for-service schedule that is adopted by the Arizona health care cost containment system administration pursuant to title 36, chapter 29, article 1 and that is in effect at the time the services are delivered.

Sec. 3. Section 8-512, Arizona Revised Statutes, is amended to read:

8-512. Comprehensive medical and dental care; guidelines

A. The department shall provide comprehensive medical and dental care, as prescribed by rules of the department, for each child WHO IS:

1. Placed in a foster home.

2. In the custody of the department and placed with a relative.

3. In the custody of the department and placed in a certified adoptive home before the entry of the final order of adoption.

4. In the custody of the department and in an independent living program as provided in section 8-521.

5. In the custody of a probation department and placed in foster care. The department shall not provide this care if the cost exceeds funds currently appropriated and available for that purpose.

B. The care may include, but is not limited to:

1. A program of regular health examinations and immunizations including as minimums:

(a) Vaccinations to prevent mumps, rubella, smallpox and polio.

(b) Tests for anemia, coccidioidomycosis and tuberculosis.

(c) Urinalysis, blood count and hemoglobin tests.

(d) Regular examinations for general health, hearing and vision, including providing corrective devices when needed.

2. Inpatient and outpatient hospital care.

3. Necessary services of physicians, surgeons, psychologists and psychiatrists.

4. Dental care consisting of at least oral examinations including diagnostic radiographs, oral prophylaxis and topical fluoride applications, restoration of permanent and primary teeth, pulp therapy, extraction when necessary, fixed space maintainers where needed and other services for relief of pain and infection.

5. Drug prescription service.

C. The facilities of any hospital or other institution within the state, public or private, may be employed by the foster parent, relative, certified adoptive parent, agency or division having responsibility for the care of the child.

D. For inpatient hospital admissions and outpatient hospital services on or after March 1, 1993, the department shall reimburse a hospital according to the ~~tiered per diem~~ rates ~~and outpatient cost-to-charge ratios~~ established by the Arizona health care cost containment system pursuant to section 36-2903.01, subsection ~~H~~ G.

E. The department shall use the Arizona health care cost containment system rates as identified in subsection D of this section for any child eligible for services under this section.

F. A hospital bill is considered received for purposes of subsection H of this section ~~upon~~ ON initial receipt of the legible, error-free claim form by the department if the claim includes the following error-free documentation in legible form:

1. An admission face sheet.

2. An itemized statement.

3. An admission history and physical.

4. A discharge summary or an interim summary if the claim is split.

5. An emergency record, if admission was through the emergency room.

6. Operative reports, if applicable.

7. A labor and delivery room report, if applicable.

G. The department shall require that the hospital pursue other third party payors before submitting a claim to the department. Payment received by a hospital from the department is considered payment by the department of the department'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.

H. For inpatient hospital admissions and outpatient hospital services rendered on and after October 1, 1997, the department shall pay a hospital's rate established according to this section subject to the following:

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

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

3. If the hospital's bill is paid any time after sixty days of the date the bill was received, the department 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.

I. For medical services other than those for which a rate has been established pursuant to section 36-2903.01, subsection ~~H~~ G, the department shall pay according to the Arizona health care cost containment system capped fee-for-service schedule adopted pursuant to section 36-2904, subsection K.

J. For any hospital or medical claims not covered under subsection D or I of this section, the department shall establish and adopt a schedule setting out maximum allowable fees that the department deems reasonable for such services after appropriate study and analysis of usual and customary fees charged by providers. The department shall not pay to any plan or intermediary that portion of the cost of any service provided that exceeds allowable charges prescribed by the department pursuant to this subsection.

K. The department shall not pay claims for services pursuant to this section that are submitted more than one hundred eighty days after the date of the service for which the payment is claimed.

L. The department may provide for payment through an insurance plan, hospital service plan, medical service plan, or any other health service plan authorized to do business in this state, fiscal intermediary or a combination of such plans or methods. The state shall not be liable for and the department shall not pay to any plan or intermediary any portion of the cost of comprehensive medical and dental care in excess of funds appropriated and available for such purpose at the time the plan or intermediary incurs the expense for such care.

M. The total amount of state monies that may be spent in any fiscal year by the department for comprehensive medical and dental care shall not exceed the amount appropriated or authorized by section 35-173 for that purpose. This section shall not be construed to impose a duty on an officer, agent or employee of this state to discharge a responsibility or to create

any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.

Sec. 4. Section 31-165, Arizona Revised Statutes, is amended to read:

31-165. Inmate medical services; rate structure

If an inmate in a county jail in a county with a population of more than one million persons or a person who, but for the circumstances, would otherwise be treated in the county jail requires health care services that the county jail cannot provide, the county shall pay claims approved by the county from a facility or provider that provides these services, unless otherwise provided by an intergovernmental agreement, as follows:

1. For inpatient and outpatient hospital services, the county shall reimburse at a level that does not exceed the reimbursement methodology established pursuant to section 36-2903.01, subsection ~~H~~ G.

2. For health and medical services, the county shall reimburse at a level that does not exceed the capped fee-for-service schedule that is adopted by the Arizona health care cost containment system administration pursuant to title 36, chapter 29, article 1 and that is in effect at the time the services are delivered.

Sec. 5. Section 36-210, Arizona Revised Statutes, is amended to read:

36-210. Expenditures

A. This article does not give the director or any employee authority to create a debt or obligation in excess of the amount appropriated by the legislature to carry out its provisions. If monies are not appropriated to carry out the purpose of this article, the director shall submit recommendations to the legislature, with a statement of the cost when an improvement is requested.

B. Except as provided by subsection D of this section, the director of the department of administration shall not issue a warrant for expenditures by the state hospital in excess of the estimate contained in the monthly financial statement unless the superintendent submits a written request that is approved in writing by the deputy director and that states the reasons for the request. The director of the department of administration shall not issue warrants in excess of the amount available for the current quarter.

C. If a patient in the state hospital requires a health care service that the state hospital or a facility or provider contracted by the state hospital cannot provide, the department of health services shall pay approved claims from a facility or provider that provides these required services as follows:

1. For inpatient and outpatient hospital services, the state shall reimburse at a level that does not exceed the reimbursement methodology established in section 36-2903.01, subsection ~~H~~ G.

2. For health and medical services, the state shall reimburse providers at a level that does not exceed the capped fee-for-service schedule that is adopted by the Arizona health care cost containment system

administration pursuant to chapter 29, article 1 of this title and that is in effect at the time the service is delivered.

D. Monies appropriated for capital investment may be expended at any time during the fiscal period for which the monies are appropriated as directed by the director.

Sec. 6. Section 36-717, Arizona Revised Statutes, is amended to read:

36-717. Responsibility for care or treatment by counties

A. The local board of health, through the board of supervisors of the county, shall be responsible for providing or arranging for the provision of medical care and treatment of persons in the county infected with tuberculosis.

B. A county with a population of more than one million persons shall pay claims approved by the county from a facility or provider for medical care or treatment that are a county charge pursuant to subsection A of this section, unless otherwise provided by an intergovernmental agreement, as follows:

1. For inpatient and outpatient hospital services, the county shall reimburse at a level that does not exceed the reimbursement methodology established pursuant to section 36-2903.01, subsection ~~H~~ G.

2. For health and medical services, the county shall reimburse at a level that does not exceed the capped fee-for-service schedule that is adopted by the Arizona health care cost containment system administration pursuant to chapter 29, article 1 of this title and that is in effect at the time the services are delivered.

Sec. 7. Section 36-2903.01, Arizona Revised Statutes, is amended to read:

36-2903.01. Additional powers and duties; report

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 ~~or H~~ 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 all outpatient hospital services before March 1, 1993, the administration shall reimburse a hospital's adjusted billed charges according to the following procedures:~~

~~1. The director shall adopt rules that, for services rendered from and after September 30, 1985 until October 1, 1986, define "adjusted billed charges" as that reimbursement level that has the effect of holding constant whichever of the following is applicable:~~

~~(a) The schedule of rates and charges for a hospital in effect on April 1, 1984 as filed pursuant to chapter 4, article 3 of this title.~~

~~(b) The schedule of rates and charges for a hospital that became effective after May 31, 1984 but before July 2, 1984, if the hospital's previous rate schedule became effective before April 30, 1983.~~

~~(c) The schedule of rates and charges for a hospital that became effective after May 31, 1984 but before July 2, 1984, limited to five per cent over the hospital's previous rate schedule, and if the hospital's previous rate schedule became effective on or after April 30, 1983 but before October 1, 1983.~~

~~For the purposes of this paragraph, "constant" means equal to or lower than.~~

~~2. The director shall adopt rules that, for services rendered from and after September 30, 1986, define "adjusted billed charges" as that~~

~~reimbursement level that has the effect of increasing by four per cent a hospital's reimbursement level in effect on October 1, 1985 as prescribed in paragraph 1 of this subsection. Beginning January 1, 1991, the Arizona health care cost containment system administration shall define "adjusted billed charges" as the reimbursement level determined pursuant to this section, increased by two and one half per cent.~~

~~3. In no event shall a hospital's adjusted billed charges exceed the hospital's schedule of rates and charges filed with the department of health services and in effect pursuant to chapter 4, article 3 of this title.~~

~~4. For services rendered the administration shall not pay a hospital's adjusted billed charges in excess of the following:~~

~~(a) If the hospital's bill is paid within thirty days of the date the bill was received, eighty-five per cent of the adjusted billed charges.~~

~~(b) If the hospital's bill is paid any time after thirty days but within sixty days of the date the bill was received, ninety-five per cent of the adjusted billed charges.~~

~~(c) If the hospital's bill is paid any time after sixty days of the date the bill was received, one hundred per cent of the adjusted billed charges.~~

~~5. The director shall define by rule the method of determining when a hospital bill will be considered received and when a hospital's billed charges will be considered paid. 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 shall be considered payment of the hospital bill in full, except that 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.~~

~~H.~~ 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, 2013, 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.

2. For rates effective on October 1, 1994, and annually ~~thereafter~~ 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 practice 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, 2013.

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 September 30, 2011 pursuant to this subsection.

12. THE ADMINISTRATION SHALL OBTAIN LEGISLATIVE APPROVAL BEFORE ADOPTING A HOSPITAL REIMBURSEMENT METHODOLOGY CONSISTENT WITH TITLE XIX OF THE SOCIAL SECURITY ACT FOR INPATIENT DATES OF SERVICE ON AND AFTER OCTOBER 1, 2013.

~~I.~~ 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.

~~J.~~ 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.

~~K.~~ 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.

~~L.~~ 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.

~~M.~~ 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.

~~N.~~ M. The director or the director's designee may employ and supervise personnel necessary to assist the director in performing the functions of the administration.

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

~~P.~~ 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.

~~Q.~~ P. 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.

~~R.~~ Q. 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.

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

~~T.~~ S. 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.

Sec. 8. Section 36-2905.01, Arizona Revised Statutes, is amended to read:

36-2905.01. Inpatient hospital reimbursement program; large counties

A. Notwithstanding any other law, beginning on October 1, 2003, pursuant to this chapter the administration shall establish and operate a program for inpatient hospital reimbursement in each county with a population of more than five hundred thousand persons.

B. Beginning on October 1, 2003, the director shall require contractors to enter into contracts with one or more hospitals in these counties and to reimburse those hospitals for services provided pursuant to this chapter based on the reimbursement levels negotiated with each hospital and specified in the contract and under the terms on which the contractor and the hospital agree and under all of the following conditions:

1. The director may review and approve or disapprove the reimbursement levels and the terms agreed on by the contractor and the hospital.
2. If the contractor implements an electronic claims submission system it may adopt procedures requiring documentation of the system.
3. Payment received by a hospital from a contractor is considered payment in full by the contractor. 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.

C. If a contractor and a hospital do not enter into a contract pursuant to subsection B of this section, the reimbursement level for inpatient services provided on dates of admission on or after October 1, 2003 for that hospital is the reimbursement level prescribed in section 36-2903.01 multiplied by ninety-five per cent.

D. For outpatient hospital services provided under the program prescribed in this section, a contractor may reimburse a hospital either pursuant to rates and terms negotiated in a contract between the contractor and the hospital or pursuant to section 36-2903.01, subsection ~~H~~ G, paragraph 3.

E. Contracts established pursuant to this section shall specify that arbitration may be used in lieu of the grievance and appeal procedure prescribed in section 36-2903.01, subsection B, paragraph 4 to resolve any disputes arising under the contract.

Sec. 9. Section 36-2905.02, Arizona Revised Statutes, is amended to read:

36-2905.02. Inpatient reimbursement; rural hospitals; definition

A. If monies are appropriated for rural hospitals, the Arizona health care cost containment system administration shall request the centers for medicare and medicaid services to approve federal matching medicaid funding for the purposes specified in this section.

B. The administration shall distribute the available monies to increase inpatient reimbursement for qualifying rural hospitals. At no time shall the reimbursement exceed the cost of providing care. The administration may make supplemental payments to qualifying rural hospitals based on utilization or adjust ~~tier~~ rates, established pursuant to section 36-2903.01, subsection ~~H~~ G, for qualifying rural hospitals. No adjustments to inpatient reimbursement under section 36-2903.01, subsection ~~H~~ G to hospitals other than rural hospitals may be made as a result of this section.

C. For the purposes of this section, "rural hospital" means either:

1. A health care institution that is licensed as an acute care hospital, that has one hundred or fewer beds and that is located in a county with a population of less than five hundred thousand persons.

2. A health care institution that is licensed as a critical access hospital.

Sec. 10. Section 36-2909, Arizona Revised Statutes, is amended to read:

36-2909. Emergency hospital services; retroactive coverage; costs

A. If a member receives emergency hospitalization and medical care on or after the date of eligibility determination or the eligibility effective date from a hospital that does not have a contract to care for the person, the administration or the contractor is liable only for the costs of emergency hospitalization and medical care up to the time the person is discharged or until the time the person can be transferred. The

administration or the ~~prepaid capitated provider~~ CONTRACTOR is also liable for further care in the following circumstances:

1. If the attending physician reasonably determines that the condition of the person receiving emergency hospitalization and medical care is such that it is medically inadvisable to transfer the person.

2. If the administration or the contractor does not transport the person from the hospital providing care after it has been determined that the person can be transferred.

B. Except for charges for services subject to section 36-2908, subsection B, all charges incurred by an eligible person who has not yet enrolled for hospitalization and medical care under subsection A of this section are payable by the administration pursuant to section 36-2903.01, subsection G ~~or H~~ or as specified in contract by the contractor pursuant to the subcontracted rate or section 36-2904, subsection H or I.

C. As a condition to receiving reimbursement pursuant to subsection B of this section, a hospital that is not a contractor or subcontractor under the system must designate a primary care physician or primary care practitioner to act as a coordinator of the services provided to persons who have been determined eligible but have not yet enrolled, before the persons' enrollment, discharge or transfer.

D. Emergency hospitalization and medical care provided pursuant to this section shall be in accordance with rules adopted pursuant to section 36-2903.01, subsection E in order to qualify for reimbursement.

E. The director shall adopt rules that provide that members who have been determined eligible shall be enrolled with contractors as soon as practicable.

F. This section does not prevent the director or the contractor from denying payment for hospitalization or medical care that is not authorized or deemed medically necessary in accordance with rules adopted by the director.

Sec. 11. Section 36-2912, Arizona Revised Statutes, is amended to read:

36-2912. Healthcare group coverage; program requirements for small businesses and public employers; related requirements; definitions

A. The administration shall administer a healthcare group program to allow willing contractors to deliver health care services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). In counties with a population of less than five hundred thousand persons, the administration may contract directly with any health care provider or entity. The administration may enter into a contract with another entity to provide administrative functions for the healthcare group program.

B. Employers with two eligible employees or up to an average of fifty eligible employees under section 36-2901, paragraph 6, subdivision (d):

1. May contract with the administration to be the exclusive health benefit plan if the employer has five or fewer eligible employees and enrolls one hundred per cent of these employees into the health benefit plan.

2. May contract with the administration for coverage available pursuant to this section if the employer has six or more eligible employees and enrolls eighty per cent of these employees into the healthcare group program.

3. Shall have a minimum of two and a maximum of fifty eligible employees at the effective date of their first contract with the administration.

C. The administration shall not enroll an employer group in healthcare group sooner than ninety days after the date that the employer's health insurance coverage under an accountable health plan is discontinued. Enrollment in healthcare group is effective on the first day of the month after the ninety day period. This subsection does not apply to an employer group if the employer's accountable health plan discontinues offering the health plan of which the employer is a member.

D. Employees with proof of other existing health care coverage who elect not to participate in the healthcare group program shall not be considered when determining the percentage of enrollment requirements under subsection B of this section if either:

1. Group health coverage is provided through a spouse, parent or legal guardian, or insured through individual insurance or another employer.

2. Medical assistance is provided by a government subsidized health care program.

3. Medical assistance is provided pursuant to section 36-2982, subsection I.

E. An employer shall not offer coverage made available pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally designated plan.

F. An employee or dependent defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may participate in healthcare group on a voluntary basis only.

G. Notwithstanding subsection B, paragraph 2 of this section, the administration shall adopt rules to allow a business that offers healthcare group coverage pursuant to this section to continue coverage if it expands its employment to include more than fifty employees.

H. The administration shall provide eligible employees with disclosure information about the health benefit plan.

I. The director shall:

1. Require that any contractor that provides covered services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a) provide separate audited reports on the assets, liabilities and financial status of any corporate activity involving providing coverage

pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

2. Prohibit the administration and program contractors from reimbursing a noncontracting hospital for services provided to a member at a noncontracting hospital except for services for an emergency medical condition.

3. Require that a contractor, the administration or an accountable health plan negotiate reimbursement rates. The reimbursement rate for an emergency medical condition for a noncontracting hospital is:

(a) In counties with a population of more than five hundred thousand persons, one hundred fourteen per cent of the reimbursement rates established pursuant to section 36-2903.01, subsection ~~H~~ G. The hospital shall notify the contractor when a member is stabilized.

(b) In counties with a population of less than five hundred thousand persons, one hundred twenty-five per cent of the reimbursement rates established pursuant to section 36-2903.01, subsection ~~H~~ G. The hospital shall notify the contractor when a member is stabilized.

4. Use monies from the healthcare group fund established by section 36-2912.01 for the administration's costs of operating the healthcare group program.

5. Ensure that the contractors are required to meet contract terms as are necessary in the judgment of the director to ensure adequate performance by the contractor. Contract provisions shall include, at a minimum, the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors that have posted other security, equal to or greater than that required for the healthcare group program, with the administration or the department of insurance for the performance of health service contracts if funds would be available to the administration from the other security on the contractor's default. In waiving, or approving waivers of, any requirements established pursuant to this section, the director shall ensure that the administration has taken into account all the obligations to which a contractor's security is associated. The director may also adopt rules that provide for the withholding or forfeiture of payments to be made to a contractor for the failure of the contractor to comply with provisions of its contract or with provisions of adopted rules.

6. Adopt rules.

7. Provide reinsurance to the contractors for clean claims based on thresholds established by the administration. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section 36-2904.

J. With respect to services provided by contractors to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e), a contractor is the payor of last resort and has the same lien or subrogation rights as those held by health care services organizations licensed pursuant to title 20, chapter 4, article 9.

K. The administration shall offer a health benefit plan on a guaranteed issuance basis to small employers as required by this section. All small employers qualify for this guaranteed offer of coverage. The administration shall offer to all small employers the available health benefit plan and shall accept any small employer that applies and meets the eligibility requirements. In addition to the requirements prescribed in this section, for any offering of any health benefit plan to a small employer, as part of the administration's solicitation and sales materials, the administration shall make a reasonable disclosure to the employer of the availability of the information described in this subsection and, on request of the employer, shall provide that information to the employer. The administration shall provide information concerning the following:

1. Provisions of coverage relating to the following, if applicable:

(a) The administration's right to establish premiums and to change premium rates and the factors that may affect changes in premium rates.

(b) Renewability of coverage.

(c) Any preexisting condition exclusion.

(d) The geographic areas served by the contractor.

2. The benefits and premiums available under all health benefit plans for which the employer is qualified.

L. The administration shall describe the information required by subsection K of this section in language that is understandable by the average small employer and with a level of detail that is sufficient to reasonably inform a small employer of the employer's rights and obligations under the health benefit plan. This requirement is satisfied if the administration provides the following information:

1. An outline of coverage that describes the benefits in summary form.

2. The rate or rating schedule that applies to the product, preexisting condition exclusion or affiliation period.

3. The minimum employer contribution and group participation rules that apply to any particular type of coverage.

4. In the case of a network plan, a map or listing of the areas served.

M. A contractor is not required to disclose any information that is proprietary and protected trade secret information under applicable law.

N. At least sixty days before the date of expiration of a health benefit plan, the administration shall provide a written notice to the employer of the terms for renewal of the plan.

O. The administration shall increase or decrease premiums based on actuarial reviews by an independent actuary of the projected and actual costs of providing health care benefits to eligible members. Before changing premiums, the administration must give sixty days' written notice to the employer. For each contract period the administration shall set premiums that in the aggregate cover projected medical and administrative costs for that contract period and that are determined pursuant to generally accepted actuarial principles and practices by an independent actuary.

P. The administration shall consider age, sex, health status-related factors, group size, geographic area and community rating when it establishes premiums for the healthcare group program.

Q. Except as provided in subsection R of this section, a health benefit plan may not deny, limit or condition the coverage or benefits based on a person's health status-related factors or a lack of evidence of insurability. A health benefit plan shall not provide or offer any service, benefit or coverage that is not part of the health benefit plan contract.

R. A health benefit plan shall not exclude coverage for preexisting conditions, except that:

1. A health benefit plan may exclude coverage for preexisting conditions for a period of not more than twelve months or, in the case of a late enrollee, eighteen months. The exclusion of coverage does not apply to services that are furnished to newborns who were otherwise covered from the time of their birth or to persons who satisfy the portability requirements under this section.

2. The contractor shall reduce the period of any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage that apply to the individual.

S. The contractor shall calculate creditable coverage according to the following:

1. The contractor shall give an individual credit for each portion of each month the individual was covered by creditable coverage.

2. The contractor shall not count a period of creditable coverage for an individual enrolled in a health benefit plan if after the period of coverage and before the enrollment date there were sixty-three consecutive days during which the individual was not covered under any creditable coverage.

3. The contractor shall give credit in the calculation of creditable coverage for any period that an individual is in a waiting period for any health coverage.

T. The contractor shall not count a period of creditable coverage with respect to enrollment of an individual if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered under any creditable coverage. The contractor shall not include in the determination of the period of continuous coverage described in this section any period that an individual is in a waiting period for health insurance coverage offered by a health care insurer or is in a waiting period for benefits under a health benefit plan offered by a contractor. In determining the extent to which an individual has satisfied any portion of any applicable preexisting condition period the contractor shall count a period of creditable coverage without regard to the specific benefits covered during that period. A contractor shall not impose any preexisting condition exclusion in the case of an individual who is covered under creditable coverage thirty-one days after the individual's date of birth. A contractor shall not impose any

preexisting condition exclusion in the case of a child who is adopted or placed for adoption before age eighteen and who is covered under creditable coverage thirty-one days after the adoption or placement for adoption.

U. The written certification provided by the administration must include:

1. The period of creditable coverage of the individual under the contractor and any applicable coverage under a COBRA continuation provision.

2. Any applicable waiting period or affiliation period imposed on an individual for any coverage under the health plan.

V. The administration shall issue and accept a written certification of the period of creditable coverage of the individual that contains at least the following information:

1. The date that the certificate is issued.

2. The name of the individual or dependent for whom the certificate applies and any other information that is necessary to allow the issuer providing the coverage specified in the certificate to identify the individual, including the individual's identification number under the policy and the name of the policyholder if the certificate is for or includes a dependent.

3. The name, address and telephone number of the issuer providing the certificate.

4. The telephone number to call for further information regarding the certificate.

5. One of the following:

(a) A statement that the individual has at least eighteen months of creditable coverage. For the purposes of this subdivision, "eighteen months" means five hundred forty-six days.

(b) Both the date that the individual first sought coverage, as evidenced by a substantially complete application, and the date that creditable coverage began.

6. The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing from the date of the certificate.

W. The administration shall provide any certification pursuant to this section within thirty days after the event that triggered the issuance of the certification. Periods of creditable coverage for an individual are established by presentation of the certifications in this section.

X. The healthcare group program shall comply with all applicable federal requirements.

Y. Healthcare group may pay a commission to an insurance producer. To receive a commission, the producer must certify that to the best of the producer's knowledge the employer group has not had insurance in the ninety days before applying to healthcare group. For the purposes of this subsection, "commission" means a one-time payment on the initial enrollment of an employer.

Z. On or before September 30 of each year, the director shall submit a report to the joint legislative budget committee regarding the number and type of businesses participating in healthcare group and that includes updated information on healthcare group marketing activities. The director, within thirty days of implementation, shall notify the joint legislative budget committee of any changes in healthcare group benefits or cost sharing arrangements.

AA. The administration shall submit the following to the joint legislative budget committee:

1. On or before September 30 of each year, a report regarding the financial condition of the healthcare group program. The report shall include the number of persons and employer groups enrolled in the program and medical loss information and projections.

2. An annual financial audit.

3. The analysis that is used to determine premiums pursuant to subsection O of this section.

BB. ~~Beginning July 1, 2009, and~~ Each fiscal year ~~thereafter~~, healthcare group shall limit employer group enrollment to not more than five per cent more than the number of employer groups enrolled in the program at the end of the preceding fiscal year. Healthcare group shall give enrollment priority to uninsured groups.

CC. For the purposes of this section:

1. "Accountable health plan" has the same meaning prescribed in section 20-2301.

2. "COBRA continuation provision" means:

(a) Section 4980B, except subsection (f)(1) as it relates to pediatric vaccines, of the internal revenue code of 1986.

(b) Title I, subtitle B, part 6, except section 609, of the employee retirement income security act of 1974.

(c) Title XXII of the public health service act.

(d) Any similar provision of the law of this state or any other state.

3. "Creditable coverage" means coverage solely for an individual, other than limited benefits coverage, under any of the following:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974.

(b) A church plan as defined in the employee retirement income security act of 1974.

(c) A health benefits plan, as defined in section 20-2301, issued by a health plan.

(d) Part A or part B of title XVIII of the social security act.

(e) Title XIX of the social security act, other than coverage consisting solely of benefits under section 1928.

(f) Title 10, chapter 55 of the United States Code.

(g) A medical care program of the Indian health service or of a tribal organization.

(h) A health benefits risk pool operated by any state of the United States.

(i) A health plan offered pursuant to title 5, chapter 89 of the United States Code.

(j) A public health plan as defined by federal law.

(k) A health benefit plan pursuant to section 5(e) of the peace corps act (22 United States Code section 2504(e)).

(l) A policy or contract, including short-term limited duration insurance, issued on an individual basis by an insurer, a health care services organization, a hospital service corporation, a medical service corporation or a hospital, medical, dental and optometric service corporation or made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

(m) A policy or contract issued by a health care insurer or the administration to a member of a bona fide association.

4. "Eligible employee" means a person who is one of the following:

(a) Eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

(b) A person who works for an employer for a minimum of twenty hours per week or who is self-employed for at least twenty hours per week.

(c) An employee who elects coverage pursuant to section 36-2982, subsection I. The restriction prohibiting employees employed by public agencies prescribed in section 36-2982, subsection I does not apply to this subdivision.

(d) A person who meets all of the eligibility requirements, who is eligible for a federal health coverage tax credit pursuant to section 35 of the internal revenue code of 1986 and who applies for health care coverage through the healthcare group program. The requirement that a person be employed with a small business that elects healthcare group coverage does not apply to this eligibility group.

5. "Emergency medical condition" has the same meaning prescribed in the emergency medical treatment and active labor act (P.L. 99-272; 100 Stat. 164; 42 United States Code section 1395dd(e)).

6. "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analyses of genes or chromosomes.

7. "Health benefit plan" means coverage offered by the administration for the healthcare group program pursuant to this section.

8. "Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in a health plan, including:

(a) Health status.
(b) Medical condition, including physical and mental illness.
(c) Claims experience.
(d) Receipt of health care.
(e) Medical history.
(f) Genetic information.
(g) Evidence of insurability, including conditions arising out of acts of domestic violence as defined in section 20-448.
(h) The existence of a physical or mental disability.

9. "Hospital" means a health care institution licensed as a hospital pursuant to chapter 4, article 2 of this title.

10. "Late enrollee" means an employee or dependent who requests enrollment in a health benefit plan after the initial enrollment period that is provided under the terms of the health benefit plan if the initial enrollment period is at least thirty-one days. Coverage for a late enrollee begins on the date the person becomes a dependent if a request for enrollment is received within thirty-one days after the person becomes a dependent. An employee or dependent shall not be considered a late enrollee if:

(a) The person:

(i) At the time of the initial enrollment period was covered under a public or private health insurance policy or any other health benefit plan.

(ii) Lost coverage under a public or private health insurance policy or any other health benefit plan due to the employee's termination of employment or eligibility, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, legal separation or divorce or the termination of employer contributions toward the coverage.

(iii) Requests enrollment within thirty-one days after the termination of creditable coverage that is provided under a COBRA continuation provision.

(iv) Requests enrollment within thirty-one days after the date of marriage.

(b) The person is employed by an employer that offers multiple health benefit plans and the person elects a different plan during an open enrollment period.

(c) The person becomes a dependent of an eligible person through marriage, birth, adoption or placement for adoption and requests enrollment no later than thirty-one days after becoming a dependent.

11. "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under a health benefit plan issued by a contractor. Preexisting condition does not include a genetic condition in the absence of a diagnosis of the condition related to the genetic information.

12. "Preexisting condition limitation" or "preexisting condition exclusion" means a limitation or exclusion of benefits for a preexisting condition under a health benefit plan offered by a contractor.

13. "Small employer" means an employer who employs at least one but not more than fifty eligible employees on a typical business day during any one calendar year.

14. "Waiting period" means the period that must pass before a potential participant or eligible employee in a health benefit plan offered by a health plan is eligible to be covered for benefits as determined by the individual's employer.

Sec. 12. Section 36-2932, Arizona Revised Statutes, is amended to read:

36-2932. Arizona long-term care system; powers and duties of the director; expenditure limitation

A. The Arizona long-term care system is established. The system includes the management and delivery of hospitalization, medical care, institutional services and home and community based services to members through the administration, the program contractors and providers pursuant to this article together with federal participation under title XIX of the social security act. The director in the performance of all duties shall consider the use of existing programs, rules and procedures in the counties and department where appropriate in meeting federal requirements.

B. The administration has full operational responsibility for the system, which shall include the following:

1. Contracting with and certification of program contractors in compliance with all applicable federal laws.

2. Approving the program contractors' comprehensive service delivery plans pursuant to section 36-2940.

3. Providing by rule for the ability of the director to review and approve or disapprove program contractors' ~~request~~ REQUESTS for proposals for providers and provider subcontracts.

4. Providing technical assistance to the program contractors.

5. Developing a uniform accounting system to be implemented by program contractors and providers of institutional services and home and community based services.

6. Conducting quality control on eligibility determinations and preadmission screenings.

7. Establishing and managing a comprehensive system for assuring the quality of care delivered by the system as required by federal law.

8. Establishing an enrollment system.

9. Establishing a member case management tracking system.

10. Establishing and managing a method to prevent fraud by applicants, members, eligible persons, program contractors, providers and noncontracting providers as required by federal law.

11. Coordinating benefits as provided in section 36-2946.

12. Establishing standards for the coordination of services.

13. Establishing financial and performance audit requirements for program contractors, providers and noncontracting providers.

14. Prescribing remedies as required pursuant to 42 United States Code section 1396r. These remedies may include the appointment of temporary management by the director, acting in collaboration with the director of the department of health services, in order to continue operation of a nursing care institution providing services pursuant to this article.

15. Establishing a system to implement medical child support requirements, as required by federal law. The administration may enter into an intergovernmental agreement with the department of economic security to implement this paragraph.

16. Establishing requirements and guidelines for the review of trusts for the purposes of establishing eligibility for the system pursuant to section 36-2934.01 and ~~posteligibilty~~ POSTELIGIBILITY treatment of income pursuant to subsection L of this section.

17. Accepting the delegation of authority from the department of health services to enforce rules that prescribe minimum certification standards for adult foster care providers pursuant to section 36-410, subsection B. The administration may contract with another entity to perform the certification functions.

18. Assessing civil penalties for improper billing as prescribed in section 36-2903.01, subsection ~~L~~ K.

C. For nursing care institutions and hospices that provide services pursuant to this article, the director shall CONTRACT periodically as deemed necessary and as required by federal law ~~contract~~ for a financial audit of the institutions and hospices that is certified by a certified public accountant in accordance with generally accepted auditing standards or conduct or contract for a financial audit or review of the institutions and hospices. The director shall notify the nursing care institution and hospice at least sixty days before beginning a periodic audit. The administration shall reimburse a nursing care institution or hospice for any additional expenses incurred for professional accounting services obtained in response to a specific request by the administration. On request, the director of the administration shall provide a copy of an audit performed pursuant to this subsection to the director of the department of health services or that person's designee.

D. Notwithstanding any other provision of this article, the administration may contract by an intergovernmental agreement with an Indian tribe, a tribal council or a tribal organization for the provision of long-term care services pursuant to section 36-2939, subsection A, paragraphs 1, 2, 3 and 4 and the home and community based services pursuant to section 36-2939, subsection B, paragraph 2 and subsection C, subject to the restrictions in section 36-2939, subsections D and E for eligible members.

E. The director shall require as a condition of a contract that all records relating to contract compliance are available for inspection by the administration subject to subsection F of this section and that these records

are maintained for five years. The director shall also require that these records are available on request of the secretary of the United States department of health and human services or its successor agency.

F. Subject to applicable law relating to privilege and protection, the director shall adopt rules prescribing the types of information that are confidential and circumstances under which that information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other law, these rules shall provide for the exchange of necessary information among the program contractors, the administration and the department for the purposes of eligibility determination under this article.

G. The director shall adopt rules ~~which~~ TO specify methods for the transition of members into, within and out of the system. The rules shall include provisions for the transfer of members, the transfer of medical records and the initiation and termination of services.

H. The director shall adopt rules ~~which~~ THAT provide for withholding or forfeiting payments made to a program contractor if it fails to comply with a provision of its contract or with the director's rules.

I. The director shall:

1. Establish by rule the time frames and procedures for all grievances and requests for hearings consistent with section 36-2903.01, subsection B, paragraph 4.

2. Apply for and accept federal monies available under title XIX of the social security act in support of the system. In addition, the director may apply for and accept grants, contracts and private donations in support of the system.

3. Not less than thirty days before the administration implements 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.

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

K. The director shall adopt rules ~~which~~ THAT establish requirements of state residency and qualified alien status as prescribed in section 36-2903.03. The administration shall enforce these requirements as part of the eligibility determination process. The rules shall also provide for the determination of the applicant's county of residence for the purpose of assignment of the appropriate program contractor.

L. The director shall adopt rules in accordance with the state plan regarding posteligibility treatment of income and resources ~~which~~ THAT determine the portion of a member's income ~~which~~ THAT shall be available for

payment for services under this article. The rules shall provide that a portion of income may be retained for:

1. A personal needs allowance for members receiving institutional services of at least fifteen per cent of the maximum monthly supplemental security income payment for an individual or a personal needs allowance for members receiving home and community based services based on a reasonable assessment of need.

2. The maintenance needs of a spouse or family at home ~~shall be~~ in accordance with federal law. The minimum resource allowance for the spouse or family at home is twelve thousand dollars adjusted annually by the same percentage as the percentage change in the consumer price index for all urban consumers (all items; United States city average) between September 1988 and the September before the calendar year involved.

3. Expenses incurred for noncovered medical or remedial care that are not subject to payment by a third party payor.

M. 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 may consider the differences between rural and urban conditions on the delivery of services.

N. The director shall not adopt any rule or enter into or approve any contract or subcontract ~~which~~ THAT does not conform to federal requirements or ~~which~~ THAT may cause the system to lose any federal monies to which it is otherwise entitled.

O. The administration, program contractors and providers may establish and maintain review committees dealing with the delivery of care. Review committees and their staff are subject to the same requirements, protections, privileges and immunities prescribed pursuant to section 36-2917.

P. If the director determines that the financial viability of a nursing care institution or hospice is in question, the director may require a nursing care institution and a hospice providing services pursuant to this article to submit quarterly financial statements within thirty days after the end of its financial quarter unless the director grants an extension in writing before that date. Quarterly financial statements submitted to the department shall include the following:

1. A balance sheet detailing the institution's assets, liabilities and net worth.

2. A statement of income and expenses, including current personnel costs and full-time equivalent statistics.

Q. The director may require monthly financial statements if the director determines that the financial viability of a nursing care institution or hospice is in question. The director shall prescribe the requirements of these statements.

R. The total amount of state monies that may be spent in any fiscal year by the administration for long-term care shall not exceed the amount appropriated or authorized by section 35-173 for that purpose. This article

shall not be construed to impose a duty on an officer, agent or employee of this state to discharge a responsibility or to create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.

Sec. 13. Section 36-2986, Arizona Revised Statutes, is amended to read:

36-2986. Administration; powers and duties of director

A. The director has full operational authority to adopt rules or to use the appropriate rules adopted for article 1 of this chapter to implement this article, including any of the following:

1. Contract administration and oversight of contractors.

2. Development of a complete system of accounts and controls for the program, including provisions designed to ensure that covered health and medical services provided through the system are not used unnecessarily or unreasonably, including inpatient behavioral health services provided in a hospital.

3. Establishment of peer review and utilization review functions for all contractors.

4. Development and management of a contractor payment system.

5. Establishment and management of a comprehensive system for assuring quality of care.

6. Establishment and management of a system to prevent fraud by members, contractors and health care providers.

7. Development of an outreach program. The administration shall coordinate with public and private entities to provide outreach services for children under this article. Priority shall be given to those families who are moving off welfare. Outreach activities shall include strategies to inform communities, including tribal communities, about the program, ensure a wide distribution of applications and provide training for other entities to assist with the application process.

8. Coordination of benefits provided under this article for any member. The director may require that contractors and noncontracting providers are responsible for the coordination of benefits for services provided under this article. Requirements for coordination of benefits by noncontracting providers under this section are limited to coordination with standard health insurance and disability insurance policies and similar programs for health coverage. The director may require members to assign to the administration rights to all types of medical benefits to which the person is entitled, including first party medical benefits under automobile insurance policies. The state has a right of subrogation against any other person or firm to enforce the assignment of medical benefits. The provisions of this paragraph are controlling over the provisions of any insurance policy that provides benefits to a member if the policy is inconsistent with this paragraph.

9. Development and management of an eligibility, enrollment and redetermination system including a process for quality control.

10. Establishment and maintenance of an encounter claims system that ensures that ninety per cent of the clean claims are paid within thirty days after receipt and ninety-nine per cent of the remaining clean claims are paid within ninety days after receipt by the administration or contractor unless an alternative payment schedule is agreed to by the contractor and the provider. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section 36-2904, subsection G.

11. Establishment of standards for the coordination of medical care and member transfers.

12. Requiring contractors to submit encounter data in a form specified by the director.

13. Assessing civil penalties for improper billing as prescribed in section 36-2903.01, subsection ~~L~~ K.

B. Notwithstanding any other law, if Congress amends title XXI of the social security act and the administration is required to make conforming changes to rules adopted pursuant to this article, the administration shall request a hearing with the joint health committee of reference for review of the proposed rule changes.

C. The director may subcontract distinct administrative functions to one or more persons who may be contractors within the system.

D. The director shall require as a condition of a contract with any contractor that all records relating to contract compliance are available for inspection by the administration and that these records be maintained by the contractor for five years. The director shall also require that these records are available by a contractor on request of the secretary of the United States department of health and human services.

E. Subject to existing law relating to privilege and protection, the director shall prescribe by rule the types of information that are confidential and circumstances under which this information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other law, these rules shall be designed to provide for the exchange of necessary information for the purposes of eligibility determination under this article. Notwithstanding any other law, a member's medical record shall be released without the member's consent in situations of suspected cases of fraud or abuse relating to the system to an officer of this state's certified Arizona health care cost containment system fraud control unit who has submitted a written request for the medical record.

F. The director shall provide for the transition of members between contractors and noncontracting providers and the transfer of members who have been determined eligible from hospitals that do not have contracts to care for these persons.

G. To the extent that services are furnished pursuant to this article, a contractor is not subject to title 20 unless the contractor is a qualifying plan and has elected to provide services pursuant to this article.

H. As a condition of a contract, the director shall require contract terms that are necessary to ensure adequate performance by the contractor. Contract provisions required by the director include the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors who have posted other security, equal to or greater than that required by the administration, with a state agency for the performance of health service contracts if monies would be available from that security for the system on default by the contractor.

I. The director shall establish solvency requirements in contract that may include withholding or forfeiture of payments to be made to a contractor by the administration for the failure of the contractor to comply with a provision of the contract with the administration. The director may also require contract terms allowing the administration to operate a contractor directly under circumstances specified in the contract. The administration shall operate the contractor only as long as it is necessary to assure delivery of uninterrupted care to members enrolled with the contractor and to accomplish the orderly transition of members to other contractors or until the contractor reorganizes or otherwise corrects the contract performance failure. The administration shall not operate a contractor unless, before that action, the administration delivers notice to the contractor providing an opportunity for a hearing in accordance with procedures established by the director. Notwithstanding the provisions of a contract, if the administration finds that the public health, safety or welfare requires emergency action, it may operate as the contractor on notice to the contractor and pending an administrative hearing, which it shall promptly institute.

J. For the sole purpose of matters concerning and directly related to this article, the administration is exempt from section 41-192.

K. The director may withhold payments to a noncontracting provider if the noncontracting provider does not comply with this article or adopted rules that relate to the specific services rendered and billed to the administration.

L. The director shall:

1. Prescribe uniform forms to be used by all contractors and furnish uniform forms and procedures, including methods of identification of members. The rules shall include requirements that an applicant personally complete or assist in the completion of eligibility application forms, except in situations in which the person is disabled.

2. By rule, establish a grievance and appeal procedure that conforms with the process and the time frames specified in article 1 of this chapter. If the program is suspended or terminated pursuant to section 36-2985, an applicant or member is not entitled to contest the denial, suspension or termination of eligibility for the program.

3. Apply for and accept federal monies available under title XXI of the social security act. Available state monies appropriated to the

administration for the operation of the program shall be used as matching monies to secure federal monies pursuant to this subsection.

M. The administration is entitled to all rights provided to the administration for liens and release of claims as specified in sections 36-2915 and 36-2916 and shall coordinate benefits pursuant to section 36-2903, subsection F and be a payor of last resort for persons who are eligible pursuant to this article.

N. The director shall follow the same procedures for review committees, immunity and confidentiality that are prescribed in article 1 of this chapter.

Sec. 14. Section 36-2987, Arizona Revised Statutes, is amended to read:

36-2987. Reimbursement for the program

A. For inpatient hospital services, the administration shall reimburse the Indian health service or a tribal facility based on the reimbursement rates for the Indian health service as published annually in the federal register. For outpatient services, the administration shall reimburse the Indian health service or a tribal facility based on the capped fee-for-service schedule established by the director. If Congress authorizes one hundred per cent pass-through of title XXI monies for services provided in an Indian health service facility or a tribal facility, the administration shall reimburse the Indian health service or the tribal facility with this enhanced federal funding based on the reimbursement rates for the Indian health service or the tribal facility as published annually in the federal register.

B. Contractors shall reimburse inpatient and outpatient services based on the reimbursement methodology established in section 36-2904 or the hospital reimbursement pilot program established by this state.

C. For services rendered on and after October 1, 1998, the administration and the contractors shall pay a hospital's rate established according to this section subject to the following:

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

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

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

D. The administration and the contractors shall pay claims pursuant to the methodology, definitions and time frames specified for clean claims in section 36-2904, subsection G.

E. The director shall specify enrollment procedures, including notice to contractors of enrollment. The administration shall specify in contract when a person who has been determined eligible will be enrolled with a contractor and the date on which the contractor will be financially responsible for health and medical services to the person.

F. The director shall monitor any third party payment collections collected by contractors and noncontracting providers according to the same procedures specified for title XIX pursuant to section 36-2903.01, subsection ~~K~~ J.

G. On oral or written notice from the member, or the member's parent or legal guardian, that the member, parent or legal guardian believes a claim should be covered by the program, a contractor or noncontracting provider shall not do either of the following unless the contractor or noncontracting provider has verified through the administration that the person is ineligible for the program, has not yet been determined eligible or, at the time services were rendered, was not eligible or enrolled in the program:

1. Charge, submit a claim to or demand or otherwise collect payment from a member or person who has been determined eligible.

2. Refer or report a member or person who has been determined eligible to a collection agency or credit reporting agency for the failure of the member or person who has been determined eligible to pay charges for covered services unless specifically authorized by this article or rules adopted pursuant to this article.

H. The administration may conduct postpayment review of all payments made by the administration and may recoup any monies erroneously paid. The director may adopt rules that specify procedures for conducting postpayment review. Contractors may conduct a postpayment review of all claims paid to providers and may recoup monies that are erroneously paid.

I. The director or the director's designee may employ and supervise personnel necessary to assist the director in performing the functions of the program.

Sec. 15. Section 36-3411, Arizona Revised Statutes, is amended to read:

36-3411. Behavioral health services; timely reimbursement; penalties

A. The division shall ensure that behavioral health service providers are reimbursed within ninety days after the service provider submits a clean claim to a regional behavioral health authority.

B. Any contract issued by or on behalf of the division for the provision of behavioral health services shall include language outlining provisions for penalties for noncompliance with contract requirements.

C. If the regional behavioral health authority does not reimburse a provider as required by this section, the director shall subject the regional behavioral health authority to the penalty provisions prescribed in the contract, which shall not exceed the interest charges prescribed in section 44-1201. The director shall impose any financial penalties levied ~~upon~~ ON

the regional behavioral health authority through a reduction in the amount of funds payable to the regional behavioral health authority for administrative expenses.

D. The ninety day deadline imposed by this section is suspended while a formal grievance regarding the legitimacy of a claim is pending.

E. The department or a regional behavioral health authority shall not pay claims for covered services that are initially submitted more than nine months after the date of the services for which payment is claimed or that are submitted as clean claims more than twelve months after the date of service for which payment is claimed. A person dissatisfied with the denial of a claim by the department or by the regional behavioral health authority has twelve months from the date of the service for which payment is claimed to institute a grievance against the department or regional behavioral health authority.

F. For claims paid by the department, either directly or through a third party payor, the director may impose a penalty on a regional behavioral health authority or a service provider who submits a claim to the department for payment more than one time after the same claim had been previously denied by the department without having attempted to address the reason given for the denial. The penalty imposed by the director shall not exceed the average cost incurred by the department for processing a claim and shall be levied ~~upon~~ ON the regional behavioral health authority or service provider through reducing any future payment or payments until the amount of the penalty has been paid.

G. This section does not apply to services provided by a hospital pursuant to section 36-2903.01, subsection G ~~or H~~, or section 36-2904, subsection H or I.

Sec. 16. Section 41-1608, Arizona Revised Statutes, is amended to read:

41-1608. Inmate medical services; rate structure

If a prisoner in a secure care facility requires health care services that the department, the facility or a private prison provider contracted by the department cannot provide, the department shall pay approved claims from a facility or provider that provides these services as follows:

1. For inpatient and outpatient hospital services, the department shall reimburse at a level that does not exceed the reimbursement methodology established pursuant to section 36-2903.01, subsection ~~H~~ G.

2. For health and medical services, the department shall reimburse at a level that does not exceed the capped fee-for-service schedule that is adopted by the Arizona health care cost containment system administration pursuant to title 36, chapter 29, article 1 and that is in effect at the time the services are delivered.

Sec. 17. Section 41-1954, Arizona Revised Statutes, is amended to read:

41-1954. Powers and duties

A. In addition to the powers and duties of the agencies listed in section 41-1953, subsection E, the department shall:

1. Administer the following services:

(a) Employment services, which shall include manpower programs and work training, field operations, technical services, unemployment compensation, community work and training and other related functions in furtherance of programs under the social security act, as amended, the Wagner-Peyser act, as amended, the federal unemployment tax act, as amended, 33 United States Code, the family support act of 1988 (P.L. 100-485) and other related federal acts and titles.

(b) Individual and family services, which shall include a section on aging, services to children, youth and adults and other related functions in furtherance of social service programs under the social security act, as amended, title IV, grants to states for aid and services to needy families with children and for child-welfare services, title XX, grants to states for services, the older Americans act, as amended, the family support act of 1988 (P.L. 100-485) and other related federal acts and titles.

(c) Income maintenance services, which shall include categorical assistance programs, special services unit, child support collection services, establishment of paternity services, maintenance and operation of a state case registry of child support orders, a state directory of new hires, a support payment clearinghouse and other related functions in furtherance of programs under the social security act, title IV, grants to states for aid and services to needy families with children and for child-welfare services, title XX, grants to states for services, as amended, and other related federal acts and titles.

(d) Rehabilitation services, which shall include vocational rehabilitation services and sections for the blind and visually impaired, communication disorders, correctional rehabilitation and other related functions in furtherance of programs under the vocational rehabilitation act, as amended, the Randolph-Sheppard act, as amended, and other related federal acts and titles.

(e) Administrative services, which shall include the coordination of program evaluation and research, interagency program coordination and in-service training, planning, grants, development and management, information, legislative liaison, budget, licensing and other related functions.

(f) Manpower planning, which shall include a state manpower planning council for the purposes of the federal-state-local cooperative manpower planning system and other related functions in furtherance of programs under the comprehensive employment and training act of 1973, as amended, and other related federal acts and titles.

(g) Economic opportunity services, which shall include the furtherance of programs prescribed under the economic opportunity act of 1967, as amended, and other related federal acts and titles.

(h) Intellectual disability and other developmental disability programs, with emphasis on referral and purchase of services. The program shall include educational, rehabilitation, treatment and training services and other related functions in furtherance of programs under the developmental disabilities services and facilities construction act, Public Law 91-517, and other related federal acts and titles.

(i) Nonmedical home and community based services and functions, including department designated case management, housekeeping services, chore services, home health aid, personal care, visiting nurse services, adult day care or adult day health, respite sitter care, attendant care, home delivered meals and other related services and functions.

2. Provide a coordinated system of initial intake, screening, evaluation and referral of persons served by the department.

3. Adopt rules it deems necessary or desirable to further the objectives and programs of the department.

4. Formulate policies, plans and programs to effectuate the missions and purposes of the department.

5. Employ, determine the conditions of employment and prescribe the duties and powers of administrative, professional, technical, secretarial, clerical and other persons as may be necessary in the performance of its duties, contract for the services of outside advisors, consultants and aides as may be reasonably necessary and reimburse department volunteers, designated by the director, for expenses in transporting clients of the department on official business.

6. Make contracts and incur obligations within the general scope of its activities and operations subject to the availability of funds.

7. Contract with or assist other departments, agencies and institutions of the state, local and federal governments in the furtherance of its purposes, objectives and programs.

8. Be designated as the single state agency for the purposes of administering and in furtherance of each federally supported state plan.

9. Accept and disburse grants, matching funds and direct payments from public or private agencies for the conduct of programs that are consistent with the overall purposes and objectives of the department.

10. Provide information and advice on request by local, state and federal agencies and by private citizens, business enterprises and community organizations on matters within the scope of its duties subject to the departmental rules on the confidentiality of information.

11. Establish and maintain separate financial accounts as required by federal law or regulations.

12. Advise and make recommendations to the governor and the legislature on all matters concerning its objectives.

13. Have an official seal that shall be judicially noticed.

14. Annually estimate the current year's population of each county, city and town in this state, using the periodic census conducted by the United States department of commerce, or its successor agency, as the basis

for such estimates and deliver such estimates to the economic estimates commission before December 15.

15. Estimate the population of any newly annexed areas of a political subdivision as of July 1 of the fiscal year in which the annexation occurs and deliver such estimates as promptly as is feasible after the annexation occurs to the economic estimates commission.

16. Establish and maintain a statewide program of services for persons who are both hearing impaired and visually impaired and coordinate appropriate services with other agencies and organizations to avoid duplication of these services and to increase efficiency. The department of economic security shall enter into agreements for the utilization of the personnel and facilities of the department of economic security, the department of health services and other appropriate agencies and organizations in providing these services.

17. Establish and charge fees for deposit in the department of economic security prelayoff assistance services fund to employers who voluntarily participate in the services of the department that provide job service and retraining for persons who have been or are about to be laid off from employment. The department shall charge only those fees necessary to cover the costs of administering the job service and retraining services.

18. Establish a focal point for addressing the issue of hunger in Arizona and provide coordination and assistance to public and private nonprofit organizations that aid hungry persons and families throughout this state. Specifically such activities shall include:

(a) Collecting and disseminating information regarding the location and availability of surplus food for distribution to needy persons, the availability of surplus food for donation to charity food bank organizations, and the needs of charity food bank organizations for surplus food.

(b) Coordinating the activities of federal, state, local and private nonprofit organizations that provide food assistance to the hungry.

(c) Accepting and disbursing federal monies, and any state monies appropriated by the legislature, to private nonprofit organizations in support of the collection, receipt, handling, storage and distribution of donated or surplus food items.

(d) Providing technical assistance to private nonprofit organizations that provide or intend to provide services to the hungry.

(e) Developing a state plan on hunger that, at a minimum, identifies the magnitude of the hunger problem in this state, the characteristics of the population in need, the availability and location of charity food banks and the potential sources of surplus food, assesses the effectiveness of the donated food collection and distribution network and other efforts to alleviate the hunger problem, and recommends goals and strategies to improve the status of the hungry. The state plan on hunger shall be incorporated into the department's state comprehensive plan prepared pursuant to section 41-1956.

(f) Establishing a special purpose advisory council on hunger pursuant to section 41-1981.

19. Establish an office to address the issue of homelessness and to provide coordination and assistance to public and private nonprofit organizations that prevent homelessness or aid homeless individuals and families throughout this state. These activities shall include:

(a) Promoting and participating in planning for the prevention of homelessness and the development of services to homeless persons.

(b) Identifying and developing strategies for resolving barriers in state agency service delivery systems that inhibit the provision and coordination of appropriate services to homeless persons and persons in danger of being homeless.

(c) Assisting in the coordination of the activities of federal, state and local governments and the private sector that prevent homelessness or provide assistance to homeless people.

(d) Assisting in obtaining and increasing funding from all appropriate sources to prevent homelessness or assist in alleviating homelessness.

(e) Serving as a clearinghouse on information regarding funding and services available to assist homeless persons and persons in danger of being homeless.

(f) Developing an annual state comprehensive homeless assistance plan to prevent and alleviate homelessness.

(g) Submitting an annual report to the governor, the president of the senate and the speaker of the house of representatives on the status of homelessness and efforts to prevent and alleviate homelessness.

20. Cooperate with the Arizona-Mexico commission in the governor's office and with researchers at universities in this state to collect data and conduct projects in the United States and Mexico on issues that are within the scope of the department's duties and that relate to quality of life, trade and economic development in this state in a manner that will help the Arizona-Mexico commission to assess and enhance the economic competitiveness of this state and of the Arizona-Mexico region.

B. If the department OF ECONOMIC SECURITY has responsibility for the care, custody or control of a child or is paying the cost of care for a child, it may serve as representative payee to receive and administer social security and ~~veterans administration~~ UNITED STATES DEPARTMENT OF VETERANS AFFAIRS benefits and other benefits payable to such child. Notwithstanding any law to the contrary, the department OF ECONOMIC SECURITY:

1. Shall deposit, pursuant to sections 35-146 and 35-147, such monies as it receives to be retained separate and apart from the state general fund on the books of the department of administration.

2. May use such monies to defray the cost of care and services expended by the department OF ECONOMIC SECURITY for the benefit, welfare and best interests of the child and invest any of the monies that the director determines are not necessary for immediate use.

3. Shall maintain separate records to account for the receipt, investment and disposition of funds received for each child.

4. On termination of the ~~department's~~ DEPARTMENT OF ECONOMIC SECURITY'S responsibility for the child, shall release any funds remaining to the child's credit in accordance with the requirements of the funding source or in the absence of such requirements shall release the remaining funds to:

(a) The child, if the child is at least eighteen years of age or is emancipated.

(b) The person responsible for the child if the child is a minor and not emancipated.

C. Subsection B of this section does not pertain to benefits payable to or for the benefit of a child receiving services under title 36.

D. Volunteers reimbursed for expenses pursuant to subsection A, paragraph 5 of this section are not eligible for workers' compensation under title 23, chapter 6.

E. In implementing the temporary assistance for needy families program pursuant to Public Law 104-193, the department shall provide for cash assistance to two parent families if both parents are able to work only on documented participation by both parents in work activities described in title 46, chapter 2, article 5, except that payments may be made to families who do not meet the participation requirements if:

1. It is determined on an individual case basis that they have emergency needs.

2. The family is determined to be eligible for diversion from long-term cash assistance pursuant to title 46, chapter 2, article 5.

F. The department shall provide for cash assistance under temporary assistance for needy families pursuant to Public Law 104-193 to two parent families for no longer than six months if both parents are able to work, except that additional assistance may be provided on an individual case basis to families with extraordinary circumstances. The department shall establish by rule the criteria to be used to determine eligibility for additional cash assistance.

G. The department shall adopt the following discount medical payment system for persons who the department determines are eligible and who are receiving rehabilitation services pursuant to subsection A, paragraph 1, subdivision (d) of this section:

1. For inpatient hospital admissions and outpatient hospital services the department shall reimburse a hospital according to the ~~tiered per diem~~ rates ~~and outpatient cost-to-charge ratios~~ established by the Arizona health care cost containment system administration pursuant to section 36-2903.01, subsection ~~H~~ G.

2. The department's liability for a hospital claim under this subsection is subject to availability of funds.

3. A hospital bill is considered received for purposes of paragraph 5 of this subsection on initial receipt of the legible, error-free claim form

by the department 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.

4. The department shall require that the hospital pursue other third-party payors before submitting a claim to the department. Payment received by a hospital from the department pursuant to this subsection is considered payment by the department of the department'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 inpatient hospital admissions and outpatient hospital services rendered on and after October 1, 1997, if the department receives the claim directly from the hospital, the department 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 department 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 department 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 department 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. For medical services other than those for which a rate has been established pursuant to section 36-2903.01, subsection ~~H~~ G, the department shall pay according to the Arizona health care cost containment system capped fee-for-service schedule adopted pursuant to section 36-2904, subsection K or any other established fee schedule the department determines reasonable.

H. The department shall not pay claims for services pursuant to this section that are submitted more than nine months after the date of service for which the payment is claimed.

I. To assist in the location of persons or assets for the purpose of establishing paternity, establishing, modifying or enforcing child support obligations and other related functions, the department has access, including automated access if the records are maintained in an automated database, to records of state and local government agencies, including:

1. Vital statistics, including records of marriage, birth and divorce.

2. State and local tax and revenue records, including information on residence address, employer, income and assets.

3. Records concerning real and titled personal property.
4. Records of occupational and professional licenses.
5. Records concerning the ownership and control of corporations, partnerships and other business entities.
6. Employment security records.
7. Records of agencies administering public assistance programs.
8. Records of the motor vehicle division of the department of transportation.
9. Records of the state department of corrections.
10. Any system used by a state agency to locate a person for motor vehicle or law enforcement purposes, including access to information contained in the Arizona criminal justice information system.

J. Notwithstanding subsection I of this section, the department or its agents shall not seek or obtain information on the assets of an individual unless paternity is presumed pursuant to section 25-814 or established.

K. Access to records of the department of revenue pursuant to subsection I of this section shall be provided in accordance with section 42-2003.

L. The department also has access to certain records held by private entities with respect to child support obligors or obligees, or individuals against whom such an obligation is sought. The information shall be obtained as follows:

1. In response to a child support subpoena issued by the department pursuant to section 25-520, the names and addresses of these persons and the names and addresses of the employers of these persons, as appearing in customer records of public utilities and cable television companies.
2. Information on these persons held by financial institutions.

M. Pursuant to department rules, the department may compromise or settle any support debt owed to the department if the director or an authorized agent determines that it is in the best interest of the state and after considering each of the following factors:

1. The obligor's financial resources.
2. The cost of further enforcement action.
3. The likelihood of recovering the full amount of the debt.

N. Notwithstanding any law to the contrary, a state or local governmental agency or private entity is not subject to civil liability for the disclosure of information made in good faith to the department pursuant to this section.

Sec. 18. Section 41-2807, Arizona Revised Statutes, is amended to read:

41-2807. Medical services; rate structure

If a youth in a secure care facility requires health care services that the department, the facility or a provider contracted by the department cannot provide, the department shall pay approved claims from a facility or provider that provides these services as follows:

1. For inpatient and outpatient hospital services, the department shall reimburse at a level that does not exceed the reimbursement methodology established pursuant to section 36-2903.01, subsection ~~H~~ G, unless the department has a contract with the vendor.

2. For health and medical services, the department shall reimburse at a level that does not exceed the capped fee-for-service schedule that is adopted by the Arizona health care cost containment system administration pursuant to title 36, chapter 29, article 1 and that is in effect at the time the services are delivered.

Sec. 19. Section 48-5501, Arizona Revised Statutes, is amended to read:

48-5501. Definitions

In this chapter, unless the context otherwise requires:

1. "Freestanding urgent care center":

(a) Means an outpatient treatment center that, regardless of its posted or advertised name, meets any of the following requirements:

(i) Is open twenty-four hours a day, excluding at its option weekends or certain holidays, but is not licensed as a hospital.

(ii) Claims to provide unscheduled medical services that are not otherwise routinely available in primary care physician offices.

(iii) By its posted or advertised name, gives the impression to the public that it provides medical care for urgent, immediate or emergency conditions.

(iv) Routinely provides ongoing unscheduled medical services for more than eight consecutive hours for an individual patient.

(b) Does not include the following:

(i) A medical facility that is licensed under a hospital's license and that uses the hospital's medical provider number.

(ii) A qualifying community health center pursuant to section 36-2907.06.

(iii) Any other health care institution that is licensed pursuant to this chapter.

(iv) A physician's office that offers extended hours or same day appointments to existing and new patients and that does not meet the requirements of subdivision (a), item (i), (iii) or (iv). For the purposes of this item, "physician" means a person licensed pursuant to title 32, chapter 13 or 17.

2. "Home health agency" has the same meaning prescribed in section 36-151.

3. "Medical clinic" means a facility that provides for physical evaluation, diagnosis and treatment of patients and that does not keep patients overnight as bed patients or treat patients under general anesthesia.

4. "Medically underserved" means populations that exhibit one or more of the following indicators:

(a) Limitations on the availability of primary care providers, prenatal care or other health care services.

(b) Residence in a health professional shortage area as defined in 42 Code of Federal Regulations part 5.

(c) A standard of living at or below a designated federal poverty level.

(d) Other factors indicative of being medically underserved, including levels of unemployment, incidence of infant mortality or low birth weights and the elderly.

5. "Nursing care institution" has the same meaning prescribed in section 36-401.

6. "Qualified electors" means persons who are qualified to vote pursuant to title 16.

7. "Special payments" means any payments made pursuant to section 36-2903.01, subsection ~~P~~ O to or on behalf of a county operated hospital, including a hospital that is owned or leased by a special health care district.

Sec. 20. Section 48-5561.01, Arizona Revised Statutes, is amended to read:

48-5561.01. Special payments to a special health care district; transfers; county treasurer; state treasurer

A. For a special health care district that is organized pursuant to this chapter and that constructs a general hospital or acquires or leases a general hospital from a county pursuant to section 48-5541.01, the following ~~applies~~ APPLY:

1. Notwithstanding section 48-5561, if the hospital receives special payments pursuant to section 36-2903.01, subsection ~~P~~ O, the county treasurer of the county in which the district is located shall withdraw monies from the monies of the district on deposit with the county treasurer and transfer those monies to the county general fund.

2. The amount of those monies transferred shall be determined by the staff director of the joint legislative budget committee based on the annual legislative appropriation for special payments and contained in a notice from the governor. The transfer shall be made on the date or dates specified in the notice from the governor.

B. If the county treasurer for the county in which the district is located is unable to make any portion of the transfer of monies required by subsection A of this section, the county treasurer shall notify the state treasurer and the state treasurer shall cease to withhold any revenues of the county in which the district is located related to the distribution of special payments made pursuant to section 36-2903.01, subsection ~~P~~ O.

C. If the state treasurer ceases to withhold revenues pursuant to subsection B of this section and if the amount of revenues previously withheld by the state treasurer exceeds the amount of transferred monies required by subsection A of this section, the state treasurer shall credit

future amounts to be withheld from transaction privilege tax revenues of the county in which the district located in an amount equal to the difference.

Sec. 21. Payment methodology; stakeholder workgroups

The Arizona health care cost containment system administration shall establish workgroups to study and provide input on a new inpatient payment methodology. The workgroups shall consist of, but are not limited to, representatives from the urban, rural and critical access hospital communities, the health plan industry and the consumer advocacy groups.

Sec. 22. Payment methodology; public hearings

Before the effective date of a new or amended rule on a new inpatient payment methodology, the director of the Arizona health care cost containment system shall provide for public hearings for both the rural and critical access hospital communities on the proposed rule.

APPROVED BY THE GOVERNOR MARCH 29, 2012.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MARCH 29, 2012.