REFERENCE TITLE: 2013-2014; health; welfare; budget reconciliation

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

SB 1009

Introduced by
Senator Pierce

AN ACT

AMENDING SECTIONS 9-499.15 AND 32-1422, ARIZONA REVISED STATUTES; AMENDING TITLE 32, CHAPTER 32, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 32-3216; AMENDING SECTION 36-427, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 4, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-437; AMENDING SECTION 36-2901, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 36-2901.07, 36-2901.08 AND 36-2901.09; AMENDING SECTIONS 36-2903.01, 36-2907 AND 41-1005, ARIZONA REVISED STATUTES; AMENDING LAWS 2011, CHAPTER 234, SECTION 2; MAKING APPROPRIATIONS AND TRANSFERS; PROVIDING FOR THE DELAYED REPEAL OF SECTIONS 32-3216, 36-437, 36-2901.07 AND 36-2901.08, ARIZONA REVISED STATUTES, AS ADDED BY THIS ACT; RELATING TO HEALTH AND WELFARE BUDGET RECONCILIATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 9-499.15, Arizona Revised Statutes, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. Pay all fees required by the board.

9. Complete the application as required by the board.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IMPORTANT NOTICE ABOUT DIRECT PAYMENT
FOR YOUR HEALTH CARE SERVICES

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

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

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

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

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

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

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

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

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

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

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

L. FOR THE PURPOSES OF THIS SECTION:

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

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

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

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

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

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

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

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

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

Sec. 4. Section 36-427, Arizona Revised Statutes, is amended to read:

36-427. Suspension or revocation; intermediate sanctions

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

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

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

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

4. FAIL TO COMPLY WITH SECTION 36-2901.08.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IMPORTANT NOTICE ABOUT DIRECT PAYMENT
FOR YOUR HEALTH CARE SERVICES

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

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

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

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

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

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

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

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

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

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

M. FOR THE PURPOSES OF THIS SECTION:

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

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

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

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

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

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

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

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

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

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

36-2901. Definitions

In this article, unless the context otherwise requires:

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

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

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

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

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

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

(a) Any of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

36-2901.07. Definition of eligible person; conditional eligibility

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

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

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

36-2901.08. Hospital assessment

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

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

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

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

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

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

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

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

36-2901.09. Hospital assessment fund

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

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

C. MONIES IN THE FUND:

1. DO NOT REVERT TO THE STATE GENERAL FUND.

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

3. ARE CONTINUOUSLY APPROPRIATED.

Sec. 8. 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 of this section for hospital services or at the rate paid by the health plan, whichever is less.

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

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

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

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

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

1. For inpatient hospital stays from March 1, 1993 through September 30, 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 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~~ PRACTICES in this state. The administration shall report to the joint legislative budget committee by February 1 of each year on the number of new residency positions as reported by the graduate medical education programs.

(f) Local, county and tribal governments and any university under the jurisdiction of the Arizona board of regents may provide monies in addition to any state general fund monies appropriated for graduate medical education in order to qualify for additional matching federal monies for providers, programs or positions in a specific locality and costs incurred pursuant to a specific contract between the administration and providers or other entities to provide graduate medical education services as an administrative activity. Payments by the administration pursuant to this subdivision may be limited to those providers designated by the funding entity and may be based on any methodology deemed appropriate by the administration, including replacing any payments that might otherwise have been paid pursuant to subdivision (a), (b) or (c) of this paragraph had sufficient state general fund monies or other monies been appropriated to fully fund those payments. These programs, positions, payment methodologies and administrative graduate medical education services must be approved by the administration and the centers for medicare and medicaid services. The administration shall report to the president of the senate, the speaker of the house of representatives and the director of the joint legislative budget committee on or before July 1 of each year on the amount of money contributed and number of residency positions funded by local, county and tribal governments, including the amount of federal matching monies used.

(g) Any funds appropriated but not allocated by the administration for subdivision (b) or (c) of this paragraph may be reallocated if funding for

either subdivision is insufficient to cover appropriate graduate medical education costs.

10. Notwithstanding section 41-1005, subsection A, paragraph 9, the administration shall adopt rules pursuant to title 41, chapter 6 establishing the methodology for determining the prospective tiered per diem payments that are in effect through September 30, 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~~ OCTOBER 1, 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.

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

I. The administration may make direct payments to hospitals for hospitalization and medical care provided to a member in accordance with this article and rules. The director may adopt rules to establish the procedures by which the administration shall pay hospitals pursuant to this subsection if a contractor fails to make timely payment to a hospital. Such payment shall be at a level determined pursuant to section 36-2904, subsection H or I. The director may withhold payment due to a contractor in the amount of any payment made directly to a hospital by the administration on behalf of a contractor pursuant to this subsection.

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

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

2. The percentage of third-party payments that is collected by a contractor or noncontracting provider and that the contractor or noncontracting provider may keep and the percentage of such payments that the contractor or noncontracting provider may be required to pay to the administration. Contractors and noncontracting providers must pay to the administration one hundred per cent of all third-party payments that are collected and that duplicate administration fee-for-service payments. A contractor that contracts with the administration pursuant to section

36-2904, subsection A may be entitled to retain a percentage of third-party payments if the payments collected and retained by a contractor are reflected in reduced capitation rates. A contractor may be required to pay the administration a percentage of third-party payments that are collected by a contractor and that are not reflected in reduced capitation rates.

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

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

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

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

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

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

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

deposited in the state general fund. Section 36-2918, subsections C, D and F, relating to the imposition, collection and enforcement of civil penalties, apply to civil penalties imposed pursuant to this paragraph.

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

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

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

O. Notwithstanding any other law, on federal approval the administration may make disproportionate share payments to private hospitals, county operated hospitals, including hospitals owned or leased by a special health care district, and state operated institutions for mental disease beginning October 1, 1991 in accordance with federal law and subject to legislative appropriation. If at any time the administration receives written notification from federal authorities of any change or difference in the actual or estimated amount of federal funds available for disproportionate share payments from the amount reflected in the legislative appropriation for such purposes, the administration shall provide written notification of such change or difference to the president and the minority leader of the senate, the speaker and the minority leader of the house of representatives, the director of the joint legislative budget committee, the legislative committee of reference and any hospital trade association within this state, within three working days not including weekends after receipt of the notice of the change or difference. In calculating disproportionate share payments as prescribed in this section, the administration may use either a methodology based on claims and encounter data that is submitted to the administration from contractors or a methodology based on data that is reported to the administration by private hospitals and state operated institutions for mental disease. The selected methodology applies to all private hospitals and state operated institutions for mental disease qualifying for disproportionate share payments. For the purposes of this subsection, "disproportionate share payment" means a payment to a hospital that serves a disproportionate share of low-income patients as described by 42 United States Code section 1396r-4.

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

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

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

S. 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. 9. Section 36-2907, Arizona Revised Statutes, is amended to read:

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

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

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

2. Outpatient health services that are ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient health services include services provided by or under the direction of a physician or a primary care practitioner.

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

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

5. Medical supplies, durable medical equipment and prosthetic devices ordered by a physician or a primary care practitioner. Suppliers of durable

medical equipment shall provide the administration with complete information about the identity of each person who has an ownership or controlling interest in their business and shall comply with federal bonding requirements in a manner prescribed by the administration.

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

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

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

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

10. Nonexperimental transplants approved for title XIX reimbursement.

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

12. Hospice care.

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

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

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

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

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

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

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

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

(f) Nonexperimental transplants do not include ~~the following:~~

~~(i)~~ pancreas only transplants.

~~(ii) Pancreas after kidney transplants.~~

~~(iii) Lung transplants.~~

~~(iv) Hemopoetic cell allogenic unrelated transplants.~~

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

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

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

(h) Well exams are not a covered health and medical service, except mammograms, pap smears and colonoscopies.

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

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

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

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

G. The director shall adopt rules for the provision of transportation services and rules providing for copayment by members for transportation for other than emergency purposes. Subject to approval by the centers for medicare and medicaid services, nonemergency medical transportation shall not be provided except for stretcher vans and ambulance transportation. Prior

authorization is required for transportation by stretcher van and for medically necessary ambulance transportation initiated pursuant to a physician's direction. Prior authorization is not required for medically necessary ambulance transportation services rendered to members or eligible persons initiated by dialing telephone number 911 or other designated emergency response systems.

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

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

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

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

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

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

L. Covered outpatient services shall be subcontracted by a primary care physician or primary care practitioner to other licensed health care providers to the extent practicable for purposes including, but not limited

to, making health care services available to underserved areas, reducing costs of providing medical care and reducing transportation costs.

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

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

Sec. 10. Section 41-1005, Arizona Revised Statutes, is amended to read:

41-1005. Exemptions

A. This chapter does not apply to any:

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

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

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

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

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

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

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

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

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

10. Fees prescribed by section 6-125.

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

12. Fees established under section 3-1086.

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

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

15. Rule or other matter relating to agency contracts.
16. Fees established under section 32-2067 or 32-2132.
17. Rules made pursuant to section 5-111, subsection A.
18. Rules made by the Arizona state parks board concerning the operation of the Tonto natural bridge state park, the facilities located in the Tonto natural bridge state park and the entrance fees to the Tonto natural bridge state park.
19. Fees or charges established under section 41-511.05.
20. Emergency medical services protocols except as provided in section 36-2205, subsection B.
21. Fee schedules established pursuant to section 36-3409.
22. Procedures of the state transportation board as prescribed in section 28-7048.
23. Rules made by the state department of corrections.
24. Fees prescribed pursuant to section 32-1527.
25. Rules made by the department of economic security pursuant to section 46-805.
26. Schedule of fees prescribed by section 23-908.
27. Procedure that is established pursuant to title 23, chapter 6, article ~~5 or~~ 6.
28. Rules, administrative policies, procedures and guidelines adopted for any purpose by the Arizona commerce authority pursuant to chapter 10 of this title if the authority provides, as appropriate under the circumstances, for notice of an opportunity for comment on the proposed rules, administrative policies, procedures and guidelines.
29. Rules made by a marketing commission or marketing committee pursuant to section 3-414.
30. Administration of public assistance program monies authorized for liabilities that are incurred for disasters declared pursuant to sections 26-303 and 35-192.
31. User charges, tolls, fares, rents, advertising and sponsorship charges, services charges or similar charges established pursuant to section 28-7705.
32. ADMINISTRATION AND IMPLEMENTATION OF THE HOSPITAL ASSESSMENT PURSUANT TO SECTION 36-2901.08, EXCEPT THAT THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION MUST PROVIDE NOTICE AND AN OPPORTUNITY FOR PUBLIC COMMENT AT LEAST THIRTY DAYS BEFORE ESTABLISHING OR IMPLEMENTING THE ADMINISTRATION OF THE ASSESSMENT.

B. Notwithstanding subsection A, paragraph 22 of this section, at such time as the federal highway administration authorizes the privatization of rest areas, the state transportation board shall make rules governing the lease or license by the department of transportation to a private entity for the purposes of privatization of a rest area.

C. Coincident with the making of a final rule pursuant to an exemption from the applicability of this chapter under this section, another statute or

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

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

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

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

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

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

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

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

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

Sec. 12. ALTCS; county contributions; fiscal year 2013-2014

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 15. AHCCCS; disproportionate share payments

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

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

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

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

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

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

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

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

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

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

Sec. 16. AHCCCS transfer; counties; federal monies

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

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

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

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

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

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

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

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

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

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

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

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

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

1.	Apache	$ 87,300
2.	Cochise	$ 162,700
3.	Coconino	$ 160,500
4.	Gila	$ 65,900
5.	Graham	$ 46,800
6.	Greenlee	$ 12,000
7.	La Paz	$ 24,900
8.	Mohave	$ 187,400
9.	Navajo	$ 122,800
10.	Pima	$1,115,900
11.	Pinal	$ 218,300
12.	Santa Cruz	$ 51,600
13.	Yavapai	$ 206,200
14.	Yuma	$ 183,900

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

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

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

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

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

Sec. 19. Proposition 204 administration; county expenditure limitation

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

Sec. 20. AHCCCS; risk contingency rate setting

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

Sec. 21. AHCCCS; ambulance services; reimbursement

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

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

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

Sec. 23. Department of health services; health research account; Alzheimer's disease research

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

Sec. 24. Department of economic security; department of administration; long-term care system fund; fiscal year 2013-2014

Notwithstanding section 36-2953, Arizona Revised Statutes:

1. The department of economic security may use monies in the department long-term care system fund established pursuant to section 36-2953, Arizona Revised Statutes, for any operational or programmatic expenses in fiscal year 2013-2014.

2. The department of administration may use monies in the department long-term care system fund established pursuant to section 36-2953, Arizona Revised Statutes, for distribution to counties for operational expenses in fiscal year 2013-2014.

Sec. 25. Transfer of monies; hearing and speech professionals fund

All monies remaining in the hearing and speech professionals fund established by section 36-1903, Arizona Revised Statutes, on the effective date of this act are transferred to the health services licensing fund established by section 36-414, Arizona Revised Statutes, as amended by Laws 2013, chapter 33, section 1.

Sec. 26. Child care assistance eligibility; notification

Notwithstanding section 46-803, Arizona Revised Statutes, for fiscal year 2013-2014, the department of economic security may reduce maximum income eligibility levels for child care assistance in order to manage within appropriated and available monies. The department of economic security shall notify the joint legislative budget committee of any change in maximum income eligibility levels for child care within fifteen days after implementing the change.

Sec. 27. Department of economic security; drug testing; TANF cash benefits recipients

During fiscal year 2013-2014, the department of economic security shall screen and test each adult recipient who is otherwise eligible for temporary assistance for needy families cash benefits and who the department has reasonable cause to believe engages in the illegal use of controlled substances. Any recipient who is found to have tested positive for the use of a controlled substance that was not prescribed for the recipient by a licensed health care provider is ineligible to receive benefits for a period of one year.

Sec. 28. AHCCCS; emergency department use; report

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

Sec. 29. Child welfare; report; accountability factors

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

1. The average duration of time from when a child enters emergency and residential placement to the initial court case associated with that child.

2. The number of children moved from emergency and residential placement to foster care, delineated by major age groupings.

3. The number of child protective services staff hired or leaving by type, specifically the caseworkers' classification level from one through four.

4. The number of new and closed foster care receiving homes, including the total available placements by age groupings of infants, children who are one through five years of age, children who are six through twelve years of age and teen children who are twelve through eighteen years of age.

5. Cohort and behavioral health data.

Sec. 30. Auditor general; children support services reports

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

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

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

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

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

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

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

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

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

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

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

Sec. 33. Hospital transparency; report

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

Sec. 34. Arizona health care cost containment system; member notice

As part of the information provided at the time of enrollment to new members who are eligible pursuant to section 36-2901.01, Arizona Revised Statutes, and section 36-2901.07, Arizona Revised Statutes, as added by this act, the Arizona health care cost containment system administration shall provide notice that the member's enrollment in the Arizona health care cost containment system may be dependent on the availability of federal financial participation for the program.

Sec. 35. Medicaid federal circuit breaker study committee; membership; duties; delayed repeal

A. The medicaid federal circuit breaker study committee is established consisting of the following members:

1. Three members of the senate who are appointed by the president of the senate, not more than two of whom are members of the same political party. At least one member must be from a county other than Maricopa county.

2. Three members of the house of representatives who are appointed by the speaker of the house of representatives, not more than two of whom are members of the same political party. At least one member must be from a county other than Maricopa county.

3. The director of the governor's office of strategic planning and budgeting, or the director's designee.

4. The director of the Arizona health care cost containment system administration, or the director's designee.

5. Two representatives of Arizona hospitals, one whom is from an urban area and one of whom is from a rural area. The governor shall appoint these members.

6. Two representatives of the health insurance industry. The governor shall appoint these members.

7. One physician who is licensed pursuant to title 32, chapter 13 or 17, Arizona Revised Statutes. The governor shall appoint this member.

8. One nurse who is licensed pursuant to title 32, chapter 15, Arizona Revised Statutes. The governor shall appoint this member.

9. One representative of the business community. The governor shall appoint this member.

B. The committee shall evaluate the potential impact on the Arizona health care cost containment system of a decrease in federal funding and shall research the following impacts of decreased federal medicaid funding:

1. Options for transitioning members to cost-effective private health insurance coverage.

2. The impact on the state general fund.

3. The impact on health care delivery in this state, including on the following:

(a) Hospitals.

(b) Health insurance companies.

(c) Health care providers.

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

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

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

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

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

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

Sec. 37. Exemption from rule making

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

Sec. 38. Intent; hospital assessment

It is the intent of the legislature that:

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

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

Sec. 39. Intent; implementation of program

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

Sec. 40. Intent; false claims act; savings

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

Sec. 41. Intent; capitation rate increases

It is the intent of the legislature that the Arizona health care cost containment system administration capitation rate increases not exceed three per cent in fiscal years 2014-2015 and 2015-2016.

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

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

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

Sec. 43. Effective date

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

Sec. 44. Delayed repeal

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

Sec. 45. Severability

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

Sec. 46. Delayed effective date

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

Sec. 47. Delayed repeal

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