REFERENCE TITLE: health; budget reconciliation; 2010-2011

State of Arizona
House of Representatives
Forty-ninth Legislature
Seventh Special Session
2010

HB 2010

Introduced by
Representative Adams

AN ACT

AMENDING SECTIONS 36-2903, 36-2903.01, 36-2905, 36-2905.08, 36-2907, 36-2907.04, 36-2907.10, 36-2907.11 AND 36-2912, ARIZONA REVISED STATUTES; REPEALING TITLE 36, CHAPTER 29, ARTICLE 4, ARIZONA REVISED STATUTES; AMENDING SECTION 36-3408, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 37, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-3718; AMENDING LAWS 2009, THIRD SPECIAL SESSION, CHAPTER 3, SECTION 2; MAKING APPROPRIATIONS, REVERSIONS AND TRANSFERS; RELATING TO HEALTH BUDGET RECONCILIATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 36-2903, Arizona Revised Statutes, is amended to read:

36-2903. Arizona health care cost containment system; administrator; powers and duties of director and administrator; exemption from attorney general representation; definition

A. The Arizona health care cost containment system is established consisting of contracts with contractors for the provision of hospitalization and medical care coverage to members. Except as specifically required by federal law and by section 36-2909, the system is only responsible for providing care on or after the date that the person has been determined eligible for the system, and is only responsible for reimbursing the cost of care rendered on or after the date that the person was determined eligible for the system.

B. An agreement may be entered into with an independent contractor, subject to title 41, chapter 23, to serve as the statewide administrator of the system. The administrator has full operational responsibility, subject to supervision by the director, for the system, which may include any or all of the following:

1. Development of county-by-county implementation and operation plans for the system that include reasonable access to hospitalization and medical care services for members.

2. Contract administration and oversight of contractors, including certification instead of licensure for title XVIII and title XIX purposes.

3. Provision of technical assistance services to contractors and potential contractors.

4. Development of a complete system of accounts and controls for the system including provisions designed to ensure that covered health and medical services provided through the system are not used unnecessarily or unreasonably including but not limited to inpatient behavioral health services provided in a hospital. Periodically the administrator shall compare the scope, utilization rates, utilization control methods and unit prices of major health and medical services provided in this state in comparison with other states' health care services to identify any unnecessary or unreasonable utilization within the system. The administrator shall periodically assess the cost effectiveness and health implications of alternate approaches to the provision of covered health and medical services through the system in order to reduce unnecessary or unreasonable utilization.

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

6. Assistance in the formation of medical care consortiums to provide covered health and medical services under the system for a county.

7. Development and management of a contractor payment system.

8. Establishment and management of a comprehensive system for assuring the quality of care delivered by the system.

9. Establishment and management of a system to prevent fraud by members, subcontracted providers of care, contractors and noncontracting providers.

10. Coordination of benefits provided under this article to any member. The administrator may require that contractors and noncontracting providers are responsible for the coordination of benefits for services provided under this article. Requirements for coordination of benefits by noncontracting providers under this section are limited to coordination with standard health insurance and disability insurance policies and similar programs for health coverage.

11. Development of a health education and information program.

12. Development and management of an enrollment system.

13. Establishment and maintenance of a claims resolution procedure to ensure that ninety per cent of the clean claims shall be paid within thirty days of receipt and ninety-nine per cent of the remaining clean claims shall be paid within ninety days of receipt. For the purposes of this paragraph, "clean claims" has the same meaning ~~as~~ prescribed in section 36-2904, subsection G.

14. Establishment of standards for the coordination of medical care and patient transfers pursuant to section 36-2909, subsection B.

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

16. Establishment of an employee recognition fund.

17. Establishment of an eligibility process to determine whether a medicare low income subsidy is available to persons who want to apply for a subsidy as authorized by title XVIII.

C. If an agreement is not entered into with an independent contractor to serve as statewide administrator of the system pursuant to subsection B of this section, the director shall ensure that the operational responsibilities set forth in subsection B of this section are fulfilled by the administration and other contractors as necessary.

D. If the director determines that the administrator will fulfill some but not all of the responsibilities set forth in subsection B of this section, the director shall ensure that the remaining responsibilities are fulfilled by the administration and other contractors as necessary.

E. The administrator or any direct or indirect subsidiary of the administrator is not eligible to serve as a contractor.

F. Except for reinsurance obtained by contractors, the administrator shall coordinate benefits provided under this article to any eligible person

who is covered by workers' compensation, disability insurance, a hospital and medical service corporation, a health care services organization, an accountable health plan or any other health or medical or disability insurance plan including coverage made available to persons defined as eligible by section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e), or who receives payments for accident-related injuries, so that any costs for hospitalization and medical care paid by the system are recovered from any other available third party payors. The administrator may require that contractors and noncontracting providers are responsible for the coordination of benefits for services provided under this article. Requirements for coordination of benefits by noncontracting providers under this section are limited to coordination with standard health insurance and disability insurance policies and similar programs for health coverage. The system shall act as payor of last resort for persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a)~~,~~ OR section 36-2974 ~~or section 36-2981, paragraph 6~~ unless specifically prohibited by federal law. By operation of law, eligible persons assign to the system and a county rights to all types of medical benefits to which the person is entitled, including first party medical benefits under automobile insurance policies based on the order of priorities established pursuant to section 36-2915. The state has a right to subrogation against any other person or firm to enforce the assignment of medical benefits. The provisions of this subsection are controlling over the provisions of any insurance policy that provides benefits to an eligible person if the policy is inconsistent with the provisions of this subsection.

G. Notwithstanding subsection E of this section, the administrator may subcontract distinct administrative functions to one or more persons who may be contractors within the system.

H. The director shall require as a condition of a contract with any contractor that all records relating to contract compliance are available for inspection by the administrator and the director subject to subsection I of this section and that such records be maintained by the contractor for five years. The director shall also require that these records be made available by a contractor on request of the secretary of the United States department of health and human services, or its successor agency.

I. Subject to existing law relating to privilege and protection, the director shall prescribe by rule the types of information that are confidential and circumstances under which such information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other provision of law, such rules shall be designed to provide for the exchange of necessary information among the counties, the administration and the department of economic security for the purposes of eligibility determination under this article. Notwithstanding any law to the contrary, a member's medical record shall be released without the member's

consent in situations or suspected cases of fraud or abuse relating to the system to an officer of the state's certified Arizona health care cost containment system fraud control unit who has submitted a written request for the medical record.

J. The director shall prescribe rules that specify methods for:

1. The transition of members between system contractors and noncontracting providers.

2. The transfer of members and persons who have been determined eligible from hospitals that do not have contracts to care for such persons.

K. The director shall adopt rules that set forth procedures and standards for use by the system in requesting county long-term care for members or persons determined eligible.

L. To the extent that services are furnished pursuant to this article, and unless otherwise required pursuant to this chapter, a contractor is not subject to ~~the provisions of~~ title 20.

M. As a condition of the contract with any contractor, the director shall require contract terms as necessary in the judgment of the director to ensure adequate performance and compliance with all applicable federal laws by the contractor of the provisions of each contract executed pursuant to this chapter. Contract provisions required by the director shall include at a minimum the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors that have posted other security, equal to or greater than that required by the system, with a state agency for the performance of health service contracts if funds would be available from such security for the system on default by the contractor. The director may also adopt rules for the withholding or forfeiture of payments to be made to a contractor by the system for the failure of the contractor to comply with a provision of the contractor's contract with the system or with the adopted rules. The director may also require contract terms allowing the administration to operate a contractor directly under circumstances specified in the contract. The administration shall operate the contractor only as long as it is necessary to assure delivery of uninterrupted care to members enrolled with the contractor and accomplish the orderly transition of those members to other system contractors, or until the contractor reorganizes or otherwise corrects the contract performance failure. The administration shall not operate a contractor unless, before that action, the administration delivers notice to the contractor and provides an opportunity for a hearing in accordance with procedures established by the director. Notwithstanding the provisions of a contract, if the administration finds that the public health, safety or welfare requires emergency action, it may operate as the contractor on notice to the contractor and pending an administrative hearing, which it shall promptly institute.

N. The administration for the sole purpose of matters concerning and directly related to the Arizona health care cost containment system and the Arizona long-term care system is exempt from section 41-192.

O. Notwithstanding subsection F of this section, if the administration determines that according to federal guidelines it is more cost-effective for a person defined as eligible under section 36-2901, paragraph 6, subdivision (a) to be enrolled in a group health insurance plan in which the person is entitled to be enrolled, the administration may pay all of that person's premiums, deductibles, coinsurance and other cost sharing obligations for services covered under section 36-2907. The person shall apply for enrollment in the group health insurance plan as a condition of eligibility under section 36-2901, paragraph 6, subdivision (a).

P. The total amount of state monies that may be spent in any fiscal year by the administration for health care shall not exceed the amount appropriated or authorized by section 35-173 for all health care purposes. This article does not impose a duty on an officer, agent or employee of this state to discharge a responsibility or to create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.

Q. Notwithstanding section 36-470, a contractor or program contractor may receive laboratory tests from a laboratory or hospital-based laboratory for a system member enrolled with the contractor or program contractor subject to all of the following requirements:

1. The contractor or program contractor shall provide a written request to the laboratory in a format mutually agreed to by the laboratory and the requesting health plan or program contractor. The request shall include the member's name, the member's plan identification number, the specific test results that are being requested and the time periods and the quality improvement activity that prompted the request.

2. The laboratory data may be provided in written or electronic format based on the agreement between the laboratory and the contractor or program contractor. If there is no contract between the laboratory and the contractor or program contractor, the laboratory shall provide the requested data in a format agreed to by the noncontracted laboratory.

3. The laboratory test results provided to the member's contractor or program contractor shall only be used for quality improvement activities authorized by the administration and health care outcome studies required by the administration. The contractors and program contractors shall maintain strict confidentiality about the test results and identity of the member as specified in contractual arrangements with the administration and pursuant to state and federal law.

4. The administration, after collaboration with the department of health services regarding quality improvement activities, may prohibit the

contractors and program contractors from receiving certain test results if the administration determines that a serious potential exists that the results may be used for purposes other than those intended for the quality improvement activities. The department of health services shall consult with the clinical laboratory licensure advisory committee established by section 36-465 before providing recommendations to the administration on certain test results and quality improvement activities.

5. The administration shall provide contracted laboratories and the department of health services with an annual report listing the quality improvement activities that will require laboratory data. The report shall be updated and distributed to the contracting laboratories and the department of health services when laboratory data is needed for new quality improvement activities.

6. A laboratory that complies with a request from the contractor or program contractor for laboratory results pursuant to this section is not subject to civil liability for providing the data to the contractor or program contractor. The administration, the contractor or a program contractor that uses data for reasons other than quality improvement activities is subject to civil liability for this improper use.

R. For the purposes of this section, "quality improvement activities" means those requirements, including health care outcome studies specified in federal law or required by the centers for medicare and medicaid services or the administration, to improve health care outcomes.

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

36-2903.01. Additional powers and duties; report

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

B. The director shall:

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

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

including those defined pursuant to section 36-2901, paragraph 6, subdivision (a).

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

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

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

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

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

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

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

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

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

4. By rule establish a procedure and time frames for the intake of grievances and requests for hearings, for the continuation of benefits and services during the appeal process and for a grievance process at the contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and 41-1092.05, the administration shall develop rules to establish the procedure and time frame for the informal resolution of grievances and appeals. A grievance that is not related to a claim for payment of system covered services shall be filed in writing with and received by the administration or the prepaid capitated provider or program contractor not later than sixty days after the date of the adverse action, decision or policy implementation being grieved. A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor within twelve months after the date of service, within twelve months after the date that eligibility is posted or within sixty days after the date of the denial of a

timely claim submission, whichever is later. A grievance for the denial of a claim for reimbursement of services may contest the validity of any adverse action, decision, policy implementation or rule that related to or resulted in the full or partial denial of the claim. A policy implementation may be subject to a grievance procedure, but it may not be appealed for a hearing. The administration is not required to participate in a mandatory settlement conference if it is not a real party in interest. In any proceeding before the administration, including a grievance or hearing, persons may represent themselves or be represented by a duly authorized agent who is not charging a fee. A legal entity may be represented by an officer, partner or employee who is specifically authorized by the legal entity to represent it in the particular proceeding.

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

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

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

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

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

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

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

1. Authorize advance payments based on estimated liability to a contractor or a noncontracting provider after the contractor or noncontracting provider has submitted a claim for services and before the claim is ultimately resolved. The rules shall specify that any advance payment shall be conditioned on the execution before payment of a contract

with the contractor or noncontracting provider that requires the administration to retain a specified percentage, which shall be at least twenty per cent, of the claimed amount as security and that requires repayment to the administration if the administration makes any overpayment.

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

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

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

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

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

G. For inpatient hospital admissions and all outpatient hospital services before March 1, 1993, the administration shall reimburse a hospital's adjusted billed charges according to the following procedures:

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

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

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

(c) The schedule of rates and charges for a hospital that became effective after May 31, 1984 but before July 2, 1984, limited to five per

cent over the hospital's previous rate schedule, and if the hospital's previous rate schedule became effective on or after April 30, 1983 but before October 1, 1983. For the purposes of this paragraph, "constant" means equal to or lower than.

2. The director shall adopt rules that, for services rendered from and after September 30, 1986, define "adjusted billed charges" as that reimbursement level that has the effect of increasing by four per cent a hospital's reimbursement level in effect on October 1, 1985 as prescribed in paragraph 1 of this subsection. Beginning January 1, 1991, the Arizona health care cost containment system administration shall define "adjusted billed charges" as the reimbursement level determined pursuant to this section, increased by two and one-half per cent.

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

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

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

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

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

5. The director shall define by rule the method of determining when a hospital bill will be considered received and when a hospital's billed charges will be considered paid. Payment received by a hospital from the administration pursuant to this subsection or from a contractor either by contract or pursuant to section 36-2904, subsection I shall be considered payment of the hospital bill in full, except that a hospital may collect any unpaid portion of its bill from other third party payors or in situations covered by title 33, chapter 7, article 3.

H. 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, the administration shall use a prospective tiered per diem methodology, using hospital peer groups if analysis shows that cost differences can be attributed to independently definable features that hospitals within a peer group share. In peer grouping the administration may consider such factors as length of stay differences and labor market variations. If there are no cost differences, the administration shall implement a stop loss-stop gain or similar mechanism. Any stop loss-stop gain or similar mechanism shall ensure that

the tiered per diem rates assigned to a hospital do not represent less than ninety per cent of its 1990 base year costs or more than one hundred ten per cent of its 1990 base year costs, adjusted by an audit factor, during the period of March 1, 1993 through September 30, 1994. The tiered per diem rates set for hospitals shall represent no less than eighty-seven and one-half per cent or more than one hundred twelve and one-half per cent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1994 through September 30, 1995 and no less than eighty-five per cent or more than one hundred fifteen per cent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1995 through September 30, 1996. For the periods after September 30, 1996 no stop loss-stop gain or similar mechanisms shall be in effect. An adjustment in the stop loss-stop gain percentage may be made to ensure that total payments do not increase as a result of this provision. If peer groups are used the administration shall establish initial peer group designations for each hospital before implementation of the per diem system. The administration may also use a negotiated rate methodology. The tiered per diem methodology may include separate consideration for specialty hospitals that limit their provision of services to specific patient populations, such as rehabilitative patients or children. The initial per diem rates shall be based on hospital claims and encounter data for dates of service November 1, 1990 through October 31, 1991 and processed through May of 1992.

2. For rates effective on October 1, 1994, and annually thereafter, 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. The administration shall adjust the capital related cost component by the data resources incorporated market basket index for prospective payment system hospitals.

9. For graduate medical education programs:

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

available under this subdivision shall not exceed the fiscal year 2005-2006 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement, except for monies distributed for expansions pursuant to subdivision (b) of this paragraph.

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

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

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

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

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

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

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

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

committee by February 1 of each year on the number of new residency positions as reported by the graduate medical education programs.

(f) Beginning July 1, 2007, local, county and tribal governments 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 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. These programs, positions 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.

(h) For the purposes of this paragraph, "graduate medical education program" 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.

10. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the payment of claims with extraordinary operating costs per day. For tiered per diem rates effective beginning on October 1, 1999, outlier cost thresholds are frozen at the levels in effect on January 1, 1999 and adjusted annually by the administration by the global insight hospital market basket index for prospective payment system hospitals. Beginning with dates of service on or after October 1, 2007, the administration shall phase in the use of the most recent statewide urban and statewide rural average medicare cost-to-charge ratios or centers for medicare and medicaid services approved cost-to-charge ratios to qualify and pay extraordinary operating costs. Cost-to-charge ratios shall be updated annually. Routine maternity charges are not eligible for outlier reimbursement. The administration shall complete full implementation of the phase-in on or before October 1, 2009.

11. 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.

I. The director may adopt rules that specify enrollment procedures, including notice to contractors of enrollment. The rules may provide for

varying time limits for enrollment in different situations. The administration shall specify in contract when a person who has been determined eligible will be enrolled with that contractor and the date on which the contractor will be financially responsible for health and medical services to the person.

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

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

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

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

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

1. On written notice from the administration or oral or written notice from a member that a claim for covered services may be in violation of this section, the provider that has a contract with a contractor or noncontracting provider shall investigate the inquiry and verify whether the person was eligible for services at the time that covered services were provided. If

the claim was paid or should have been paid by the system, the provider that has a contract with a contractor or noncontracting provider shall not continue billing the member.

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

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

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

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

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

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

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

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

P. 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.

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

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

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

Sec. 3. Section 36-2905, Arizona Revised Statutes, is amended to read:

36-2905. Removal of medicaid special exemption for payments to contractors; civil penalty

A. Notwithstanding any other law, beginning on October 1, 2003, each contractor shall pay to the director of the department of insurance a tax equal to two per cent of the total capitation, including reinsurance, and any other reimbursement paid to the contractor by the administration for persons eligible pursuant to section 36-2901, paragraph 6, subdivisions (a) and (g) ~~and article 4 of this chapter~~. The tax shall be paid in four payments pursuant to subsection C of this section and deposited in the state general fund pursuant to sections 35-146 and 35-147.

B. The contractor shall not deduct any disallowance or penalty imposed by the administration pursuant to this chapter from the financial information submitted to the director of the department of insurance.

C. Each contractor shall file the estimated tax and documentation with the director of the department of insurance on a form prescribed by the director of the department of insurance to pay the estimated tax. A contractor shall make estimated tax payments to the director of the department of insurance for deposit in the state general fund pursuant to sections 35-146 and 35-147. The tax payments are due on or before September 15, December 15, March 15 and June 15 of each year. The amount of the payments shall be an estimate of the tax due for the quarter that ends in the month that payment is due.

D. On or before April 1, 2004 and annually on or before April 1 thereafter, the director of the department of insurance shall use data provided by the administration to reconcile the amount paid by each contractor pursuant to this section with the actual amount of title XIX ~~and title XXI~~ reimbursement made by the administration to the contractor in the preceding calendar year. If there is a discrepancy in the two amounts, the director of the department of insurance shall notify the contractor of the difference, provide a notice of right of appeal and bill the contractor for the unpaid amount of the premium tax or, if there is an overpayment, the director of the department of insurance shall either refund the amount of the overpayment to the contractor or issue a credit for the amount of the overpayment that the contractor can apply against future tax obligations prescribed by this section.

E. A contractor who fails to file an estimated payment or pay an unpaid premium tax as prescribed by this section is subject to a civil penalty equal to the greater of twenty-five dollars or five per cent of the amount due and is subject to interest on the amount due at the rate of one per cent per month from the date the amount was due.

Sec. 4. Section 36-2905.08, Arizona Revised Statutes, is amended to read:

36-2905.08. Nicotine replacement therapies; tobacco use medications

A. ~~Notwithstanding section 36-2989,~~ For contract years beginning October 1, 2008, the administration may expend monies to provide nicotine replacement therapies and tobacco use medications to members eligible pursuant to this article or article 2 or 3 of this chapter.

B. The administration shall not use monies from the state general fund for the purposes of this section.

Sec. 5. Section 36-2907, Arizona Revised Statutes, is amended to read:

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

A. ~~Unless modified pursuant to this section~~ 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 ~~but do not include occupational therapy, or speech therapy for eligible persons who are twenty-one years of age or older~~.

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. Beginning January 1, 2006, 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. Emergency dental care and extractions for persons who are at least twenty-one years of age.~~

~~6.~~ 5. Medical supplies, DURABLE MEDICAL equipment and prosthetic devices~~, not including hearing aids or dentures,~~ 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.

~~7.~~ 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.

~~8.~~ 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.

~~9.~~ 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.

~~10.~~ 9. Podiatry services ~~performed by a podiatrist licensed pursuant to title 32, chapter 7 and~~ ordered by a primary care physician or primary care practitioner.

~~11.~~ 10. Nonexperimental transplants approved for title XIX reimbursement.

~~12.~~ 11. Ambulance and nonambulance transportation, EXCEPT AS PROVIDED IN SUBSECTION G OF THIS SECTION.

B. THE LIMITATIONS AND EXCLUSIONS FOR HEALTH AND MEDICAL SERVICES PROVIDED UNDER THIS SECTION ARE AS FOLLOWS:

1. Beginning on October 1, 2002, 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 TRANSPLANTS.

(v) ALLOGENIC UNRELATED TRANSPLANTS.

(vi) HEART TRANSPLANTS FOR NON-ISCHEMIC CARDIOMYOPATHY.

(vii) 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 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 TO PERSONS WHO ARE ELIGIBLE PURSUANT TO SECTIONS 36-2901.01 AND 36-2901.04 AND WHO RESIDE IN A COUNTY WITH A POPULATION OF MORE THAN FIVE HUNDRED THOUSAND PERSONS. 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.

Sec. 6. Section 36-2907.04, Arizona Revised Statutes, is amended to read:

36-2907.04. Family planning services

A woman whose eligibility under section 36-2901, paragraph 6, subdivision (a), item (ii) ended no earlier than March 1, 1995 and who is not otherwise enrolled in the system is eligible to receive voluntary family planning services for two years, if approval of the waiver requesting family planning services pursuant to this section is approved by the United States department of health and human services. This two year period begins on the first day following the end of that woman's sixty day federal eligibility period that begins on the last day of her pregnancy. Family planning services under this section are limited to those available pursuant to section 36-2907, subsection A, paragraph ~~9~~ 8.

Sec. 7. Section 36-2907.10, Arizona Revised Statutes, is amended to read:

36-2907.10. Transplants; extended eligibility

A. If during a redetermination process for eligibility pursuant to this article a person who is enrolled and who is eligible pursuant to this article for a medically necessary and appropriate transplant pursuant to section 36-2907, subsection A, paragraph ~~11~~ 10 is determined ineligible for coverage pursuant to section 36-2901.04 due to excess income or ineligible for coverage pursuant to section 36-2901, paragraph 6, subdivision (a), item (i), (ii) or (iii) and that person has not yet received the transplant, the person may extend the person's eligibility based on the total spend down requirement for the household divided by the number of persons in the household.

B. In order to extend eligibility the person shall enter into a contractual agreement with a hospital to pay the amount of excess income determined pursuant to this section. The hospital shall only be reimbursed by the administration at the contracted rate of the transplantation surgery, including up to one hundred days of posttransplantation care. The administration shall deduct the amount of excess income that the person agrees to pay the hospital before payment is made to the hospital for transplant services authorized by this section. The amount of excess income shall not be changed once the extended period of eligibility begins. The administration is not responsible to pay any of the spend down amount if the person does not pay the hospital. The contracting hospital shall submit a copy of the person's contractual agreement with the hospital to the administration.

C. The administration shall authorize extended eligibility services only for transplant candidates.

D. Extended eligibility pursuant to this section is for one twelve-month continuous period of time and is funded only pursuant to section 36-2907.12.

E. This section does not prohibit a person from applying for eligibility pursuant to any other applicable law.

F. If the administration and a hospital that performed a transplant surgery on a person who is eligible pursuant to this section do not have a contracted rate, the administration shall not reimburse the hospital more than the contracted rate established by the administration.

G. A person who has extended eligibility pursuant to section 36-2907.11 is not eligible for services pursuant to this section.

H. The extended eligibility of a person who is determined to be no longer medically eligible for a transplant terminates at the end of the month in which it is determined the person is not medically eligible for the transplant unless the person is otherwise eligible for services pursuant to section 36-2901, paragraph 6, subdivision (a).

Sec. 8. Section 36-2907.11, Arizona Revised Statutes, is amended to read:

36-2907.11. Retaining transplant status

A. If during a redetermination process for eligibility pursuant to this article a person who is eligible for a medically necessary and appropriate transplant as determined by the administration pursuant to section 36-2907, subsection A, paragraph ~~11~~ 10 is determined ineligible for coverage pursuant to section 36-2901.04 due to excess income or ineligible for coverage pursuant to section 36-2901, paragraph 6, subdivision (a), item (i), (ii) or (iii) and that person has not yet received the transplant, the person may enter into a contract with a hospital to pay the amount of excess income. For purposes of this section, the administration shall compute excess income based on the total spend down requirement for the household divided by the number of persons in the household. The administration shall recompute excess income pursuant to this section at the time the transplant becomes available.

B. If the hospital enters into the contractual agreement with the person, the hospital shall allow the person to retain the person's transplant candidacy status as long as the person is medically eligible but the person is not eligible for services pursuant to this article unless that person is determined eligible pursuant to subsection D of this section.

C. A person who has extended eligibility pursuant to section 36-2907.10 is not eligible for services pursuant to this section.

D. Once a transplant is scheduled or performed the person shall reapply for eligibility pursuant to section 36-2901, paragraph 6, subdivision (a) and, if a spend down of excess income is necessary in order to be eligible for services pursuant to this article, the administration shall compute this income pursuant to the process specified in subsection A of this

section. If the transplant is performed within thirty days before the date of the eligibility determination, the administration shall pay the hospital on a retroactive basis at the contracted rate for costs of the transplant surgery, including up to one hundred days of posttransplantation care. The administration shall deduct the amount of excess income that the person has agreed to pay the hospital before payment is made to the hospital for transplant services pursuant to this section. The amount of excess income shall not be recomputed after the date the person becomes eligible pursuant to this section. The administration is not responsible for paying any spend down amount if the person does not pay the hospital. The contracting hospital shall submit a copy of the person's contractual agreement with the hospital to the administration.

E. Eligibility pursuant to this section shall be funded only pursuant to section 36-2907.12.

F. This section does not prohibit a person from applying for eligibility pursuant to any other applicable law.

G. If the administration and a hospital that performed a transplant surgery on a person eligible pursuant to this section do not have a contracted rate, the administration shall not reimburse the hospital more than the contracted rate established by the administration.

Sec. 9. Section 36-2912, Arizona Revised Statutes, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. The director shall:

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

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

3. ~~Beginning on July 1, 2005,~~ Require that a contractor, the administration or an accountable health plan negotiate reimbursement rates.

The reimbursement rate for an emergency medical condition for a noncontracting hospital is:

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

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

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

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

6. Adopt rules.

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

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

K. The administration shall offer a health benefit plan on a guaranteed issuance basis to small employers as required by this section. All small employers qualify for this guaranteed offer of coverage. The administration shall offer to all small employers the available health benefit plan and shall accept any small employer that applies and meets the eligibility requirements. In addition to the requirements prescribed in this

section, for any offering of any health benefit plan to a small employer, as part of the administration's solicitation and sales materials, the administration shall make a reasonable disclosure to the employer of the availability of the information described in this subsection and, on request of the employer, shall provide that information to the employer. The administration shall provide information concerning the following:

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

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

(b) Renewability of coverage.

(c) Any preexisting condition exclusion.

(d) The geographic areas served by the contractor.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

placed for adoption before age eighteen and who is covered under creditable coverage thirty-one days after the adoption or placement for adoption.

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

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

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

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

1. The date that the certificate is issued.

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

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

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

5. One of the following:

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

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

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

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

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

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

Z. On or before June 15 and November 15 of each year, the director shall submit a report to the joint legislative budget committee regarding the number and type of businesses participating in healthcare group and that includes updated information on healthcare group marketing activities. The director, within thirty days of implementation, shall notify the joint legislative budget committee of any changes in healthcare group benefits or cost sharing arrangements.

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

1. Quarterly reports regarding the financial condition of the healthcare group program. The reports shall include the number of persons and employer groups enrolled in the program and medical loss information and projections.

2. An annual financial audit.

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

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

CC. For the purposes of this section:

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

2. "COBRA continuation provision" means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Health status.

(b) Medical condition, including physical and mental illness.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence as defined in section 20-448.

(h) The existence of a physical or mental disability.

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

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

(a) The person:

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

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

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

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

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

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

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

contractor. Preexisting condition does not include a genetic condition in the absence of a diagnosis of the condition related to the genetic information.

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

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

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

Sec. 10. Repeal; children's health insurance program; reversion

A. Title 36, chapter 29, article 4, Arizona Revised Statutes, is repealed.

B. Any monies remaining in the children's health insurance program fund shall revert to the state general fund one year after the effective date of this act.

Sec. 11. Section 36-3408, Arizona Revised Statutes, is amended to read:

36-3408. Eligibility for behavioral health service system; screening process; required information

A. Any person OR THE PERSON'S PARENT OR LEGAL GUARDIAN who requests behavioral health services pursuant to this chapter ~~or the person's parent or legal guardian~~ shall comply with a preliminary financial screening and eligibility process developed by the department of health services in coordination with the Arizona health care cost containment system administration and administered at the initial intake level. A person who receives behavioral health services pursuant to this chapter and who has not been determined eligible for title XVIII and for the medicare part D prescription drug benefit~~,~~ OR title XIX ~~or title XXI~~ services shall comply annually with the eligibility determination process. If the results indicate that the person may be eligible for title XVIII and for the medicare part D prescription drug benefit~~,~~ OR title XIX ~~or title XXI~~, in order to continue to receive services pursuant to this chapter, the applicant shall submit a completed application within ten working days to the social security administration, the department of economic security or the Arizona health care cost containment system administration, which shall determine the applicant's eligibility pursuant to title XVIII and for the medicare part D prescription drug benefit, section 36-2901, paragraph 6, subdivision (a)~~,~~ OR section 36-2931, paragraph 5 ~~or section 36-2981, paragraph 6~~ for health and medical or long-term care services pursuant to chapter 29 of this title. The applicant shall cooperate fully with the eligibility determination process.

If the person is in need of emergency services provided pursuant to this chapter, the person may begin to receive these services immediately provided that within five days from the date of service a financial screening is initiated.

B. Applicants who refuse to cooperate in the financial screening and eligibility process are not eligible for services pursuant to this chapter. A form explaining loss of benefits due to refusal to cooperate shall be signed by the applicant. Refusal to cooperate shall not be construed to mean the applicant's inability to obtain documentation required for eligibility determination. The department of economic security and the Arizona health care cost containment system administration shall promptly inform the department of health services of the applications that are denied based on an applicant's failure to cooperate with the eligibility determination process and, on request, of applicants who do not submit an application as required by this section.

C. The department of economic security, in coordination with the department of health services, shall provide on-site eligibility determinations at appropriate program locations subject to legislative appropriation.

D. This section only applies to persons who receive services that are provided pursuant to this section and that are paid for in whole or in part with state funds.

E. A person who requests treatment services under this chapter shall provide personally identifying information required by the department of health services.

F. Except as otherwise provided by law, this section and cooperation with the eligibility determination process do not entitle any person to any particular services that are subject to legislative appropriation.

Sec. 12. Title 36, chapter 37, article 1, Arizona Revised Statutes, is amended by adding section 36-3718, to read:

36-3718. Sexually violent persons; county reimbursement; deposit; tax withholding

A. IF THIS STATE PAYS THE COSTS OF A COMMITMENT OF AN INDIVIDUAL DETERMINED TO BE SEXUALLY VIOLENT BY THE COURT PURSUANT TO THIS ARTICLE, THE COUNTY SHALL REIMBURSE THE DEPARTMENT OF HEALTH SERVICES FOR ONE HUNDRED PER CENT OF THESE COSTS. THE DEPARTMENT OF HEALTH SERVICES SHALL DEPOSIT THE REIMBURSEMENTS, PURSUANT TO SECTIONS 35-146 AND 35-147, IN THE ARIZONA STATE HOSPITAL FUND ESTABLISHED BY SECTION 36-545.08.

B. 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 FROM

ANY TRANSACTION PRIVILEGE TAX DISTRIBUTIONS TO THE COUNTY. THE TREASURER SHALL DEPOSIT THE WITHHOLDINGS, PURSUANT TO SECTIONS 35-146 AND 35-147, IN THE ARIZONA STATE HOSPITAL FUND ESTABLISHED BY SECTION 36-545.08.

C. 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.

D. COUNTY CONTRIBUTIONS MADE PURSUANT TO THIS SECTION ARE EXCLUDED FROM THE COUNTY EXPENDITURE LIMITATIONS.

Sec. 13. Laws 2009, third special session, chapter 3, section 2 is amended to read:

Sec. 2. ALTCS; reversion of excess appropriation; counties; fiscal year 2008-2009

Notwithstanding the distribution percentage specified in section 11-292, subsection M, Arizona Revised Statutes, for fiscal ~~years~~ YEAR 2008-2009 ~~and 2009-2010~~, while the state is receiving the enhanced federal match rate, if any monies in the funds for the purpose of title 36, chapter 29, article 2, Arizona Revised Statutes, remain unexpended at the end of the fiscal year, of the amount specified by the director of the Arizona health care cost containment system administration, the state treasurer shall distribute sixty-two and two-tenths per cent to the counties pursuant to section 11-292, subsection B or C, Arizona Revised Statutes.

Sec. 14. ALTCS; transfer of excess elderly and physically disabled lump sum appropriation; counties; fiscal year 2009-2010

Notwithstanding the distribution percentage specified in section 11-292, subsection M, Arizona Revised Statutes, for fiscal year 2009-2010 the Arizona health care cost containment system administration shall transfer to the counties such portion, if any, of the federal monies received by this state under section 5001 of the American recovery and reinvestment act of 2009 (P.L. 111-5), as may be necessary to ensure that the final savings achieved as a result of section 5001 of the American recovery and reinvestment act of 2009 (P.L. 111-5) are split sixty per cent to the counties and forty per cent to this state.

Sec. 15. ALTCS; transfer of long-term care medicare clawback payments; counties; fiscal years 2008-2009 and 2009-2010

Notwithstanding the distribution percentage specified in section 11-292, subsection M, Arizona Revised Statutes, for fiscal years 2008-2009 and 2009-2010 the Arizona health care cost containment system administration shall transfer to the counties such portion, if any, of the federal monies received by this state under section 5001 of the American recovery and reinvestment act of 2009 (P.L. 111-5), as may be necessary to ensure that the final savings achieved as a result of section 5001 of the American recovery

and reinvestment act of 2009 (P.L. 111-5) are 45.5 per cent to the counties and 54.5 per cent to this state for long-term care medicare clawback payments.

Sec. 16. ALTCS; county contributions; fiscal year 2010-2011

A. Notwithstanding section 11-292, Arizona Revised Statutes, county contributions for the Arizona long-term care system for fiscal year 2010-2011 are as follows:

1.	Apache	$ 563,100
2.	Cochise	$ 4,827,600
3.	Coconino	$ 1,690,400
4.	Gila	$ 1,948,100
5.	Graham	$ 1,287,300
6.	Greenlee	$ 146,600
7.	La Paz	$ 743,600
8.	Maricopa	$138,339,400
9.	Mohave	$ 6,574,900
10.	Navajo	$ 2,330,600
11.	Pima	$ 35,803,700
12.	Pinal	$ 13,357,800
13.	Santa Cruz	$ 1,721,400
14.	Yavapai	$ 8,428,400
15.	Yuma	$ 7,220,800

B. The amounts specified in subsection A of this section reflect $39,706,700 in decreases in county contributions for the Arizona long-term care system pursuant to section 5001(g)(2) of the American recovery and reinvestment act of 2009 (P.L. 111-5).

C. The amounts specified in subsection A of this section reflect $3,221,700 in decreases in county contributions for the Arizona long-term care system pursuant to section 5001(g)(2) of the American recovery and reinvestment act of 2009 (P.L. 111-5) for medicare clawback savings.

D. The county contributions for the Arizona long-term care system would have otherwise totaled $267,912,100 in fiscal year 2010-2011.

Sec. 17. ALTCS; transfer of excess elderly and physically disabled lump sum appropriation; counties; fiscal year 2010-2011

Notwithstanding the distribution percentage specified in section 11-292, subsection M, Arizona Revised Statutes, for fiscal year 2010-2011 the Arizona health care cost containment system administration shall transfer to the counties such portion, if any, of the federal monies received by this state under section 5001 of the American recovery and reinvestment act of 2009 (P.L. 111-5), as may be necessary to ensure that the final savings achieved as a result of section 5001 of the American recovery and reinvestment act of 2009 (P.L. 111-5) are split 59.3 per cent to the counties and 40.7 per cent to this state.

Sec. 18. ALTCS; transfer of long-term care medicare clawback payments; counties; fiscal year 2010-2011

Notwithstanding the distribution percentage specified in section 11-292, subsection M, Arizona Revised Statutes, for fiscal year 2010-2011 the Arizona health care cost containment system administration shall transfer to the counties such portion, if any, of the federal monies received by this state under section 5001 of the American recovery and reinvestment act of 2009 (P.L. 111-5), as may be necessary to ensure that the final savings achieved as a result of section 5001 of the American recovery and reinvestment act of 2009 (P.L. 111-5) are 45.3 per cent to the counties and 54.7 per cent to this state for long-term care medicare clawback payments.

Sec. 19. AHCCCS transfer; counties; federal monies

On or before December 31, 2010, notwithstanding any other law, for fiscal year 2009-2010 the Arizona health care cost containment system administration shall transfer to the counties such portion, if any, of the federal monies received by this state under section 5001 of the American recovery and reinvestment act of 2009 (P.L. 111-5), as may be necessary to comply with section 5001(g)(2) of the American recovery and reinvestment act of 2009 (P.L. 111-5), but not more than the counties' proportional percentage of the original amount of the county acute care contribution and the hospital and medical care contribution to the state's contribution for fiscal year 2009-2010.

Sec. 20. AHCCCS transfer; counties; federal monies

Notwithstanding any other law, on or before December 31, 2011, for fiscal year 2010-2011 the Arizona health care cost containment system administration shall transfer to the counties such portion, if any, of the federal monies received by this state under section 5001 of the American recovery and reinvestment act of 2009 (P.L. 111-5), as may be necessary to comply with section 5001(g)(2) of the American recovery and reinvestment act of 2009 (P.L. 111-5), but not more than the counties' proportional percentage of the original amount of the county acute care contribution and the hospital and medical care contribution to the state's contribution for fiscal year 2010-2011.

Sec. 21. AHCCCS; local expenditure; federal matching monies

Notwithstanding any other law, subject to the approval of the centers for medicare and medicaid services, the Arizona health care cost containment system administration may spend federal monies made available by local or tribal spending. The administration shall not spend these federal monies if the expenditure would reduce the enhanced funding available under the American recovery and reinvestment act of 2009 (P.L. 111-5) or would cause the administration to exceed any limitations on federal spending.

Sec. 22. County administrative costs; refund

Notwithstanding any other law, for fiscal year 2010-2011, the Arizona health care cost containment system administration shall refund to the counties the portion, if any, of the monies received by this state from the counties pursuant to section 11-292, subsection O, Arizona Revised Statutes, for the costs of administering sections 36-2901.01 and 36-2901.04, Arizona Revised Statutes, as may be necessary to comply with section 5001 (g)(2) of the American recovery and reinvestment act of 2009 (P.L. 111-5).

Sec. 23. Competency restoration treatment; city and county reimbursement; fiscal year 2010-2011; deposit; tax 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 2010-2011.

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. 24. State employee health benefits

Beginning October 1, 2010, for fiscal year 2010-2011, the department of administration shall not implement a differentiated health insurance premium based on the integrated or nonintegrated status of a health insurance provider available through the state employee health insurance program.

Sec. 25. AHCCCS; reimbursement rates

A. Notwithstanding any other law, for rates effective October 1, 2010 through September 30, 2011, the Arizona health care cost containment system administration shall not increase the institutional or noninstitutional schedule rates above the rates in effect on September 30, 2010.

B. Notwithstanding any other law, in addition to any rate adjustments made pursuant to subsection A of this section, for rates effective October 1, 2010 through September 30, 2011, the Arizona health care cost containment system administration may reduce the institutional and noninstitutional schedule rates up to five per cent.

C. If proposition 100 is not approved by the voters at the May 18, 2010 special election, in addition to any reductions made pursuant to subsections A and B of this section, the Arizona health care cost containment system administration may reduce the institutional and noninstitutional schedule rates an additional ten per cent.

Sec. 26. AHCCCS; disproportionate share payments

Disproportionate share payments for fiscal year 2010-2011 made pursuant to section 36-2903.01, subsection P, Arizona Revised Statutes, include:

1. $89,877,700 for a qualifying nonstate operated public hospital. The Maricopa county special health care district shall provide a certified public expense form for the amount of qualifying disproportionate share hospital expenditures made on behalf of this state to the administration on or before May 1, 2011 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, the administration shall distribute $4,202,300 to the Maricopa county special health care district and deposit the balance of the federal funds participation in the state general fund. If the certification provided is for an amount less than $89,877,700, and the administration determines that the revised amount is 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 less than $89,877,700 and the administration determines that the revised amount is not correct pursuant to the methodology used by the administration pursuant to section 36-2903.01, Arizona Revised Statutes, 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.

2. $28,474,900 for the Arizona state hospital. The Arizona state hospital shall provide a certified public expense form for the amount of qualifying disproportionate share hospital expenditures made on behalf of the state to the administration on or before March 31, 2011. The administration shall assist the Arizona state hospital in determining the amount of qualifying disproportionate share hospital expenditures. Once the administration files a claim with the federal government and receives federal funds participation based on the amount certified by the Arizona state hospital, the administration shall distribute the entire amount of federal financial participation to the state general fund. If the certification provided is for an amount less than $28,474,900, the administration shall notify the governor, the president of the senate and the speaker of the house of representatives and shall distribute the entire amount of federal financial participation to the state general fund. The certified public expense form provided by the Arizona state hospital 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. $500,000 for private qualifying disproportionate share hospitals.

Sec. 27. County acute care contribution; fiscal year 2010-2011

A. Notwithstanding section 11-292, Arizona Revised Statutes, for fiscal year 2010-2011 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	$20,761,900
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. 28. Hospitalization and medical care contribution; fiscal year 2010-2011

A. Notwithstanding any other law, for fiscal year 2010-2011, 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 2010-2011, 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. 29. 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. 30. AHCCCS; capitation payments; suspension

A. Notwithstanding any other law, the Arizona health care cost containment system shall suspend acute care capitation payments in 2011 in the amount of $344,201,700 for up to two months.

B. Notwithstanding sections 35-342 and 44-1201, Arizona Revised Statutes, delinquent payments to health care plans that are made pursuant to subsection A of this section and that are due in 2011 bear interest at a rate of five-tenths of one per cent a year.

Sec. 31. AHCCCS; ambulance rates; fiscal year 2010-2011

For fiscal year 2010-2011, section 36-2239, subsections D, F and G, Arizona Revised Statutes, do not apply to a remuneration made pursuant to the Arizona health care cost containment system.

Sec. 32. Department of health services; behavioral health services; priority; liability

A. For fiscal year 2010-2011, the department of health services when allocating the available appropriated monies to behavioral health services shall establish a list of priority services for the nontitle XIX behavioral health population and post this list on its website. The department shall provide at least thirty days notice before changing the list of priorities.

B. During fiscal year 2010-2011, behavioral health providers and contractors with the division of behavioral health services shall not be liable for failing or refusing to provide uncompensated or underfunded nonemergency, nontitle XIX behavioral health services to persons who are not seriously mentally ill.

Sec. 33. AHCCCS; risk contingency rate setting

Notwithstanding any other law, for the contract year beginning October 1, 2010 and ending September 30, 2011, 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, 2009 and ending September 30, 2010.

Sec. 34. Exemption from rule making; Arizona health care cost containment system

The Arizona health care cost containment system is exempt from the rule making requirements of title 41, chapter 6, Arizona Revised Statutes, for two years after the effective date of this act, for the following purposes:

1. Implementing section 36-2907, Arizona Revised Statutes, as amended by this act, and for the purpose of making changes to the amount, duration or scope of services provided pursuant to section 36-2907, subsection D, Arizona Revised Statutes.

2. Establishing and maintaining rules regarding standards, methods and procedures for determining eligibility necessary to implement a program within the available appropriation. The agency shall provide public notice and an opportunity for public comment on proposed rules at least thirty days before rules are adopted or amended pursuant to this paragraph.

Sec. 35. 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. 36. Retroactivity

Section 36-3718, Arizona Revised Statutes, as added by this act, is effective retroactively to from and after June 30, 2009.