Senate Engrossed

FILED
MICHELE REAGAN
SECRETARY OF STATE

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CHAPTER 14

SENATE BILL 1475

AN ACT

REPEALING SECTION 36-108.01, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 1, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING A NEW SECTION 36-108.01; AMENDING SECTIONS 36-2239, 36-2903.01 AND 41-4255, ARIZONA REVISED STATUTES; AMENDING LAWS 2014, CHAPTER 11, SECTION 12; 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. Repeal

Section 36-108.01, Arizona Revised Statutes, is repealed.

Sec. 2. Title 36, chapter 1, article 1, Arizona Revised Statutes, is amended by adding a new section 36-108.01, to read:

36-108.01. Department of health services funds; purposes; annual report

A. THE INTERAGENCY SERVICE AGREEMENT FOR BEHAVIORAL HEALTH SERVICES FUND IS ESTABLISHED CONSISTING OF STATE AND FEDERAL MONIES RECEIVED BY THE DEPARTMENT TO PROVIDE BEHAVIORAL HEALTH SERVICES, EXCEPT FOR MONIES FOR NON-TITLE XIX BEHAVIORAL HEALTH SERVICES. THE DEPARTMENT SHALL ADMINISTER THE FUND. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED.

B. THE INTERGOVERNMENTAL AGREEMENTS FOR COUNTY BEHAVIORAL HEALTH SERVICES FUND IS ESTABLISHED CONSISTING OF COUNTY MONIES RECEIVED BY THE DEPARTMENT TO PROVIDE BEHAVIORAL HEALTH SERVICES TO PERSONS IDENTIFIED THROUGH AGREEMENTS WITH THE COUNTIES. THE DEPARTMENT SHALL ADMINISTER THE FUND. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED.

C. THE HEALTH SERVICES LOTTERY MONIES FUND IS ESTABLISHED CONSISTING OF MONIES TRANSFERRED PURSUANT TO SECTION 5-572, SUBSECTION C FOR TEENAGE PREGNANCY PREVENTION PROGRAMS ESTABLISHED BY LAWS 1995, CHAPTER 190, SECTIONS 2 AND 3, THE HEALTH START PROGRAM ESTABLISHED BY SECTION 36-697 AND THE FEDERAL WOMEN, INFANTS AND CHILDREN FOOD PROGRAM. THE DEPARTMENT SHALL ADMINISTER THE FUND. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED.

D. THE INTERGOVERNMENTAL AGREEMENTS/INTERAGENCY SERVICES AGREEMENTS FUND IS ESTABLISHED CONSISTING OF ALL MONIES RECEIVED BY THE DEPARTMENT THROUGH INTERGOVERNMENTAL AGREEMENTS, INTERAGENCY SERVICES AGREEMENTS AND TRANSFERS BETWEEN THE DEPARTMENT AND OTHER STATE AND LOCAL ENTITIES. THE DEPARTMENT SHALL ADMINISTER THE FUND. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED.

E. BEGINNING NOVEMBER 1, 2015, THE DEPARTMENT SHALL REPORT ANNUALLY TO THE JOINT LEGISLATIVE BUDGET COMMITTEE ON THE REVENUES, EXPENDITURES AND ENDING BALANCES FROM THE PREVIOUS, CURRENT AND SUBSEQUENT FISCAL YEARS OF THE FUNDS ESTABLISHED IN THIS SECTION.

Sec. 3. Section 36-2239, Arizona Revised Statutes, is amended to read:

36-2239. Rates or charges of ambulance service

A. An ambulance service that applies for an adjustment in its rates or charges shall automatically be granted a rate increase equal to the amount determined under section 36-2234, subsection E, if the ambulance service is so entitled. An automatic rate adjustment that is granted pursuant to this subsection and that is filed on or before April 1 is effective June 1 of that year. The department shall notify the applicant and each health care services organization as defined in section 20-1051 of the rate adjustment on or before May 1 of that year.

B. Notwithstanding subsection E of this section, if the department does not hold a hearing within ninety days after an ambulance service submits an application to the department for an adjustment of its rates or charges, the ambulance service may adjust its rates or charges to an amount not to exceed the amount sought by the ambulance service in its application to the department. An ambulance service shall not apply for an adjustment of its rates or charges more than once every six months.

C. At the time it holds a hearing on the rates or charges of an ambulance service pursuant to section 36-2234, the department may adjust the rates or charges adjusted by the ambulance service pursuant to subsection B of this section, but the adjustment shall not be retroactive.

D. Except as provided in subsection H of this section, an ambulance service shall not charge, demand or collect any remuneration for any service greater or less than or different from the rate or charge determined and fixed by the department as the rate or charge for that service. An ambulance service may charge for disposable supplies, medical supplies and medication and oxygen related costs if the charges do not exceed the manufacturer's suggested retail price, are uniform throughout the ambulance service's certificated area and are filed with the director. An ambulance service shall not refund or limit in any manner or by any device any portion of the rates or charges for a service that the department has determined and fixed or ordered as the rate or charge for that service.

E. The department shall determine and render its decision regarding all rates or charges within ninety days after commencement of the applicant's hearing for an adjustment of rates or charges. If the department does not render its decision as required by this subsection, the ambulance service may adjust its rates and charges to an amount that does not exceed the amounts sought by the ambulance service in its application to the department. If the department renders a decision to adjust the rates or charges to an amount less than that requested in the application and the ambulance service has made an adjustment to its rates and charges that is higher than the adjustment approved by the department, within thirty days after the department's decision the ambulance service shall refund to the appropriate ratepayer the difference between the ambulance service's adjusted rates and charges and the rates and charges ordered by the department. The ambulance service shall provide evidence to the department that the refund has been made. If the ambulance service fails to comply with this subsection, the director may impose a civil penalty subject to the limitations provided in section 36-2245.

F. An ambulance service shall charge the advanced life support base rate as prescribed by the director under any of the following circumstances:

1. A person requests an ambulance by dialing telephone number 911, or a similarly designated telephone number for emergency calls, and the ambulance service meets the following:

(a) The ambulance is staffed with at least one ambulance attendant.

(b) The ambulance is equipped with all required advanced life support medical equipment and supplies for the advanced life support attendants in the ambulance.

(c) The patient receives advanced life support services or is transported by the advanced life support unit.

2. Advanced life support is requested by a medical authority or by the patient.

3. The ambulance attendants administer one or more specialized treatment activities or procedures as prescribed by the department by rule.

G. An ambulance service shall charge the basic life support base rate as prescribed by the director under any of the following circumstances:

1. A person requests an ambulance by dialing telephone number 911, or a similarly designated telephone number for emergency calls, and the ambulance service meets the following:

(a) The ambulance is staffed with two ambulance attendants certified by this state.

(b) The ambulance is equipped with all required basic life support medical equipment and supplies for the basic life support medical attendants in the ambulance.

(c) The patient receives basic life support services or is transported by the basic life support unit.

2. Basic life support transportation or service is requested by a medical authority or by the patient, unless any provision of subsection F of this section applies, in which case the advanced life support rate shall apply.

H. For each contract year, the Arizona health care cost containment system administration and its contractors and subcontractors shall provide remuneration for ambulance services for persons who are enrolled in or covered by the Arizona health care cost containment system in an amount equal to ~~eighty per cent~~ 68.59 PERCENT of the amounts as prescribed by the department as of July 1 of each year for services specified in subsections F and G of this section and ~~eighty per cent~~ 68.59 PERCENT of the mileage charges as determined by the department as of July 1 of each year pursuant to section 36-2232. The Arizona health care cost containment system administration shall make annual adjustments to the Arizona health care cost containment system fee schedule according to the department's approved ambulance service rate in effect as of July 1 of each year. The rate adjustments made pursuant to this subsection are effective beginning October 1 of each year.

I. In establishing rates and charges the director shall consider the following factors:

1. The transportation needs assessment of the medical response system in a political subdivision.

2. The medical care consumer price index of the United States department of labor, bureau of labor statistics.

3. Whether a review is made by a local emergency medical services coordinating system in regions where that system is designated as to the appropriateness of the proposed service level.

4. The rate of return on gross revenue.

5. Response times pursuant to section 36-2232, subsection A, paragraph 2.

J. Notwithstanding section 36-2234, an ambulance service may charge an amount for medical assessment, equipment or treatment that exceeds the requirements of section 36-2205 if requested or required by a medical provider or patient.

K. Notwithstanding subsections D, F and G of this section, an ambulance service may provide gratuitous services if an ambulance is dispatched and the patient subsequently declines to be treated or transported.

Sec. 4. Section 36-2903.01, Arizona Revised Statutes, is amended to read:

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

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

B. The director shall:

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

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

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

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

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

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

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

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

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

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

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

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

the administration, including a grievance or hearing, persons may represent themselves or be represented by a duly authorized agent who is not charging a fee. A legal entity may be represented by an officer, partner or employee who is specifically authorized by the legal entity to represent it in the particular proceeding.

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

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

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

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

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

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

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

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

2. Defer liability, in whole or in part, of contractors for care provided to members who are hospitalized on the date of enrollment or under other circumstances. Payment shall be on a capped fee-for-service basis for services other than hospital services and at the rate established pursuant to

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

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

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

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

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

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

1. For inpatient hospital stays from March 1, 1993 through September 30, 2014, the administration shall use a prospective tiered per diem methodology, using hospital peer groups if analysis shows that cost differences can be attributed to independently definable features that hospitals within a peer group share. In peer grouping the administration may consider such factors as length of stay differences and labor market variations. If there are no cost differences, the administration shall implement a stop loss-stop gain or similar mechanism. Any stop loss-stop gain or similar mechanism shall ensure that the tiered per diem rates assigned to a hospital do not represent less than ninety ~~per cent~~ PERCENT of its 1990 base year costs or more than one hundred ten ~~per cent~~ PERCENT 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~~ PERCENT or more than one hundred twelve and one-half ~~per cent~~ PERCENT 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~~ PERCENT or more than one hundred fifteen ~~per cent~~ PERCENT of its 1990 base year costs, adjusted by an audit factor, from October 1, 1995 through September 30, 1996. For the periods after September 30, 1996 no stop loss-stop gain or similar

mechanisms shall be in effect. An adjustment in the stop loss-stop gain percentage may be made to ensure that total payments do not increase as a result of this provision. If peer groups are used, the administration shall establish initial peer group designations for each hospital before implementation of the per diem system. The administration may also use a negotiated rate methodology. The tiered per diem methodology may include separate consideration for specialty hospitals that limit their provision of services to specific patient populations, such as rehabilitative patients or children. The initial per diem rates shall be based on hospital claims and encounter data for dates of service November 1, 1990 through October 31, 1991 and processed through May of 1992. The administration may also establish a separate reimbursement methodology for claims with extraordinarily high costs per day that exceed thresholds established by the administration.

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

3. Through June 30, 2004, for outpatient hospital services, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to the covered charges. Beginning on July 1, 2004 through June 30, 2005, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona department of health services pursuant to chapter 4, article 3 of this title, by more than 4.7 ~~per cent~~ PERCENT 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~~ PERCENT. If charges exceed 4.7 ~~per cent~~ PERCENT, 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~~ PERCENT 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~~ PERCENT 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~~ PERCENT of the rate plus a fee of one ~~per cent~~ PERCENT 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~~ PERCENT of the hospital specific capital cost and sixty ~~per cent~~ PERCENT of the statewide average capital cost in effect as of January 1, 1999 and as further adjusted by the calculation of tier rates for maternity and nursery as prescribed by law. Through September 30, 2011, the administration shall adjust the capital related cost component by the data resources incorporated market basket index for prospective payment system hospitals.

9. For graduate medical education programs:

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

(b) The monies available for graduate medical education programs pursuant to this subdivision shall not exceed the fiscal year 2006-2007 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective

hospital reimbursement. Graduate medical education programs eligible for such reimbursement are not precluded from receiving reimbursement for funding under subdivision (c) of this paragraph. Beginning July 1, 2006, the administration shall distribute any monies appropriated for graduate medical education above the amount prescribed in subdivision (a) of this paragraph in the following order or priority:

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

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

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

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

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

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

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

(f) Local, county and tribal governments and any university under the jurisdiction of the Arizona board of regents may provide monies in addition to any state general fund monies appropriated for graduate medical education in order to qualify for additional matching federal monies for providers, programs or positions in a specific locality and costs incurred pursuant to a specific contract between the administration and providers or other entities to provide graduate medical education services as an administrative activity. Payments by the administration pursuant to this subdivision may be limited to

those providers designated by the funding entity and may be based on any methodology deemed appropriate by the administration, including replacing any payments that might otherwise have been paid pursuant to subdivision (a), (b) or (c) of this paragraph had sufficient state general fund monies or other monies been appropriated to fully fund those payments. These programs, positions, payment methodologies and administrative graduate medical education services must be approved by the administration and the centers for medicare and medicaid services. The administration shall report to the president of the senate, the speaker of the house of representatives and the director of the joint legislative budget committee on or before July 1 of each year on the amount of money contributed and number of residency positions funded by local, county and tribal governments, including the amount of federal matching monies used.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

O. Notwithstanding any other law, on federal approval the administration may make disproportionate share payments to private hospitals, county operated hospitals, including hospitals owned or leased by a special health care district, and state operated institutions for mental disease

beginning October 1, 1991 in accordance with federal law and subject to legislative appropriation. If at any time the administration receives written notification from federal authorities of any change or difference in the actual or estimated amount of federal funds available for disproportionate share payments from the amount reflected in the legislative appropriation for such purposes, the administration shall provide written notification of such change or difference to the president and the minority leader of the senate, the speaker and the minority leader of the house of representatives, the director of the joint legislative budget committee, the legislative committee of reference and any hospital trade association within this state, within three working days not including weekends after receipt of the notice of the change or difference. In calculating disproportionate share payments as prescribed in this section, the administration may use either a methodology based on claims and encounter data that is submitted to the administration from contractors or a methodology based on data that is reported to the administration by private hospitals and state operated institutions for mental disease. The selected methodology applies to all private hospitals and state operated institutions for mental disease qualifying for disproportionate share payments.

P. Disproportionate share payments made pursuant to subsection O of this section include amounts for disproportionate share hospitals designated by political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents. Subject to the approval of the centers for medicare and medicaid services, any amount of federal funding allotted to this state pursuant to section 1923(f) of the social security act and not otherwise spent under subsection O of this section shall be made available for distribution pursuant to this subsection. Political subdivisions of this state, tribal governments and universities under the jurisdiction of the Arizona board of regents may designate hospitals eligible to receive disproportionate share payments in an amount up to the limit prescribed in section 1923(g) of the social security act if those political subdivisions, tribal governments or universities provide sufficient monies to qualify for the matching federal monies for the disproportionate share payments.

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 G of this section requiring documentation different than prescribed under subsection G, paragraph 4 of this section.

T. In addition to any requirements adopted pursuant to subsection D, paragraph 4 of this section, notwithstanding any other law, subject to approval by the centers for medicare and medicaid services, beginning July 1, 2011, members eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section 36-2981, paragraph 6 shall pay the following:

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

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

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

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

U. SUBJECT TO THE APPROVAL OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, POLITICAL SUBDIVISIONS OF THIS STATE, TRIBAL GOVERNMENTS AND ANY UNIVERSITY UNDER THE JURISDICTION OF THE ARIZONA BOARD OF REGENTS MAY PROVIDE TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION MONIES IN ADDITION TO ANY STATE GENERAL FUND MONIES APPROPRIATED FOR CRITICAL ACCESS HOSPITALS IN ORDER TO QUALIFY FOR ADDITIONAL FEDERAL MONIES. ANY AMOUNT OF FEDERAL MONIES RECEIVED BY THIS STATE PURSUANT TO THIS SUBSECTION SHALL BE DISTRIBUTED AS SUPPLEMENTAL PAYMENTS TO CRITICAL ACCESS HOSPITALS.

~~U.~~ V. For the purposes of this section, "disproportionate share payment" means a payment to a hospital that serves a disproportionate share of low-income patients as described by 42 United States Code section 1396r-4.

Sec. 5. Section 41-4255, Arizona Revised Statutes, is amended to read:

41-4255. Annual report

A. On or before September 1 of each year, the department of homeland security ~~and the department of health services~~ shall submit a homeland security allocation and expenditure report to the governor, the president of the senate, the speaker of the house of representatives, the chairperson of the senate appropriations committee, the chairperson of the house appropriations committee, the staff and cochairpersons of the joint legislative budget committee and the members of the joint legislative committee on border and homeland security.

B. The director shall provide a copy of the report to the secretary of state. The department may redact sensitive information contained in the report if necessary.

C. The report shall include:

1. Each local and state project that was awarded funding for the current year.

2. Expenditures for each local and state project that was awarded funding for the current year.

3. Expenditures from federal appropriations and grants that were used by the department for administrative and state agency purposes.

4. A narrative description detailing each state project awarded funding, including the goals and objectives of each state project.

5. The progress made on each project since the last report.

6. Project awards and expenditures from prior years beginning with fiscal year 2001-2002.

7. A detailed plan on how homeland security efforts will be continued in the event of decreased federal funding.

Sec. 6. Laws 2014, chapter 11, section 12 is amended to read:

Sec. 12. AHCCCS; disproportionate share payments

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

1. ~~$89,877,700~~ $105,945,500 for a qualifying nonstate operated public hospital. The Maricopa county special health care district shall provide a certified public expense form for the amount of qualifying disproportionate share hospital expenditures made on behalf of this state to the Arizona health care cost containment system administration on or before May 1, 2015 for all state plan years as required by the Arizona health care cost containment system 1115 waiver standard terms and conditions. The administration shall assist the district in determining the amount of qualifying disproportionate share hospital expenditures. Once the administration files a claim with the federal government and receives federal funds participation based on the amount certified by the Maricopa county special health care district, if the certification is equal to or less than ~~$89,877,700~~ $105,945,500 and the administration determines that the revised amount is correct pursuant to the methodology used by the administration pursuant to section 36-2903.01, Arizona Revised Statutes, ~~as amended by this act,~~ the administration shall notify the governor, the president of the senate and the speaker of the house of representatives, shall distribute $4,202,300 to the Maricopa county special health care district and shall deposit the balance of the federal funds participation in the state general fund. If the certification provided is for an amount less than ~~$89,877,700~~ $105,945,500 and the administration determines that the revised amount is not correct pursuant to the methodology used by the administration pursuant to section 36-2903.01, Arizona Revised Statutes, ~~as amended by this act,~~ the administration shall notify the governor, the president of the senate and the speaker of the house of representatives and shall deposit the total amount of the federal funds participation in the state general fund. ~~The disproportionate share hospital payment attributed to the Maricopa county special health care district may not exceed $89,877,700.~~ IF THE CERTIFICATION PROVIDED IS FOR AN AMOUNT GREATER THAN $105,945,500, THE ADMINISTRATION SHALL DISTRIBUTE $4,202,300 TO THE MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT AND SHALL DEPOSIT $68,328,000 OF THE FEDERAL FUNDS PARTICIPATION IN THE STATE GENERAL FUND. THE ADMINISTRATION MAY MAKE ADDITIONAL DISPROPORTIONATE SHARE HOSPITAL PAYMENTS TO THE MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT PURSUANT TO SECTION 36-2903.01, SUBSECTION P, ARIZONA REVISED STATUTES, AND SUBSECTION B OF THIS SECTION.

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

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

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

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

B. AFTER THE DISTRIBUTIONS MADE PURSUANT TO SUBSECTION A OF THIS SECTION, THE ALLOCATIONS OF DISPROPORTIONATE SHARE HOSPITAL PAYMENTS MADE PURSUANT TO SECTION 36-2903.01, SUBSECTION P, ARIZONA REVISED STATUTES, SHALL BE MADE AVAILABLE FIRST TO QUALIFYING PRIVATE HOSPITALS LOCATED OUTSIDE OF THE PHOENIX METROPOLITAN STATISTICAL AREA AND THE TUCSON METROPOLITAN STATISTICAL AREA BEFORE BEING MADE AVAILABLE TO QUALIFYING HOSPITALS WITHIN THE PHOENIX METROPOLITAN STATISTICAL AREA AND THE TUCSON METROPOLITAN STATISTICAL AREA.

Sec. 7. ALTCS; county contributions; fiscal year 2015-2016

A. Notwithstanding section 11-292, Arizona Revised Statutes, county contributions for the Arizona long-term care system for fiscal year 2015-2016 are as follows:

1.	Apache	$ 618,900
2.	Cochise	$ 5,165,500
3.	Coconino	$ 1,858,500
4.	Gila	$ 2,117,900
5.	Graham	$ 1,336,700
6.	Greenlee	$ 79,700
7.	La Paz	$ 696,300
8.	Maricopa	$153,303,200

9.	Mohave	$ 8,033,700
10.	Navajo	$ 2,562,200
11.	Pima	$ 39,303,600
12.	Pinal	$ 15,539,700
13.	Santa Cruz	$ 1,942,200
14.	Yavapai	$ 8,416,600
15.	Yuma	$ 8,259,900

B. If the overall cost for the Arizona long-term care system exceeds the amount specified in the general appropriation act for fiscal year 2015-2016, the state treasurer shall collect from the counties the difference between the amount specified in subsection A of this section and the counties' share of the state's actual contribution. The counties' share of the state's contribution shall be in compliance with any federal maintenance of effort requirements. The director of the Arizona health care cost containment system administration shall notify the state treasurer of the counties' share of the state's contribution and report the amount to the director of the joint legislative budget committee. The state treasurer shall withhold from any other monies payable to a county from whatever state funding source is available an amount necessary to fulfill that county's requirement specified in this subsection. The state treasurer may not withhold distributions from the Arizona highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes. The state treasurer shall deposit the amounts withheld pursuant to this subsection and amounts paid pursuant to subsection A of this section in the long-term care system fund established by section 36-2913, Arizona Revised Statutes.

Sec. 8. Sexually violent persons; county reimbursement; fiscal year 2015-2016; deposit; tax distribution withholding; definition

A. Notwithstanding any other law, if this state pays the costs of a commitment of a sexually violent individual, the county shall reimburse the department of health services for thirty-one percent of these costs for fiscal year 2015-2016.

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

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

35-147, Arizona Revised Statutes, the withholdings in the Arizona state hospital fund established by section 36-545.08, Arizona Revised Statutes.

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

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

F. For the purposes of this section, "costs of a commitment" means the costs associated with the detainment of a person in a licensed facility under the supervision of the superintendent of the Arizona state hospital before the court determines that the person is sexually violent and the cost of detainment of the person after the court has determined that the person is sexually violent.

Sec. 9. Competency restoration treatment; city and county reimbursement; fiscal year 2015-2016; deposit; tax distribution withholding

A. Notwithstanding section 13-4512, Arizona Revised Statutes, if this state pays the costs of a defendant's inpatient, in custody competency restoration treatment pursuant to section 13-4512, Arizona Revised Statutes, the city or county shall reimburse the department of health services for one hundred percent of these costs for fiscal year 2015-2016.

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

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

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

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

Sec. 10. AHCCCS; disproportionate share payments

A. Disproportionate share payments for fiscal year 2015-2016 made pursuant to section 36-2903.01, subsection O, Arizona Revised Statutes, include:

1. $113,818,500 for a qualifying nonstate operated public hospital. The Maricopa county special health care district shall provide a certified public expense form for the amount of qualifying disproportionate share hospital expenditures made on behalf of this state to the Arizona health care cost containment system administration on or before May 1, 2016 for all state plan years as required by the Arizona health care cost containment system 1115 waiver standard terms and conditions. The administration shall assist the district in determining the amount of qualifying disproportionate share hospital expenditures. Once the administration files a claim with the federal government and receives federal funds participation based on the amount certified by the Maricopa county special health care district, if the certification is equal to or less than $113,818,500 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 $113,818,500 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. If the certification provided is for an amount greater than $113,818,500, the administration shall distribute $4,202,300 to the Maricopa county special health care district and shall deposit $74,241,400 of the federal funds participation in the state general fund. The administration may make additional disproportionate share hospital payments to the Maricopa county special health care district pursuant to section 36-2903.01, subsection P, Arizona Revised Statutes, and subsection B of this section.

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, 2016. 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. $884,800 for private qualifying disproportionate share hospitals. The Arizona health care cost containment system administration shall make payments to hospitals consistent with this appropriation and the terms of the section 1115 waiver, but payments are limited to those hospitals that either:

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

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

B. After the distributions made pursuant to subsection A of this section, the allocations of disproportionate share hospital payments made pursuant to section 36-2903.01, subsection P, Arizona Revised Statutes, shall be made available first to qualifying private hospitals located outside of the Phoenix metropolitan statistical area and the Tucson metropolitan statistical area before being made available to qualifying hospitals within the Phoenix metropolitan statistical area and the Tucson metropolitan statistical area.

Sec. 11. AHCCCS transfer; counties; federal monies

On or before December 31, 2016, notwithstanding any other law, for fiscal year 2015-2016 the Arizona health care cost containment system administration shall transfer to the counties such portion, if any, as may be necessary to comply with section 10201(c)(6) of the patient protection and affordable care act (P.L. 111-148), regarding the counties' proportional share of the state's contribution.

Sec. 12. County acute care contribution; fiscal year 2015-2016

A. Notwithstanding section 11-292, Arizona Revised Statutes, for fiscal year 2015-2016 for the provision of hospitalization and medical care, the counties shall contribute the following amounts:

1.	Apache	$ 268,800
2.	Cochise	$ 2,214,800
3.	Coconino	$ 742,900
4.	Gila	$ 1,413,200
5.	Graham	$ 536,200
6.	Greenlee	$ 190,700
7.	La Paz	$ 212,100
8.	Maricopa	$19,203,200

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 may not withhold distributions from the Arizona highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes.

C. Payment of an amount equal to one-twelfth of the total amount determined pursuant to subsection A of this section 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 established by section 36-2913, Arizona Revised Statutes.

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. 13. Hospitalization and medical care contribution; fiscal year 2015-2016

A. Notwithstanding any other law, for fiscal year 2015-2016, 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 a county's funding requirement as specified in subsection A of this section, the state treasurer shall withhold from any other monies payable to that county from whatever state funding source is available an amount necessary to fulfill that county's requirement. The state treasurer may not withhold distributions from the Arizona highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes.

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

D. In fiscal year 2015-2016, 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. 14. 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. 15. AHCCCS; risk contingency rate setting

Notwithstanding any other law, for the contract year beginning October 1, 2015 and ending September 30, 2016, the Arizona health care cost containment system administration may continue the risk contingency rate setting for all managed care organizations and the funding for all managed care organizations administrative funding levels that was imposed for the contract year beginning October 1, 2010 and ending September 30, 2011.

Sec. 16. AHCCCS; health care provider rate reduction

A. Notwithstanding any other law, for rates effective October 1, 2015 through September 30, 2016, the Arizona health care cost containment system administration may reduce payments up to an aggregate of five percent for all health care providers, excluding nursing facility, developmental disability and home and community based health care providers.

B. The administration may reduce provider payments by less than the percentage specified under subsection A of this section if adjustments to capitation rates for changes in utilization for the period October 1, 2015 through September 30, 2016 are less than the amounts appropriated in the general appropriation act to the Arizona health care cost containment system administration for a three percent capitation rate increase in fiscal year 2015-2016. The fiscal impact of reducing provider payments by less than the percentage specified under subsection A of this section may not exceed the amount by which the appropriation for capitation rates in fiscal year 2015-2016 exceeds utilization adjustments.

Sec. 17. Department of health services; health care provider rate reduction

A. Notwithstanding any other law, for rates effective October 1, 2015 through September 30, 2016, the department of health services may reduce payments up to an aggregate of five percent for all health care providers, excluding nursing facility, developmental disability and home and community based health care providers.

B. The department of health services may reduce provider payments by less than the percentage specified under subsection A of this section if adjustments to capitation rates for changes in utilization for the period October 1, 2015 through September 30, 2016 are less than the amounts appropriated in the general appropriation act to the department of health services for a three percent capitation rate increase in fiscal year 2015-2016. The fiscal impact of reducing provider payments by less than the

percentage specified under subsection A of this section may not exceed the amount by which the appropriation for capitation rates in fiscal year 2015-2016 exceeds utilization adjustments.

Sec. 18. AHCCCS; voluntary critical access hospital payments; appropriation; fiscal year 2015-2016; notification

Any monies received for critical access hospital payments from political subdivisions of this state, tribal governments and any university under the jurisdiction of the Arizona board of regents, and any federal monies used to match those payments, that are received in fiscal year 2015-2016 by the Arizona health care cost containment system administration are appropriated to the administration in fiscal year 2015-2016. Before the expenditure of these monies, the administration shall notify the joint legislative budget committee and the governor's office of strategic planning and budgeting of the amount of monies that will be expended under this section.

Sec. 19. AHCCCS; cost sharing requirements; rulemaking exemption

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

B. Subject to approval by the centers for medicare and medicaid services, beginning January 1, 2016, the administration shall charge and collect from each person who is enrolled pursuant to section 36-2901.01, Arizona Revised Statutes:

1. A premium of two percent of the person's household income.

2. A copayment of eight dollars for nonemergency use of an emergency room for the first incident and twenty-five dollars for each subsequent incident if the person is not admitted to the hospital. The administration may not impose a copayment on a person who is admitted to the hospital by the emergency department.

3. A copayment of twenty-five dollars for nonemergency use of an emergency room for the first incident and twenty-five dollars for each subsequent incident if there is a community health center, rural health center or urgent care center within twenty miles of the hospital.

C. Subject to approval by the centers for medicare and medicaid services, beginning January 1, 2016, the administration shall charge and collect from each person who is enrolled pursuant to section 36-2901.07, Arizona Revised Statutes:

1. A premium of two percent of the person's household income.

2. A copayment of twenty-five dollars for nonemergency use of an emergency room if the person is not admitted to the hospital. The administration may not impose a copayment on a person who is admitted to the hospital by the emergency department.

3. A copayment of twenty-five dollars for nonemergency use of an emergency room if there is a community health center, rural health center or urgent care center within twenty miles of the hospital.

4. An exemption from providing nonemergency medical transportation services from October 1, 2015 to September 30, 2016.

D. For the purpose of implementing cost sharing pursuant to this section, the Arizona health care cost containment system administration is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, for one year after the effective date of this act.

Sec. 20. AHCCCS; social security administration; medicare liability waiver; report

The Arizona health care cost containment system may participate in any special disability workload 1115 demonstration waiver offered by the centers for medicare and medicaid services. Any credits provided by the 1115 demonstration waiver process are to be used in the fiscal year when those credits are made available to fund the state share of any medical assistance expenditures that qualify for federal financial participation under the medicaid program. The Arizona health care cost containment system administration shall report the receipt of any credits to the director of the joint legislative budget committee on or before December 31, 2015 and June 30, 2016.

Sec. 21. Department of health services; health research account; Alzheimer's disease research

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

Sec. 22. AHCCCS; emergency department use; report

On or before December 1, 2015, the Arizona health care cost containment system administration shall report to the directors of the joint legislative budget committee and the governor's office of strategic planning and budgeting on the use of emergency departments for nonemergency purposes by Arizona health care cost containment system enrollees.

Sec. 23. Hospital transparency; joint report

On or before January 1, 2016, the director of the Arizona health care cost containment system administration and the director of the department of health services shall submit a joint report on hospital charge master transparency to the governor, the speaker of the house of representatives and the president of the senate and shall provide a copy to the secretary of state. The report shall provide a summary of the current charge master reporting process, a summary of hospital billed charges compared to costs and examples of how charge masters or hospital prices are reported and used in other states. The report shall include recommendations to improve the state's use of hospital charge master information, including reporting and oversight changes.

Sec. 24. Third-party liability payments; report

On or before December 31, 2016, the department of health services, or the state agency that administers behavioral health services for this state, shall report to the directors of the joint legislative budget committee and the governor's office of strategic planning and budgeting on the efforts to increase third-party liability payments for behavioral health services.

Sec. 25. Intent; implementation of program

It is the intent of the legislature that for fiscal year 2015-2016 the Arizona health care cost containment system administration implement a program within the available appropriation.

Sec. 26. AHCCCS; capitation rate increases

The Arizona health care cost containment system administration capitation rate increases may not exceed one and one-half percent in fiscal years 2016-2017 and 2017-2018.

Sec. 27. Department of health services; capitation rate increases

The department of health services capitation rate increases may not exceed one and one-half percent in fiscal years 2016-2017 and 2017-2018.

Sec. 28. Retroactivity

Laws 2014, chapter 11, section 12, as amended by this act, applies retroactively to from and after June 30, 2014.

APPROVED BY THE GOVERNOR MARCH 12, 2015.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MARCH 12, 2015.

Passed the House March 7, 2015,

by the following vote: ~~March 7~~ 32 Ayes,

27 Nays, 1 Not Voting

Speaker of the House

Chief Clerk of the House

Passed the Senate March 7, 2015,

by the following vote: 17 Ayes,

12 Nays, 1 Not Voting

President of the Senate

Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill was received by the Governor this

9th day of March, 2015,

at 2:44 o'clock P. M.

Secretary to the Governor

Approved this 12th day of

March, 2015,

at 5:47 o'clock P M.

Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this 12th day of March, 2015,

at 6:01 o'clock P. M.

Secretary of State

S.B. 1475