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CHAPTER 96

SENATE BILL 1202

AN ACT

AMENDING SECTIONS 36-2903.01 AND 36-2932, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 36-2903.01, Arizona Revised Statutes, is amended to read:

36-2903.01. Additional powers and duties; violation; classification

A. The director may adopt rules which provide that the system may withhold or forfeit payments to be made to a nonprovider by the system if the nonprovider fails to comply with the provisions of this article or rules adopted pursuant to this article which 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 providers and shall prescribe and furnish uniform forms and procedures, including methods of identification of members, to counties to be used for determining and reporting eligibility of members. The rules may include requirements that an applicant shall personally complete or assist in the completion of eligibility application forms, except in situations in which the person is disabled. The auditor general shall make recommendations to the director regarding the format of forms in order to ensure that the system records are readily available.

2. Enter into an interagency agreement with the department of economic security or Arizona works agency established by title 46, chapter 2, article 9 under which the department of economic security or Arizona works agency established by title 46, chapter 2, article 9 shall be required to determine the eligibility of all persons defined pursuant to section 36-2901, paragraph 4, subdivision (b) and ensure that the eligibility process is designed to maximize the enrollment of such persons with the county of residence. 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 4, subdivision (b). As part of the agreement, the administration shall recoup from the department of economic security or Arizona works agency all federal fiscal sanctions that result from the department of economic security's or Arizona works agency's inaccurate eligibility determinations for these persons.

3. Enter into an interagency agreement with the department of economic security or Arizona works agency established by title 46, chapter 2, article 9 which shall require the department of economic security or Arizona works agency established by title 46, chapter 2, article 9 to notify the administration of persons determined eligible for the federal food stamp program (P.L. 95-113; 91 Stat. 958-979) for the purpose of determining eligibility for the system pursuant to section 36-2905.03.

4. By rule establish a procedure and time frames for the intake of grievances and ~~appeals~~ REQUESTS FOR HEARINGS, for the continuation of benefits and services during the appeal process, for the informal resolution of grievances and ~~appeals~~ REQUESTS FOR HEARINGS and for a grievance process

at the contractor level. ~~With the exception of grievances filed pursuant to section 36-2904, subsection H,~~ 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 ~~appeal tribunal~~ 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 (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)).

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.

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 shall adopt rules for use by the counties in determining whether an applicant is a resident of this state and of the county and is either a United States citizen, a qualified alien as prescribed in section 36-2903.03 or eligible for state assisted emergency care under

1 section 36-2905.05. The rules shall require that state residency is not
2 established unless the requirements of paragraphs 1 and 2 of this subsection
3 are met or unless residency is proved pursuant to paragraph 3 of this
4 subsection:
5 1. The applicant produces one of the following:
6 (a) A recent Arizona rent or mortgage receipt or utility bill.
7 (b) A current Arizona motor vehicle driver license.
8 (c) A current Arizona motor vehicle registration.
9 (d) A document showing that the applicant is employed in this state.
10 (e) A document showing that the applicant has registered with a public
11 or private employment service in this state.
12 (f) Evidence that the applicant has enrolled the applicant's children
13 in a school in this state.
14 (g) Evidence that the applicant is receiving public assistance in this
15 state.
16 (h) Evidence of registration to vote in this state.
17 2. The applicant signs an affidavit attesting that all of the
18 following apply to the applicant:
19 (a) The applicant does not own or lease a residence outside this
20 state.
21 (b) The applicant does not own or lease a motor vehicle registered
22 outside this state.
23 (c) The applicant is not receiving public assistance outside this
24 state. As used in this subdivision, "public assistance" does not include
25 unemployment insurance benefits.
26 (d) The applicant is actively seeking employment in this state if he
27 is able to work and is not employed.
28 3. An applicant who does not meet the requirements of paragraph 1 or
29 2 of this subsection may apply to have residency determined by a special
30 eligibility officer who shall be appointed by the county board of
31 supervisors. The special eligibility officer shall receive any proof of
32 residency offered by the applicant and may inquire into any facts relevant
33 to the question of residency. A determination of residency shall not be
34 granted unless a preponderance of the credible evidence supports the
35 applicant's intent to remain indefinitely in this state. A denial of a
36 determination of residency may be appealed in the same manner as any other
37 denial of eligibility for the system.
38 4. An applicant who has relocated to this state from another state or
39 foreign country within six months before the date of application for the
40 purpose of obtaining state assisted medical care pursuant to this article
41 shall have the applicant's residency determined by a special eligibility
42 officer appointed pursuant to paragraph 3 of this subsection. The special
43 eligibility officer shall require, at a minimum, compliance with paragraphs
44 1 and 2 of this subsection. The special eligibility officer shall also
45 receive any additional proof of residency offered by the applicant and may

1 inquire into any facts relevant to the question of residency. A
2 determination of residency shall not be made unless a preponderance of the
3 credible evidence supports the applicant's intent to remain indefinitely in
4 this state. A denial of the determination of residency may be appealed in
5 the same manner as any other denial of eligibility for the system.
6 E. In accordance with constitutional standards and pursuant to
7 subsection D of this section, the director of the department of economic
8 security shall establish and maintain residency standards for those public
9 benefit programs related to eligibility in the system which are equivalent
10 to those residency standards established for the purposes of this article.
11 F. The director may adopt rules OR PROCEDURES to do the following:
12 1. Authorize advance payments based on estimated liability to a
13 provider or a nonprovider after the provider or nonprovider has submitted a
14 claim for services and before the claim is ultimately resolved. The rules
15 shall specify that any advance payment shall be conditioned on the execution
16 ~~prior to~~ BEFORE payment of a contract with the provider or nonprovider which
17 requires the administration to retain a specified percentage, which shall be
18 at least twenty per cent, of the claimed amount as security and which
19 requires repayment to the administration if the administration makes any
20 overpayment.
21 2. Defer liability, in whole or in part, of prepaid capitated contract
22 providers for care provided to members who are hospitalized on the date of
23 enrollment or under other circumstances. Payment shall be on a capped
24 fee-for-service basis for services other than hospital services and at the
25 rate established pursuant to subsection I or J of this section for hospital
26 services or at the rate paid by the health plan, whichever is less.
27 3. DEPUTIZE, IN WRITING, ANY QUALIFIED OFFICER OR EMPLOYEE IN THE
28 ADMINISTRATION TO PERFORM ANY ACT THAT THE DIRECTOR BY LAW IS EMPOWERED TO
29 DO OR CHARGED WITH THE RESPONSIBILITY OF DOING, INCLUDING THE AUTHORITY TO
30 ISSUE FINAL ADMINISTRATIVE DECISIONS PURSUANT TO SECTION 41-1092.08.
31 G. The director shall adopt rules which further specify the medical
32 care and hospital services which are covered by the system pursuant to
33 section 36-2907.
34 H. In addition to the rules otherwise specified in this article, the
35 director may adopt necessary rules pursuant to title 41, chapter 6 to carry
36 out this article. Rules adopted by the director pursuant to this subsection
37 shall consider the differences between rural and urban conditions on the
38 delivery of hospitalization and medical care.
39 I. For inpatient hospital admissions and all outpatient hospital
40 services before March 1, 1993, the administration shall reimburse a
41 hospital's adjusted billed charges according to the following procedures:
42 1. The director shall adopt rules which, for services rendered from
43 and after September 30, 1985 until October 1, 1986, define "adjusted billed
44 charges" as that reimbursement level which has the effect of holding constant
45 whichever of the following is applicable:

1 (a) The schedule of rates and charges for a hospital in effect on
2 April 1, 1984 as filed pursuant to chapter 4, article 3 of this title.
3 (b) The schedule of rates and charges for a hospital which became
4 effective after May 31, 1984 but ~~prior to~~ BEFORE July 2, 1984, if the
5 hospital's previous rate schedule became effective ~~prior to~~ BEFORE April 30,
6 1983.
7 (c) The schedule of rates and charges for a hospital which became
8 effective after May 31, 1984 but ~~prior to~~ BEFORE July 2, 1984, limited to
9 five per cent over the hospital's previous rate schedule, and if the
10 hospital's previous rate schedule became effective on or after April 30, 1983
11 but ~~prior to~~ BEFORE October 1, 1983. For the purposes of this paragraph
12 "constant" means equal to or lower than.
13 2. The director shall adopt rules which, for services rendered from
14 and after September 30, 1986, define "adjusted billed charges" as that
15 reimbursement level which has the effect of increasing by four per cent a
16 hospital's reimbursement level in effect on October 1, 1985 as prescribed in
17 paragraph 1 of this subsection. Beginning January 1, 1991, the Arizona
18 health care cost containment system administration shall define "adjusted
19 billed charges" as the reimbursement level determined pursuant to this
20 section, increased by two and one-half per cent.
21 3. In no event shall a hospital's adjusted billed charges exceed the
22 hospital's schedule of rates and charges filed with the department of health
23 services and in effect pursuant to chapter 4, article 3 of this title.
24 4. For services rendered the administration shall not pay a hospital's
25 adjusted billed charges in excess of the following:
26 (a) If the hospital's bill is paid within thirty days of the date the
27 bill was received, eighty-five per cent of the adjusted billed charges.
28 (b) If the hospital's bill is paid any time after thirty days but
29 within sixty days of the date the bill was received, ninety-five per cent of
30 the adjusted billed charges.
31 (c) If the hospital's bill is paid any time after sixty days of the
32 date the bill was received, one hundred per cent of the adjusted billed
33 charges.
34 5. The director shall define by rule the method of determining when
35 a hospital bill will be considered received and when a hospital's billed
36 charges will be considered paid. Payment received by a hospital from the
37 administration pursuant to this subsection or from a provider either by
38 contract or pursuant to section 36-2904, subsection K shall be considered
39 payment of the hospital bill in full, except that a hospital may collect any
40 unpaid portion of its bill from other third party payors or in situations
41 covered by title 33, chapter 7, article 3.
42 J. For inpatient hospital admissions and outpatient hospital services
43 on and after March 1, 1993 the administration shall adopt rules for the
44 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 which limit their provision of services to specific patient populations, such as rehabilitative patients or children. The initial per diem rates shall be based ~~upon~~ 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. For outpatient hospital services, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to the covered charges.

4. Except if submitted under an electronic claims submission system, a hospital bill is considered received for purposes of this paragraph ~~upon~~ 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:

1 (a) An admission face sheet.
2 (b) An itemized statement.
3 (c) An admission history and physical.
4 (d) A discharge summary or an interim summary if the claim is split.
5 (e) An emergency record, if admission was through the emergency room.
6 (f) Operative reports, if applicable.
7 (g) A labor and delivery room report, if applicable.
8 Payment received by a hospital from the administration pursuant to this
9 subsection or from a provider either by contract or pursuant to section
10 36-2904, subsection K is considered payment by the administration or the
11 provider of the administration's or provider's liability for the hospital
12 bill. A hospital may collect any unpaid portion of its bill from other third
13 party payors or in situations covered by title 33, chapter 7, article 3.
14 5. For services rendered on and after October 1, 1997, the
15 administration shall pay a hospital's rate established according to this
16 section subject to the following:
17 (a) Except for members who are eligible pursuant to section 36-2901,
18 paragraph 4, subdivisions (a), (c), (h) and (j), if the hospital's bill is
19 paid within thirty days of the date the bill was received, the administration
20 shall pay ninety-nine per cent of the rate.
21 (b) If the hospital's bill is paid after thirty days but within sixty
22 days of the date the bill was received, the administration shall pay one
23 hundred per cent of the rate.
24 (c) If the hospital's bill is paid any time after sixty days of the
25 date the bill was received, the administration shall pay one hundred per cent
26 of the rate plus a fee of one per cent per month for each month or portion
27 of a month following the sixtieth day of receipt of the bill until the date
28 of payment.
29 6. In developing the reimbursement methodology, if a review of the
30 reports filed by a hospital pursuant to section 36-125.04 indicates that
31 further investigation is considered necessary to verify the accuracy of the
32 information in the reports, the administration may examine the hospital's
33 records and accounts related to the reporting requirements of section
34 36-125.04. The administration shall bear the cost incurred in connection
35 with this examination unless the administration finds that the records
36 examined are significantly deficient or incorrect, in which case the
37 administration may charge the cost of the investigation to the hospital
38 examined.
39 7. Except for privileged medical information, the administration shall
40 make available for public inspection the cost and charge data and the
41 calculations used by the administration to determine payments under the
42 tiered per diem system, provided that individual hospitals are not identified
43 by name. The administration shall make the data and calculations available
44 for public inspection during regular business hours and shall provide copies
45 of the data and calculations to individuals requesting such copies within

1 thirty days of receipt of a written request. The administration may charge
2 a reasonable fee for the provision of the data or information.
3 8. The prospective tiered per diem payment methodology for inpatient
4 hospital services shall include a mechanism for the prospective payment of
5 inpatient hospital capital related costs. The capital payment shall include
6 hospital specific and statewide average amounts. For tiered per diem rates
7 beginning on October 1, 1999, the capital related cost component is frozen
8 at the blended rate of forty per cent of the hospital specific capital cost
9 and sixty per cent of the statewide average capital cost in effect as of
10 January 1, 1999 and as further adjusted by the calculation of tier rates for
11 maternity and nursery as prescribed by law. The administration shall adjust
12 the capital related cost component by the data resources incorporated market
13 basket index for prospective payment system hospitals.
14 9. Beginning September 30, 1997, the administration shall establish
15 a separate graduate medical education program to reimburse hospitals that had
16 graduate medical education programs that were approved by the administration
17 as of October 1, 1999. The administration shall separately account for
18 monies for the graduate medical education program based on the total
19 reimbursement for graduate medical education reimbursed to hospitals by the
20 system in federal fiscal year 1995-1996 pursuant to the tiered per diem
21 methodology specified in this section. The graduate medical education
22 program reimbursement shall be adjusted annually by the increase or decrease
23 in the index published by the data resources incorporated hospital market
24 basket index for prospective hospital reimbursement. Subject to legislative
25 appropriation, on an annual basis, each qualified hospital shall receive a
26 single payment from the graduate medical education program that is equal to
27 the same percentage of graduate medical education reimbursement that was paid
28 by the system in federal fiscal year 1995-1996. Any reimbursement for
29 graduate medical education made by the administration shall not be subject
30 to future settlements or appeals by the hospitals to the administration.
31 10. The prospective tiered per diem payment methodology for inpatient
32 hospital services may include a mechanism for the payment of claims with
33 extraordinary operating costs per day. For tiered per diem rates effective
34 beginning on October 1, 1999, outlier cost thresholds are frozen at the
35 levels in effect on January 1, 1999 and adjusted annually by the
36 administration by the data resources incorporated market basket index for
37 prospective payment system hospitals.
38 11. NOTWITHSTANDING SECTION 41-1005, SUBSECTION A, PARAGRAPH 9, THE
39 ADMINISTRATION SHALL ADOPT RULES PURSUANT TO TITLE 41, CHAPTER 6 ESTABLISHING
40 THE METHODOLOGY FOR DETERMINING THE PROSPECTIVE TIERED PER DIEM PAYMENTS.
41 K. The director may adopt rules which specify enrollment procedures
42 including notice to providers of enrollment. The rules may provide for
43 varying time limits for enrollment in different situations. The rules shall
44 provide for continuous enrollment of a pregnant woman who is determined
45 eligible pursuant to section 11-297 or 36-2905 and whose condition of

1 pregnancy is clinically verified in writing by a health care professional
2 licensed pursuant to title 32, chapter 13, 15, 17 or 25 or chapter 6, article
3 7 of this title until the last day of the month after the month of the
4 estimated date of delivery. The rules shall provide that as a condition of
5 continuous enrollment pursuant to this subsection the woman must notify her
6 county of residence and provide necessary verification of her pregnancy and
7 estimated date of delivery before the end of her certification period. The
8 rules shall specify the procedures by which the county shall notify the
9 administration that a pregnant woman qualifies for continuous enrollment and
10 shall specify procedures for the pregnant woman to notify the county of any
11 change in her financial or clinical status that might disqualify her from
12 continuous enrollment pursuant to this subsection. Pursuant to rules adopted
13 by the director, a child born to a woman under continuous enrollment shall
14 also be enrolled until the last day of the month after the month of the
15 estimated date of delivery. This subsection does not prevent a person from
16 qualifying for continued eligibility as otherwise provided in section 11-297
17 or this article. The administration shall specify in contract when a person
18 who has been determined eligible will be enrolled with that provider and the
19 date on which the provider will be financially responsible for health and
20 medical services to the person.
21 L. The administration may make direct payments to hospitals for
22 hospitalization and medical care provided to a member in accordance with the
23 provisions of this article and rules. The director may adopt rules which
24 shall establish the procedures by which the administration shall pay
25 hospitals pursuant to this subsection if a provider fails to make timely
26 payment to a hospital. Such payment shall be at a level determined pursuant
27 to section 36-2904, subsection J or K. The director may withhold payment due
28 to a provider in the amount of any payment made directly to a hospital by the
29 administration on behalf of a provider pursuant to this subsection.
30 M. The director shall establish a special unit within the
31 administration for the purpose of monitoring the third party payment
32 collections required by providers and nonproviders pursuant to section
33 36-2903, subsection C, paragraph 10 and subsection G and section 36-2915,
34 subsection E. The director shall determine by rule:
35 1. The type of third party payments to be monitored pursuant to this
36 subsection.
37 2. The percentage of third party payments collected by a provider or
38 nonprovider which the provider or nonprovider may keep and the percentage of
39 such payments which the provider or nonprovider may be required to pay to the
40 administration. Both providers and nonproviders are required to pay to the
41 administration one hundred per cent of all third party payments collected
42 which duplicate administration fee-for-service payments. A provider that
43 contracts with the administration pursuant to section 36-2904, subsection A
44 may be entitled to retain a percentage of third party payments if the
45 payments collected and retained by a provider are reflected in reduced

capitation rates. A provider may be required to pay the administration a percentage of third party payments collected by a provider that are not reflected in reduced capitation rates.

N. ~~Upon~~ ON oral or written notice from the patient that the patient believes the claims to be covered by the system, a provider or nonprovider of health and medical services prescribed in section 36-2907 shall not do either of the following unless the provider or nonprovider has verified through the administration that the person has been determined ineligible, has not yet been determined eligible or was not, at the time services were rendered, eligible or enrolled:

1. Charge, submit a claim to or demand or otherwise collect payment from a member or person who has been determined eligible unless specifically authorized by this article or rules adopted pursuant to this article.

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

O. 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. Prepaid capitated providers may conduct a postpayment review of all claims paid by prepaid capitated providers and may recoup monies that are erroneously paid.

P. The director or ~~his~~ THE DIRECTOR'S designees may employ and supervise personnel necessary to assist the director in performing the functions of the administration.

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

R. Notwithstanding any law to the contrary, on federal approval the administration may make disproportionate share payments to hospitals 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, public hospitals receiving disproportionate share payments 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

1 share payments as prescribed in this section, the administration may use
2 either a methodology based on claims and encounter data that is submitted to
3 the administration from prepaid capitated providers or a methodology based
4 on data that is reported to the administration by hospitals. The selected
5 methodology applies to all hospitals qualifying for disproportionate share
6 payments.
7 S. Notwithstanding any law to the contrary, the administration may
8 receive confidential adoption information for the purposes of identifying
9 adoption related third party payors in order to recover the total costs for
10 prenatal care and the delivery of the child, including capitation,
11 reinsurance and any fee-for-service costs incurred by the administration on
12 behalf of an eligible person who the administration has reason to believe had
13 an arrangement to have the eligible person's newborn adopted. Except for the
14 sole purpose of identifying adoption related third party payors, the
15 administration shall not further disclose any information obtained pursuant
16 to this subsection and shall develop and implement safeguards to protect the
17 confidentiality of this information including limiting access to the
18 information to only those administration personnel whose official duties
19 require it. At no time shall the administration release to the adoptive
20 parents' or birth parents' insurance carrier personally identifying
21 information regarding the other party. A person who knowingly violates the
22 requirements of this subsection pertaining to confidentiality is guilty of
23 a class 6 felony.
24 T. The adoption agency or the adoption attorney shall notify the
25 administration within thirty days after an eligible person receiving services
26 has placed that person's child for adoption.
27 U. The administration shall not seek maternity expenditure cost
28 recovery from a third party payor on arrangements involving the placement of
29 a newborn with special needs as defined in section 8-141, children in the
30 custody of the state or children placed with relatives.
31 V. If the administration implements an electronic claims submission
32 system it may adopt procedures pursuant to subsection J of this section
33 requiring documentation different than prescribed under subsection J,
34 paragraph 4 of this section.
35 Sec. 2. Section 36-2932, Arizona Revised Statutes, is amended to read:
36 36-2932. <u>Arizona long-term care system; powers and duties of</u>
37 <u>the director; expenditure limitation</u>
38 A. The Arizona long-term care system is established. The system
39 includes the management and delivery of hospitalization, medical care,
40 institutional services and home and community based services to members
41 through the administration, the program contractors and providers pursuant
42 to this article together with federal participation under title XIX of the
43 social security act. The director in the performance of all duties shall
44 consider the use of existing programs, rules and procedures in the counties
45 and department where appropriate in meeting federal requirements.

1 B. The administration has full operational responsibility for the
2 system which shall include the following:
3 1. Contracting with and certification of program contractors in
4 compliance with all applicable federal laws.
5 2. Approving the program contractors' comprehensive service delivery
6 plans pursuant to section 36-2940.
7 3. Providing by rule for the ability of the director to review and
8 approve or disapprove program contractors' request for proposals for
9 providers and provider subcontracts.
10 4. Providing technical assistance to the program contractors.
11 5. Developing a uniform accounting system to be implemented by program
12 contractors and providers of institutional services and home and community
13 based services.
14 6. Conducting quality control on eligibility determinations and
15 preadmission screenings.
16 7. Establishing and managing a comprehensive system for assuring the
17 quality of care delivered by the system as required by federal law.
18 8. Establishing an enrollment system.
19 9. Establishing a member case management tracking system.
20 10. Establishing and managing a method to prevent fraud by applicants,
21 members, eligible persons, program contractors, providers and noncontracting
22 providers as required by federal law.
23 11. Coordinating benefits as provided in section 36-2946.
24 12. Establishing standards for the coordination of services.
25 13. Establishing financial and performance audit requirements for
26 program contractors, providers and noncontracting providers.
27 14. Prescribing remedies as required pursuant to the provisions of 42
28 United States Code section 1396r. These remedies may include the appointment
29 of temporary management by the director, acting in collaboration with the
30 director of the department of health services, in order to continue operation
31 of a nursing care institution providing services pursuant to this article.
32 15. Establishing a system to implement medical child support
33 requirements, as required by federal law. The administration may enter into
34 an intergovernmental agreement with the department of economic security to
35 implement the provisions of this paragraph.
36 16. Establishing requirements and guidelines for the review of trusts
37 for the purposes of establishing eligibility for the system pursuant to
38 section 36-2934.01 and post-eligibility treatment of income pursuant to
39 subsection L of this section.
40 C. For nursing care institutions and hospices that provide services
41 pursuant to this article, the director shall periodically as deemed necessary
42 and as required by federal law contract for a financial audit of the
43 institutions and hospices that is certified by a certified public accountant
44 in accordance with generally accepted auditing standards or conduct or
45 contract for a financial audit or review of the institutions and hospices.

The director shall notify the nursing care institution and hospice at least sixty days ~~prior to~~ BEFORE beginning a periodic audit. The administration shall reimburse a nursing care institution or hospice for any additional expenses incurred for professional accounting services obtained in response to a specific request by the administration. ~~Upon~~ ON request, the director of the administration shall provide a copy of an audit performed pursuant to this subsection to the director of the department of health services or ~~his~~ THAT PERSON'S designee.

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

E. The director shall require as a condition of a contract that all records relating to contract compliance are available for inspection by the administration subject to subsection F of this section and that these records ~~shall be~~ ARE maintained for five years. The director shall also require that these records ~~shall be made~~ ARE available on request of the secretary of the United States department of health and human services or its successor agency.

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

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

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

I. The director shall:

~~1. Establish by rule a grievance and appeal procedure, including time limits for appeals of eligibility, for use by program contractors, providers, noncontracting providers, counties, members, eligible persons, those persons who apply to be providers and those persons who apply to be members, including persons who have been determined to be ineligible for system coverage. Grievance procedures shall cover grievances arising pursuant to this article. With the exception of eligibility appeals and grievances filed~~

~~pursuant to section 36-2904, subsection H, a grievance or appeal shall be filed in writing with and received by the administration not later than sixty days after the date of the adverse action, decision or policy implementation being grieved. A grievance for the denial of a claim for reimbursement for 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. The grievance and appeal procedure shall contain provisions relating to the notice to be provided to aggrieved parties, including notification of final decisions, complaint processes and internal appeals mechanisms. A grievance and appeal procedure not specified pursuant to this paragraph, but identified pursuant to title 41, chapter 6, article 6, also applies. Final decisions of the director under the grievance and appeal procedure established pursuant to this paragraph are subject to judicial review under title 12, chapter 7, article 6.~~

1. ESTABLISH BY RULE THE TIME FRAMES AND PROCEDURES FOR ALL GRIEVANCES AND REQUESTS FOR HEARINGS CONSISTENT WITH SECTION 36-2903.01, SUBSECTION B, PARAGRAPH 4.

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

3. ~~No~~ NOT less than thirty days ~~prior to the implementation of~~ BEFORE THE ADMINISTRATION IMPLEMENTS a policy or a change to an existing policy relating to reimbursement, ~~the director shall~~ provide notice to interested parties. Parties interested in receiving notification of policy changes shall submit a written request for notification to the administration.

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

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

L. The director shall adopt rules in accordance with the state plan regarding post-eligibility treatment of income and resources which determine the portion of a member's income which shall be available for payment for services under this article. The rules shall provide that a portion of income may be retained for:

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

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

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

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

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

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

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

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

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

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

1 R. The total amount of state monies that may be spent in any fiscal
2 year by the administration for long-term care shall not exceed the amount
3 appropriated or authorized by section 35-173 for that purpose. This article
4 shall not be construed to impose a duty on an officer, agent or employee of
5 this state to discharge a responsibility or to create any right in a person
6 or group if the discharge or right would require an expenditure of state
7 monies in excess of the expenditure authorized by legislative appropriation
8 for that specific purpose.

APPROVED BY THE GOVERNOR APRIL 11, 2001.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 12, 2001.

Passed the House April 04, 20 01,

by the following vote: 54 Ayes,

6 Nays, 0 Not Voting

Speaker of the House

Chief Clerk of the House

Passed the Senate February 14, 20 01,

by the following vote: 28 Ayes,

2 Nays, 0 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

5 day of April, 2001,

at 1:07 o'clock P M.

Secretary to the Governor

Approved this 11 day of

April, 2001,

at 1:43 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 12 day of April, 2001,

at 3:30 o'clock P M.

Secretary of State

S.B. 1202