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First Regular Session
2005

CHAPTER 100

SENATE BILL 1249

AN ACT

AMENDING SECTIONS 36-2903.01, 36-2932 AND 36-2986, ARIZONA REVISED STATUTES;
RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

4 36-2903.01. Additional powers and duties

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

11 B. The director shall:

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

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

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

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

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

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

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

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

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

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

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

8 4. By rule establish a procedure and time frames for the intake of
9 grievances and requests for hearings, for the continuation of benefits and
10 services during the appeal process and for a grievance process at the
11 contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and
12 41-1092.05, the administration shall develop rules to establish the procedure
13 and time frame for the informal resolution of grievances and appeals. A
14 grievance that is not related to a claim for payment of system covered
15 services shall be filed in writing with and received by the administration or
16 the prepaid capitated provider or program contractor not later than sixty
17 days after the date of the adverse action, decision or policy implementation
18 being grieved. A grievance that is related to a claim for payment of system
19 covered services must be filed in writing and received by the administration
20 or the prepaid capitated provider or program contractor within twelve months
21 after the date of service, within twelve months after the date that
22 eligibility is posted or within sixty days after the date of the denial of a
23 timely claim submission, whichever is later. A grievance for the denial of a
24 claim for reimbursement of services may contest the validity of any adverse
25 action, decision, policy implementation or rule that related to or resulted
26 in the full or partial denial of the claim. A policy implementation may be
27 subject to a grievance procedure, but it may not be appealed for a hearing.
28 The administration is not required to participate in a mandatory settlement
29 conference if it is not a real party in interest. In any proceeding before
30 the administration, including a grievance or hearing, persons may represent
31 themselves or be represented by a duly authorized agent who is not charging a
32 fee. A legal entity may be represented by an officer, partner or employee
33 who is specifically authorized by the legal entity to represent it in the
34 particular proceeding.

35 5. Apply for and accept federal funds available under title XIX of the
36 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section
37 1396 (1980)) in support of the system. The application made by the director
38 pursuant to this paragraph shall be designed to qualify for federal funding
39 primarily on a prepaid capitated basis. Such funds may be used only for the
40 support of persons defined as eligible pursuant to title XIX of the social
41 security act or the approved section 1115 waiver.

42 6. At least thirty days before the implementation of a policy or a
43 change to an existing policy relating to reimbursement, provide notice to
44 interested parties. Parties interested in receiving notification of policy

1 changes shall submit a written request for notification to the
2 administration.

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

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

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

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

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

28 4. Notwithstanding any other law, require persons eligible pursuant to
29 section 36-2901, paragraph 6, subdivision (a), section 36-2931, paragraph 5
30 and section 36-2981, paragraph 6, ~~and before July 1, 2004, pursuant to~~
31 ~~section 36-2981.01~~ to be financially responsible for any cost sharing
32 requirements established in a state plan or a section 1115 waiver and
33 approved by the centers for medicare and medicaid services. Cost sharing
34 requirements may include copayments, coinsurance, deductibles, enrollment
35 fees and monthly premiums for enrolled members, including households with
36 children enrolled in the Arizona long-term care system.

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

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

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

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

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

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

13 (c) The schedule of rates and charges for a hospital that became
14 effective after May 31, 1984 but before July 2, 1984, limited to five per
15 cent over the hospital's previous rate schedule, and if the hospital's
16 previous rate schedule became effective on or after April 30, 1983 but before
17 October 1, 1983. For the purposes of this paragraph, "constant" means equal
18 to or lower than.

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

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

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

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

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

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

40 5. The director shall define by rule the method of determining when a
41 hospital bill will be considered received and when a hospital's billed
42 charges will be considered paid. Payment received by a hospital from the
43 administration pursuant to this subsection or from a contractor either by
44 contract or pursuant to section 36-2904, subsection I shall be considered
45 payment of the hospital bill in full, except that a hospital may collect any

1 unpaid portion of its bill from other third party payors or in situations
2 covered by title 33, chapter 7, article 3.

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

6 1. For inpatient hospital stays, the administration shall use a
7 prospective tiered per diem methodology, using hospital peer groups if
8 analysis shows that cost differences can be attributed to independently
9 definable features that hospitals within a peer group share. In peer
10 grouping the administration may consider such factors as length of stay
11 differences and labor market variations. If there are no cost differences,
12 the administration shall implement a stop loss-stop gain or similar
13 mechanism. Any stop loss-stop gain or similar mechanism shall ensure that
14 the tiered per diem rates assigned to a hospital do not represent less than
15 ninety per cent of its 1990 base year costs or more than one hundred ten per
16 cent of its 1990 base year costs, adjusted by an audit factor, during the
17 period of March 1, 1993 through September 30, 1994. The tiered per diem
18 rates set for hospitals shall represent no less than eighty-seven and
19 one-half per cent or more than one hundred twelve and one-half per cent of
20 its 1990 base year costs, adjusted by an audit factor, from October 1, 1994
21 through September 30, 1995 and no less than eighty-five per cent or more than
22 one hundred fifteen per cent of its 1990 base year costs, adjusted by an
23 audit factor, from October 1, 1995 through September 30, 1996. For the
24 periods after September 30, 1996 no stop loss-stop gain or similar mechanisms
25 shall be in effect. An adjustment in the stop loss-stop gain percentage may
26 be made to ensure that total payments do not increase as a result of this
27 provision. If peer groups are used the administration shall establish
28 initial peer group designations for each hospital before implementation of
29 the per diem system. The administration may also use a negotiated rate
30 methodology. The tiered per diem methodology may include separate
31 consideration for specialty hospitals that limit their provision of services
32 to specific patient populations, such as rehabilitative patients or children.
33 The initial per diem rates shall be based on hospital claims and encounter
34 data for dates of service November 1, 1990 through October 31, 1991 and
35 processed through May of 1992.

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

42 3. Through June 30, 2004, for outpatient hospital services, the
43 administration shall reimburse a hospital by applying a hospital specific
44 outpatient cost-to-charge ratio to the covered charges. Beginning on July 1,
45 2004 through June 30, 2005, the administration shall reimburse a hospital by

1 applying a hospital specific outpatient cost-to-charge ratio to covered
2 charges. If the hospital increases its charges for outpatient services filed
3 with the Arizona department of health services pursuant to chapter 4, article
4 3 of this title, by more than 4.7 per cent for dates of service effective on
5 or after July 1, 2004, the hospital specific cost-to-charge ratio will be
6 reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7
7 per cent, the effective date of the increased charges will be the effective
8 date of the adjusted Arizona health care cost containment system
9 cost-to-charge ratio. The administration shall develop the methodology for a
10 capped fee-for-service schedule and a statewide cost-to-charge ratio. Any
11 covered outpatient service not included in the capped fee-for-service
12 schedule shall be reimbursed by applying the statewide cost-to-charge ratio
13 that is based on the services not included in the capped fee-for-service
14 schedule. Beginning on July 1, 2005, the administration shall reimburse
15 clean claims with dates of service on or after July 1, 2005, based on the
16 capped fee-for-service schedule or the statewide cost-to-charge ratio
17 established pursuant to this paragraph. The administration may make
18 additional adjustments to the outpatient hospital rates established pursuant
19 to this section based on other factors, including the number of beds in the
20 hospital, specialty services available to patients and the geographic
21 location of the hospital.

22 4. Except if submitted under an electronic claims submission system, a
23 hospital bill is considered received for purposes of this paragraph on
24 initial receipt of the legible, error-free claim form by the administration
25 if the claim includes the following error-free documentation in legible form:

- 26 (a) An admission face sheet.
- 27 (b) An itemized statement.
- 28 (c) An admission history and physical.
- 29 (d) A discharge summary or an interim summary if the claim is split.
- 30 (e) An emergency record, if admission was through the emergency room.
- 31 (f) Operative reports, if applicable.
- 32 (g) A labor and delivery room report, if applicable.

33 Payment received by a hospital from the administration pursuant to this
34 subsection or from a contractor either by contract or pursuant to section
35 36-2904, subsection ~~J~~ I is considered payment by the administration or the
36 contractor of the administration's or contractor's liability for the hospital
37 bill. A hospital may collect any unpaid portion of its bill from other third
38 party payors or in situations covered by title 33, chapter 7, article 3.

39 5. For services rendered on and after October 1, 1997, the
40 administration shall pay a hospital's rate established according to this
41 section subject to the following:

- 42 (a) If the hospital's bill is paid within thirty days of the date the
43 bill was received, the administration shall pay ninety-nine per cent of the
44 rate.

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

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

9 6. In developing the reimbursement methodology, if a review of the
10 reports filed by a hospital pursuant to section 36-125.04 indicates that
11 further investigation is considered necessary to verify the accuracy of the
12 information in the reports, the administration may examine the hospital's
13 records and accounts related to the reporting requirements of section
14 36-125.04. The administration shall bear the cost incurred in connection
15 with this examination unless the administration finds that the records
16 examined are significantly deficient or incorrect, in which case the
17 administration may charge the cost of the investigation to the hospital
18 examined.

19 7. Except for privileged medical information, the administration shall
20 make available for public inspection the cost and charge data and the
21 calculations used by the administration to determine payments under the
22 tiered per diem system, provided that individual hospitals are not identified
23 by name. The administration shall make the data and calculations available
24 for public inspection during regular business hours and shall provide copies
25 of the data and calculations to individuals requesting such copies within
26 thirty days of receipt of a written request. The administration may charge a
27 reasonable fee for the provision of the data or information.

28 8. The prospective tiered per diem payment methodology for inpatient
29 hospital services shall include a mechanism for the prospective payment of
30 inpatient hospital capital related costs. The capital payment shall include
31 hospital specific and statewide average amounts. For tiered per diem rates
32 beginning on October 1, 1999, the capital related cost component is frozen at
33 the blended rate of forty per cent of the hospital specific capital cost and
34 sixty per cent of the statewide average capital cost in effect as of January
35 1, 1999 and as further adjusted by the calculation of tier rates for
36 maternity and nursery as prescribed by law. The administration shall adjust
37 the capital related cost component by the data resources incorporated market
38 basket index for prospective payment system hospitals.

39 9. Beginning September 30, 1997, the administration shall establish a
40 separate graduate medical education program to reimburse hospitals that had
41 graduate medical education programs that were approved by the administration
42 as of October 1, 1999. The administration shall separately account for
43 monies for the graduate medical education program based on the total
44 reimbursement for graduate medical education reimbursed to hospitals by the
45 system in federal fiscal year 1995-1996 pursuant to the tiered per diem

1 methodology specified in this section. The graduate medical education
2 program reimbursement shall be adjusted annually by the increase or decrease
3 in the index published by the data resources incorporated hospital market
4 basket index for prospective hospital reimbursement. Subject to legislative
5 appropriation, on an annual basis, each qualified hospital shall receive a
6 single payment from the graduate medical education program that is equal to
7 the same percentage of graduate medical education reimbursement that was paid
8 by the system in federal fiscal year 1995-1996. Any reimbursement for
9 graduate medical education made by the administration shall not be subject to
10 future settlements or appeals by the hospitals to the administration.

11 10. The prospective tiered per diem payment methodology for inpatient
12 hospital services may include a mechanism for the payment of claims with
13 extraordinary operating costs per day. For tiered per diem rates effective
14 beginning on October 1, 1999, outlier cost thresholds are frozen at the
15 levels in effect on January 1, 1999 and adjusted annually by the
16 administration by the data resources incorporated market basket index for
17 prospective payment system hospitals.

18 11. Notwithstanding section 41-1005, subsection A, paragraph 9, the
19 administration shall adopt rules pursuant to title 41, chapter 6 establishing
20 the methodology for determining the prospective tiered per diem payments.

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

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

37 K. The director shall establish a special unit within the
38 administration for the purpose of monitoring the third party payment
39 collections required by contractors and noncontracting providers pursuant to
40 section 36-2903, subsection B, paragraph 10 and subsection F and section
41 36-2915, subsection E. The director shall determine by rule:

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

44 2. The percentage of third party payments that is collected by a
45 contractor or noncontracting provider and that the contractor or

1 noncontracting provider may keep and the percentage of such payments that the
2 contractor or noncontracting provider may be required to pay to the
3 administration. Contractors and noncontracting providers must pay to the
4 administration one hundred per cent of all third party payments that are
5 collected and that duplicate administration fee-for-service payments. A
6 contractor that contracts with the administration pursuant to section
7 36-2904, subsection A may be entitled to retain a percentage of third party
8 payments if the payments collected and retained by a contractor are reflected
9 in reduced capitation rates. A contractor may be required to pay the
10 administration a percentage of third party payments that are collected by a
11 contractor and that are not reflected in reduced capitation rates.

12 ~~L. On oral or written notice from the patient that the patient~~
13 ~~believes the claims to be covered by the system, a contractor or~~
14 ~~noncontracting provider of health and medical services prescribed in section~~
15 ~~36-2907 shall not do either of the following unless the contractor or~~
16 ~~noncontracting provider has verified through the administration that the~~
17 ~~person has been determined ineligible, has not yet been determined eligible~~
18 ~~or was not, at the time services were rendered, eligible or enrolled:~~

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

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

27 L. THE ADMINISTRATION SHALL ESTABLISH PROCEDURES TO APPLY TO THE
28 FOLLOWING IF A PROVIDER THAT HAS A CONTRACT WITH A CONTRACTOR OR
29 NONCONTRACTING PROVIDER SEEKS TO COLLECT FROM AN INDIVIDUAL OR FINANCIALLY
30 RESPONSIBLE RELATIVE OR REPRESENTATIVE A CLAIM THAT EXCEEDS THE AMOUNT THAT
31 IS REIMBURSED OR SHOULD BE REIMBURSED BY THE SYSTEM:

32 1. ON WRITTEN NOTICE FROM THE ADMINISTRATION OR ORAL OR WRITTEN NOTICE
33 FROM A MEMBER THAT A CLAIM FOR COVERED SERVICES MAY BE IN VIOLATION OF THIS
34 SECTION, THE PROVIDER THAT HAS A CONTRACT WITH A CONTRACTOR OR NONCONTRACTING
35 PROVIDER SHALL INVESTIGATE THE INQUIRY AND VERIFY WHETHER THE PERSON WAS
36 ELIGIBLE FOR SERVICES AT THE TIME THAT COVERED SERVICES WERE PROVIDED. IF
37 THE CLAIM WAS PAID OR SHOULD HAVE BEEN PAID BY THE SYSTEM, THE PROVIDER THAT
38 HAS A CONTRACT WITH A CONTRACTOR OR NONCONTRACTING PROVIDER SHALL NOT
39 CONTINUE BILLING THE MEMBER.

40 2. IF THE CLAIM WAS PAID OR SHOULD HAVE BEEN PAID BY THE SYSTEM AND
41 THE DISPUTED CLAIM HAS BEEN REFERRED FOR COLLECTION TO A COLLECTION AGENCY OR
42 REFERRED TO A CREDIT REPORTING BUREAU, THE PROVIDER THAT HAS A CONTRACT WITH
43 A CONTRACTOR OR NONCONTRACTING PROVIDER SHALL:

44 (a) NOTIFY THE COLLECTION AGENCY AND REQUEST THAT ALL ATTEMPTS TO
45 COLLECT THIS SPECIFIC CHARGE BE TERMINATED IMMEDIATELY.

1 (b) ADVISE ALL CREDIT REPORTING BUREAUS THAT THE REPORTED DELINQUENCY
2 WAS IN ERROR AND REQUEST THAT THE AFFECTED CREDIT REPORT BE CORRECTED TO
3 REMOVE ANY NOTATION ABOUT THIS SPECIFIC DELINQUENCY.

4 (c) NOTIFY THE ADMINISTRATION AND THE MEMBER THAT THE REQUEST FOR
5 PAYMENT WAS IN ERROR AND THAT THE COLLECTION AGENCY AND CREDIT REPORTING
6 BUREAUS HAVE BEEN NOTIFIED.

7 3. IF THE ADMINISTRATION DETERMINES THAT A PROVIDER THAT HAS A
8 CONTRACT WITH A CONTRACTOR OR NONCONTRACTING PROVIDER HAS BILLED A MEMBER FOR
9 CHARGES THAT WERE PAID OR SHOULD HAVE BEEN PAID BY THE ADMINISTRATION, THE
10 ADMINISTRATION SHALL SEND WRITTEN NOTIFICATION BY CERTIFIED MAIL OR OTHER
11 SERVICE WITH PROOF OF DELIVERY TO THE PROVIDER THAT HAS A CONTRACT WITH A
12 CONTRACTOR OR NONCONTRACTING PROVIDER STATING THAT THIS BILLING IS IN
13 VIOLATION OF FEDERAL AND STATE LAW. IF, TWENTY-ONE DAYS OR MORE AFTER
14 RECEIVING THE NOTIFICATION, A PROVIDER THAT HAS A CONTRACT WITH A CONTRACTOR
15 OR NONCONTRACTING PROVIDER KNOWINGLY CONTINUES BILLING A MEMBER FOR CHARGES
16 THAT WERE PAID OR SHOULD HAVE BEEN PAID BY THE SYSTEM, THE ADMINISTRATION MAY
17 ASSESS A CIVIL PENALTY IN AN AMOUNT EQUAL TO THREE TIMES THE AMOUNT OF THE
18 BILLING AND REDUCE PAYMENT TO THE PROVIDER THAT HAS A CONTRACT WITH A
19 CONTRACTOR OR NONCONTRACTING PROVIDER ACCORDINGLY. RECEIPT OF DELIVERY
20 SIGNED BY THE ADDRESSEE OR THE ADDRESSEE'S EMPLOYEE IS PRIMA FACIE EVIDENCE
21 OF KNOWLEDGE. CIVIL PENALTIES COLLECTED PURSUANT TO THIS SUBSECTION SHALL BE
22 DEPOSITED IN THE STATE GENERAL FUND. SECTION 36-2918, SUBSECTIONS C, D AND
23 F, RELATING TO THE IMPOSITION, COLLECTION AND ENFORCEMENT OF CIVIL PENALTIES
24 APPLIES TO CIVIL PENALTIES IMPOSED PURSUANT TO THIS PARAGRAPH.

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

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

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

36 P. Notwithstanding any law to the contrary, on federal approval the
37 administration may make disproportionate share payments to private hospitals,
38 county operated hospitals, including hospitals owned or leased by a special
39 health care district, and state operated institutions for mental disease
40 beginning October 1, 1991 in accordance with federal law and subject to
41 legislative appropriation. If at any time the administration receives
42 written notification from federal authorities of any change or difference in
43 the actual or estimated amount of federal funds available for
44 disproportionate share payments from the amount reflected in the legislative
45 appropriation for such purposes, the administration shall provide written

1 notification of such change or difference to the president and the minority
2 leader of the senate, the speaker and the minority leader of the house of
3 representatives, the director of the joint legislative budget committee, the
4 legislative committee of reference and any hospital trade association within
5 this state, within three working days not including weekends after receipt of
6 the notice of the change or difference. In calculating disproportionate
7 share payments as prescribed in this section, the administration may use
8 either a methodology based on claims and encounter data that is submitted to
9 the administration from contractors or a methodology based on data that is
10 reported to the administration by private hospitals and state operated
11 institutions for mental disease. The selected methodology applies to all
12 private hospitals and state operated institutions for mental disease
13 qualifying for disproportionate share payments.

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

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

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

24 Sec. 2. Section 36-2932, Arizona Revised Statutes, is amended to read:

25 36-2932. Arizona long-term care system; powers and duties of
26 the director; expenditure limitation

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

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

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

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

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

44 4. Providing technical assistance to the program contractors.

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

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

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

8 8. Establishing an enrollment system.

9 9. Establishing a member case management tracking system.

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

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

14 12. Establishing standards for the coordination of services.

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

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

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

26 16. Establishing requirements and guidelines for the review of trusts
27 for the purposes of establishing eligibility for the system pursuant to
28 section 36-2934.01 and ~~post-eligibility~~ POSTELIGIBILTY treatment of income
29 pursuant to subsection L of this section.

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

35 18. ASSESSING CIVIL PENALTIES FOR IMPROPER BILLING AS PRESCRIBED IN
36 SECTION 36-2903.01, SUBSECTION L.

37 C. For nursing care institutions and hospices that provide services
38 pursuant to this article, the director shall periodically as deemed necessary
39 and as required by federal law contract for a financial audit of the
40 institutions and hospices that is certified by a certified public accountant
41 in accordance with generally accepted auditing standards or conduct or
42 contract for a financial audit or review of the institutions and hospices.
43 The director shall notify the nursing care institution and hospice at least
44 sixty days before beginning a periodic audit. The administration shall
45 reimburse a nursing care institution or hospice for any additional expenses

1 incurred for professional accounting services obtained in response to a
2 specific request by the administration. On request, the director of the
3 administration shall provide a copy of an audit performed pursuant to this
4 subsection to the director of the department of health services or that
5 person's designee.

6 D. Notwithstanding any other provision of this article, the
7 administration may contract by an intergovernmental agreement with an Indian
8 tribe, a tribal council or a tribal organization for the provision of
9 long-term care services pursuant to section 36-2939, subsection A, paragraphs
10 1, 2, 3 and 4 and the home and community based services pursuant to section
11 36-2939, subsection B, paragraph 2 and subsection C, subject to the
12 restrictions in section 36-2939, subsections D and E for eligible members.

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

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

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

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

34 I. The director shall:

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

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

42 3. Not less than thirty days before the administration implements a
43 policy or a change to an existing policy relating to reimbursement, provide
44 notice to interested parties. Parties interested in receiving notification

1 of policy changes shall submit a written request for notification to the
2 administration.

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

8 K. The director shall adopt rules which establish requirements of
9 state residency and qualified alien status as prescribed in section
10 36-2903.03. The administration shall enforce these requirements as part of
11 the eligibility determination process. The rules shall also provide for the
12 determination of the applicant's county of residence for the purpose of
13 assignment of the appropriate program contractor.

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

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

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

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

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

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

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

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

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

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

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

16 R. The total amount of state monies that may be spent in any fiscal
17 year by the administration for long-term care shall not exceed the amount
18 appropriated or authorized by section 35-173 for that purpose. This article
19 shall not be construed to impose a duty on an officer, agent or employee of
20 this state to discharge a responsibility or to create any right in a person
21 or group if the discharge or right would require an expenditure of state
22 monies in excess of the expenditure authorized by legislative appropriation
23 for that specific purpose.

24 Sec. 3. Section 36-2986, Arizona Revised Statutes, is amended to read:
25 36-2986. Administration; powers and duties of director

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

29 1. Contract administration and oversight of contractors.

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

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

37 4. Development and management of a contractor payment system.

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

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

42 7. Development of an outreach program. The administration shall
43 coordinate with public and private entities to provide outreach services for
44 children under this article. Priority shall be given to those families who
45 are moving off welfare. Outreach activities shall include strategies to

1 inform communities, including tribal communities, about the program, ensure a
2 wide distribution of applications and provide training for other entities to
3 assist with the application process.

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

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

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

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

29 12. ~~Require~~ REQUIRING contractors to submit encounter data in a form
30 specified by the director.

31 13. ASSESSING CIVIL PENALTIES FOR IMPROPER BILLING AS PRESCRIBED IN
32 SECTION 36-2903.01, SUBSECTION L.

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

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

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

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

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

16 G. To the extent that services are furnished pursuant to this article
17 a contractor is not subject to ~~the provisions of~~ title 20 unless the
18 contractor is a qualifying plan and has elected to provide services pursuant
19 to this article.

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

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

1 contractor and pending an administrative hearing, which it shall promptly
2 institute.

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

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

9 L. The director shall:

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

15 2. By rule, establish a grievance and appeal procedure that conforms
16 with the process and the time frames specified in article 1 of this
17 chapter. If the program is suspended or terminated pursuant to section
18 36-2985, an applicant or member is not entitled to contest the denial,
19 suspension or termination of eligibility for the program.

20 3. Apply for and accept federal monies available under title XXI of
21 the social security act. Available state monies appropriated to the
22 administration for the operation of the program shall be used as matching
23 monies to secure federal monies pursuant to this subsection.

24 M. The administration is entitled to all rights provided to the
25 administration for liens and release of claims as specified in sections
26 36-2915 and 36-2916 and shall coordinate benefits pursuant to section
27 36-2903, subsection F and be a payor of last resort for persons who are
28 eligible pursuant to this article.

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

APPROVED BY THE GOVERNOR APRIL 18, 2005.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 18, 2005.

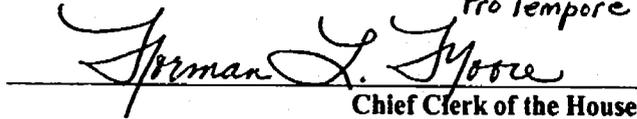
Passed the House April 12, 20 05

by the following vote: 45 Ayes,

14 Nays, 1 Not Voting



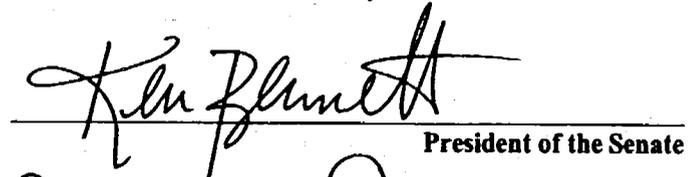
Speaker of the House
Pro Tempore


Chief Clerk of the House

Passed the Senate March 7, 20 05

by the following vote: 29 Ayes,

0 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

13th day of April, 20 05

at 12:44 o'clock P M.


Secretary of the Governor

Approved this 18 day of

April, 20 05

at 1:00 o'clock 7 M.


Governor of Arizona

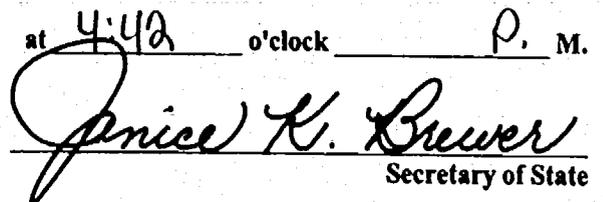
S.B. 1249

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this 18 day of April, 20 05

at 4:42 o'clock P M.


Secretary of State