Senate Engrossed House Bill

FILED

JANICE K. BREWER
SECRETARY OF STATE

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CHAPTER 158

HOUSE BILL 2208

AN ACT

AMENDING SECTION 36-2903.01. ARIZONA REVISED STATUTES; RELATING TO GRADUATE MEDICAL EDUCATION.

(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; report

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

B. The director shall:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) An admission face sheet.

(b) An itemized statement.

(c) An admission history and physical.

(d) A discharge summary or an interim summary if the claim is split.

(e) An emergency record, if admission was through the emergency room.

(f) Operative reports, if applicable.

(g) A labor and delivery room report, if applicable.

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

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

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

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
35 January 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. For graduate medical education programs:
40 (a) Beginning September 30, 1997, the administration shall establish a
41 separate graduate medical education program to reimburse hospitals that had
42 graduate medical education programs that were approved by the administration
43 as of October 1, 1999. The administration shall separately account for
44 monies for the graduate medical education program based on the total
45 reimbursement for graduate medical education reimbursed to hospitals by the

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

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

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

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

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

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

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

residency position was established. These programs must be approved by the administration.

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

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

(f) Beginning July 1, 2007, local, county and tribal governments may provide monies in addition to any state general fund monies appropriated for graduate medical education in order to qualify for additional matching federal monies for programs or positions in a specific locality ~~or at a specific institution~~ AND COSTS INCURRED PURSUANT TO A SPECIFIC CONTRACT BETWEEN THE ADMINISTRATION AND PROVIDERS OR OTHER ENTITIES TO PROVIDE GRADUATE MEDICAL EDUCATION SERVICES AS AN ADMINISTRATIVE ACTIVITY. These programs, ~~and~~ positions AND ADMINISTRATIVE GRADUATE MEDICAL EDUCATION SERVICES must be approved by the administration AND THE CENTERS FOR MEDICARE AND MEDICAID SERVICES. The administration shall report to the president of the senate, the speaker of the house of representatives and the director of the joint legislative budget committee on or before July 1 of each year on the amount of money contributed and number of residency positions funded by local, county and tribal governments, including the amount of federal matching monies used.

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

(h) For the purposes of this paragraph, "graduate medical education program" means a program, including an approved fellowship, that prepares a physician for the independent practice of medicine by providing didactic and clinical education in a medical discipline to a medical student who has completed a recognized undergraduate medical education program.

10. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the payment of claims with extraordinary operating costs per day. For tiered per diem rates effective beginning on October 1, 1999, outlier cost thresholds are frozen at the levels in effect on January 1, 1999 and adjusted annually by the administration by the global insight hospital market basket index for prospective payment system hospitals. Beginning with dates of service on or after October 1, 2007, the administration shall phase in the use of the most

recent statewide urban and statewide rural average medicare cost-to-charge ratios or centers for medicare and medicaid services approved cost-to-charge ratios to qualify and pay extraordinary operating costs. Cost-to-charge ratios shall be updated annually. Routine maternity charges are not eligible for outlier reimbursement. The administration shall complete full implementation of the phase-in on or before October 1, 2009.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPROVED BY THE GOVERNOR MAY 6, 2008.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 6, 2008.