

State of Arizona
Senate
Fiftieth Legislature
First Regular Session
2011

SENATE BILL 1619

AN ACT

AMENDING TITLE 36, CHAPTER 2, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-260; AMENDING SECTIONS 36-261, 36-262, 36-263 AND 36-264, ARIZONA REVISED STATUTES; REPEALING SECTION 36-265, ARIZONA REVISED STATUTES; AMENDING SECTIONS 36-341, 36-797.43, 36-797.44, 36-2903.01, 36-2906 AND 36-2907, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-2930; AMENDING SECTIONS 36-2988, 38-654 AND 43-1088, ARIZONA REVISED STATUTES; AMENDING LAWS 2010, CHAPTER 232, SECTION 13; MAKING APPROPRIATIONS AND TRANSFERS; RELATING TO HEALTH BUDGET RECONCILIATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Title 36, chapter 2, article 3, Arizona Revised Statutes,
3 is amended by adding section 36-260, to read:

4 36-260. Definitions

5 IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

6 1. "ADMINISTRATION" MEANS THE ARIZONA HEALTH CARE COST CONTAINMENT
7 SYSTEM ADMINISTRATION.

8 2. "CHRONICALLY ILL OR PHYSICALLY DISABLED CHILDREN" MEANS CHILDREN
9 WHO ARE UNDER TWENTY-ONE YEARS OF AGE AND WHOSE PRIMARY DIAGNOSIS IS A SEVERE
10 PHYSICAL CONDITION THAT MAY REQUIRE ONGOING, MEDICAL OR SURGICAL
11 INTERVENTION.

12 3. "DIRECTOR" MEANS THE DIRECTOR OF THE ARIZONA HEALTH CARE COST
13 CONTAINMENT SYSTEM ADMINISTRATION.

14 Sec. 2. Section 36-261, Arizona Revised Statutes, is amended to read:

15 36-261. Powers and duties; expenditure limitation

16 A. The ~~department of health services~~ ARIZONA HEALTH CARE COST
17 CONTAINMENT SYSTEM ADMINISTRATION shall:

18 1. Employ a full-time or part-time medical director and a full-time or
19 part-time administrator for children's rehabilitative services who shall have
20 such titles and duties as shall be fixed by the director. Compensation of
21 the medical director and the administrator shall be as determined pursuant to
22 section 38-611.

23 2. Supervise, control and establish policies for children's
24 rehabilitative services.

25 3. Adopt all rules and policies for the operation of a children's
26 rehabilitative services program.

27 4. Employ ~~such~~ NECESSARY medical and other staff ~~as may be needed~~,
28 including resident physicians, whose compensation shall be as determined
29 pursuant to section 38-611.

30 5. Establish and administer a program of service for children who are
31 ~~crippled~~ CHRONICALLY ILL OR PHYSICALLY DISABLED or who are suffering from
32 conditions ~~which~~ THAT lead to ~~crippling~~ A CHRONIC ILLNESS OR PHYSICAL
33 DISABILITIES. The program shall provide for:

34 (a) Development, extension and improvement of services for locating
35 ~~such~~ THESE children.

36 (b) Furnishing of medical, surgical, corrective and other services and
37 care.

38 (c) Furnishing of facilities for diagnosis, hospitalization and
39 aftercare.

40 (d) Supervision of the administration of services in the program ~~which~~
41 THAT are not administered directly by the ~~department~~ ADMINISTRATION.

42 (e) The extension and improvement of any services included in the
43 program of services for chronically ill or physically disabled children as
44 required by this section.

1 (f) Cooperation with medical, health, nursing and welfare groups and
2 organizations and with any agency of the state charged with administration of
3 laws providing for vocational rehabilitation of physically ~~handicapped~~
4 **DISABLED** children.

5 (g) Cooperation with the federal government through its appropriate
6 agency or instrumentality in developing, extending and improving services for
7 chronically ill or physically disabled children.

8 (h) Receipt and expenditure of funds made available to the ~~department~~
9 **ADMINISTRATION** for services to chronically ill or physically disabled
10 children by the federal government, ~~the~~ **THIS** state or its political
11 subdivisions or from other sources excluding monies received from parents or
12 guardians for the care of children.

13 (i) Carrying on research and compiling statistics.

14 (j) Making necessary expenditures in connection with the duties
15 provided in this section.

16 (k) Establishing and maintaining safeguards relating to the
17 confidential aspect of medical records.

18 (l) Acceptance and use of federal funds for children's rehabilitative
19 services at the discretion of the ~~department~~ **ADMINISTRATION** and subject to
20 any limitations imposed by the annual state appropriation bill.

21 (m) Such other duties ~~and responsibilities~~ found necessary for the
22 effective operation of a program for chronically ill or physically disabled
23 children.

24 6. Establish a statewide computerized information and referral service
25 for chronically ill or physically disabled children to link those children
26 and their families with local service providers.

27 7. Deposit in the state general fund all monies received from parents
28 or guardians for the care of children.

29 8. Deposit in the state general fund all monies received from adults,
30 other responsible persons, agencies or third party payors for care provided
31 pursuant to section 36-797.44.

32 B. In order to carry out the provisions of subsection A of this
33 section, the director may operate outpatient treatment facilities for
34 chronically ill or physically disabled children and shall contract on the
35 basis of competitive sealed bids for the care and treatment of chronically
36 ill or physically disabled children ~~in accordance with~~ **PURSUANT TO** subsection
37 C of this section.

38 C. The director shall prepare and issue a public request for proposal
39 including a proposed contract format, at least once every four years, to
40 contract for the care and treatment of chronically ill or physically disabled
41 children subject to the following authorizations and limitations:

42 1. The scope of the contracted services shall include inpatient
43 treatment services, physician services and other care and treatment services
44 and outpatient treatment services which shall not be mandated at a single
45 location.

1 2. Bids may be accepted from hospital and medical service
2 corporations, health care services organizations, hospitals, physicians and
3 any other qualified public or private persons.

4 3. A bidder's direct costs, as defined in the request for proposal,
5 shall be disclosed in and be the basis of the bid submitted. Direct costs
6 shall not include depreciable real or personal property with an original cost
7 of over one thousand dollars. For bid evaluation purposes only, the director
8 shall specify a uniform assumed collection rate applicable to all
9 bidders. If the director executes fee-for-services health care contracts,
10 the contracts shall provide the maximum payment to be made for specific
11 procedures and services.

12 4. The ~~department~~ ADMINISTRATION may award a contract at an amount
13 less than the amount bid, by use of any procedure authorized by the
14 procurement code.

15 5. If the director receives an insufficient number of bids for a
16 category of services or in a medical emergency, the director may contract
17 directly for ~~such~~ THESE services.

18 6. An invitation for bids, a request for proposals or ANY other
19 solicitation may be cancelled or any or all bids or proposals may be rejected
20 in whole or in part as may be specified in the solicitation if it is in the
21 best interests of this state. The reasons for the cancellation or rejection
22 shall be made part of the contract file. If the amount appropriated for
23 services provided pursuant to this section is insufficient to pay for the
24 scope of services as bid, the director may reduce the scope of services to
25 reflect the amount appropriated or may cancel any invitation for bids,
26 requests for proposals or other solicitation and contract directly for ~~such~~
27 THESE services. ~~Such~~ Reductions or suspensions ~~shall DO~~ not apply to the
28 continuity of care for persons already receiving ~~such~~ THE services. Any
29 decision to reduce services shall be made independently from any other
30 modification of services.

31 7. The provisions of title 41, chapter 23 shall apply to the
32 procurement process ~~set forth~~ PRESCRIBED in this section to the extent that
33 they are not inconsistent with the provisions of this section. The director
34 may vary the bid format and the terms of the request for proposal each bid
35 term.

36 D. In awarding contracts for inpatient and outpatient treatment
37 services under this section, the ~~department~~ ADMINISTRATION shall use the
38 following criteria in addition to other consistent criteria:

39 1. Cost to this state.

40 2. The treatment facility's demonstrated experience in and
41 qualifications for providing pediatric services.

42 E. If the provision of any services ~~under~~ PURSUANT TO this section
43 requires compliance with chapter 4, article 2 of this title, the contractor
44 shall comply ~~prior to~~ BEFORE commencement of services ~~under~~ PURSUANT TO this
45 section.

1 F. SUBJECT TO THE AVAILABILITY OF APPROPRIATIONS, the ~~department~~
2 ADMINISTRATION may, ~~subject to appropriation therefor,~~ provide or arrange for
3 the provision of health services and supervisory care for child patients of
4 other state agencies.

5 G. The ~~department may~~ ADMINISTRATION, through the children's
6 rehabilitative services division, MAY establish and administer a program for
7 children with sickle cell anemia, as provided for in section 36-797.43.

8 H. The ~~department may~~ ADMINISTRATION, through the children's
9 rehabilitative services division, MAY establish and administer a program for
10 adults with sickle cell anemia, as provided for in section 36-797.44.

11 I. The director may provide for the education of inpatients at any
12 facility ~~which~~ THAT contracts with the director to provide care and treatment
13 of chronically ill or physically disabled children. The director shall
14 include in ~~his~~ THE DIRECTOR'S annual proposed budget a request for sufficient
15 monies to finance the education of inpatients as authorized in this
16 subsection.

17 J. The total amount of state monies that may be spent in any fiscal
18 year by the ~~department of health services~~ ADMINISTRATION for children's
19 rehabilitative services shall not exceed the amount appropriated or
20 authorized by section 35-173 for that purpose. This section ~~shall~~ DOES
21 ~~be construed to~~ impose a duty on an officer, agent or employee of this state
22 to discharge a responsibility or to create any right in a person or group if
23 the discharge or right would require an expenditure of state monies in excess
24 of the expenditure authorized by legislative appropriation for that specific
25 purpose.

26 Sec. 3. Section 36-262, Arizona Revised Statutes, is amended to read:
27 ~~36-262.~~ Central statewide information and referral service for
28 chronically ill or physically disabled children

29 ~~A. For the purposes of this section, "chronically ill or physically~~
30 ~~disabled children" means children who are under twenty one years of age and~~
31 ~~whose primary diagnosis is a severe physical condition which may require~~
32 ~~ongoing, medical or surgical intervention.~~

33 ~~B.~~ A. The purposes of the information and referral service for
34 chronically ill or physically disabled children AS PRESCRIBED PURSUANT TO
35 THIS ARTICLE are to:

36 1. Establish a roster of agencies providing medical, educational,
37 financial, social and transportation services to chronically ill or
38 physically disabled children.

39 2. Develop or use an existing statewide, computerized information and
40 referral service that provides information on services for chronically ill or
41 physically disabled children.

42 ~~C.~~ B. ~~Nothing in~~ This section ~~shall~~ DOES NOT require any person or
43 public or private agency or other entity to participate in the information
44 and referral service.

1 this article so that any costs for services payable by the ~~department~~
2 ~~ADMINISTRATION~~ are costs avoided or recovered from any available provider of
3 first party health insurance medical benefits, subject to the specific scope
4 of benefits of the provider of first party medical insurance benefits. The
5 ~~department~~ ~~ADMINISTRATION~~ may require that health care service providers are
6 responsible for the coordination of benefits provided pursuant to this
7 article. The ~~department~~ ~~ADMINISTRATION~~ shall act as a payor of last resort
8 unless this is specifically prohibited by federal law.

9 B. The director ~~of the department of health services~~ shall require
10 each parent or legal guardian of a child receiving services ~~under~~ ~~PURSUANT TO~~
11 this article to assign to the ~~department~~ ~~ADMINISTRATION~~ rights that the
12 ~~individual~~ ~~PERSON~~ or ~~his~~ ~~THE PERSON'S~~ parents or guardian has to first party
13 health insurance medical benefits to which the ~~individual~~ ~~PERSON~~ is entitled
14 and ~~which~~ ~~THAT~~ relate to the specific services ~~which~~ ~~THAT~~ the person has
15 received or will receive pursuant to this program. This state has a right to
16 subrogation against a provider of first party health insurance medical
17 benefits to enforce the assignment of first party health insurance medical
18 benefits for services provided ~~under the provisions of~~ ~~PURSUANT TO~~ this
19 article.

20 C. The provisions of this section are controlling over the provisions
21 of a first party health insurance medical benefits policy issued after the
22 ~~effective date of this section~~ ~~SEPTEMBER 30, 1992~~. If the policy provisions
23 exclude or limit coverage on the basis of a child's eligibility for services
24 under this article, the ~~department~~ ~~ADMINISTRATION~~ shall monitor payments from
25 providers of first party health insurance medical benefits ~~which~~ ~~THAT~~ are
26 collected by providers of medical care.

27 D. ~~The provisions of~~ This section ~~shall apply~~ ~~APPLIES~~ to a health care
28 services organization subject to ~~the provisions of~~ title 20, chapter 4,
29 article 9 in which a child is enrolled and who is receiving services pursuant
30 to this article. If a ~~health care services organization's enrolled~~ child
31 ~~ENROLLED IN A HEALTH CARE SERVICES ORGANIZATION~~ requires services under this
32 article and if the benefits for the services are contractually available
33 through the health care services organization, the health care services
34 organization may require the enrolled child to receive the services through
35 the health care services organization's contracted provider network up to the
36 coverage limits set forth in the health care services organization's evidence
37 of coverage. If the health care services organization elects not to provide
38 the covered services either directly or through its contracted provider
39 network or is unable to provide the covered services directly or through its
40 contracted provider network and the services are covered benefits as set
41 forth in the health care services organization's evidence of coverage, then
42 the health care services organization shall reimburse the ~~department~~
43 ~~ADMINISTRATION~~ for the services provided through the ~~department~~
44 ~~ADMINISTRATION~~ for the enrolled child. The health care services organization
45 ~~shall~~ ~~IS~~ not ~~be~~ required to reimburse the ~~department~~ ~~ADMINISTRATION~~ for

1 services beyond the coverage limits set forth in the health care services
2 organization's evidence of coverage for the enrolled child. The amount of
3 reimbursement paid by a health care services organization to the ~~department~~
4 ~~ADMINISTRATION~~ shall not be greater than the level of compensation the health
5 care services organization pays to its contracted provider network. A health
6 care services organization may impose prior authorization, referral and other
7 utilization review requirements in providing or paying for services to an
8 enrolled child under this section.

9 E. For ~~THE~~ purposes of this section, "first party health insurance
10 medical benefits" ~~include~~ ~~INCLUDES~~ benefits payable from a hospital, medical,
11 dental and optometric service corporation subject to ~~the provisions of~~ title
12 20, chapter 4, article 3, a health care services organization subject to ~~the~~
13 ~~provisions of~~ title 20, chapter 4, article 9, an insurer providing disability
14 insurance subject to ~~the provisions of~~ title 20, chapter 6, article 4, an
15 insurer providing group disability insurance subject to ~~the provisions of~~
16 title 20, chapter 6, article 5, and any other available first party health
17 insurance medical benefits, but does not include monies available under a
18 social services block grant or an optional state supplemental payment program
19 if federal monies are available.

20 Sec. 6. Repeal

21 Section ~~36-265~~, Arizona Revised Statutes, is repealed.

22 Sec. 7. Section 36-341, Arizona Revised Statutes, is amended to read:

23 ~~36-341.~~ Fees received by state and local registrars

24 A. The ~~state registrar~~ ~~DIRECTOR~~ shall establish ~~by rule~~ the fees, ~~if~~
25 ~~any~~, to be charged for searches, copies of registered certificates, certified
26 copies of registered certificates, amending registered certificates and
27 correcting certificates that are processed by the department. ~~THE DIRECTOR~~
28 ~~MAY ESTABLISH A SURCHARGE TO BE ASSESSED ON ANY LOCAL REGISTRAR WHO OBTAINS~~
29 ~~ACCESS TO THE DEPARTMENT'S VITAL RECORDS AUTOMATION SYSTEM.~~ A local
30 registrar may establish the local registrar's own fees to be charged for
31 searches, copies of registered certificates, certified copies of registered
32 certificates, amending registered certificates and correcting certificates as
33 determined necessary by the local entity.

34 B. In addition to fees collected pursuant to subsection A of this
35 section, the state registrar shall assess an additional one dollar surcharge
36 on fees for all certified copies of registered birth certificates. The state
37 registrar shall deposit, pursuant to sections 35-146 and 35-147, all monies
38 received from the surcharge in the confidential intermediary and fiduciary
39 fund established by section 8-135.

40 C. The state registrar shall keep a true and accurate account of all
41 fees collected by the state registrar under this chapter and shall deposit,
42 pursuant to sections 35-146 and 35-147: ~~—~~

43 1. ~~EIGHTY-FIVE PER CENT OF THE FIRST FOUR MILLION DOLLARS COLLECTED~~
44 ~~EACH FISCAL YEAR IN THE VITAL RECORDS ELECTRONIC SYSTEMS FUND ESTABLISHED BY~~

1 SECTION 36-341.01 AND THE REMAINING FIFTEEN PER CENT OF THE FIRST FOUR
2 MILLION DOLLARS COLLECTED EACH FISCAL YEAR IN THE STATE GENERAL FUND.

3 2. Forty per cent of ~~these monies~~ THE AMOUNT COLLECTED IN EXCESS OF
4 FOUR MILLION DOLLARS EACH FISCAL YEAR in the vital records electronic systems
5 fund established by section 36-341.01 and the remaining sixty per cent in the
6 state general fund.

7 D. A local registrar shall keep a true and accurate account of all
8 fees collected by the local registrar under this chapter and shall deposit
9 them with the county treasurer to be credited to a special registration and
10 statistical revenue account of the health department fund.

11 E. In addition to fees collected pursuant to subsection A of this
12 section, the department shall assess an additional one dollar surcharge on
13 fees for all certified copies of registered death certificates. The
14 department shall deposit, pursuant to sections 35-146 and 35-147, monies
15 received from the surcharge in the child fatality review fund established by
16 section 36-3504.

17 F. The state and local registrars may exempt an agency as defined in
18 section 41-1001 from any fee required by this section, section 8-135 or
19 section 36-3504.

20 Sec. 8. Section 36-797.43, Arizona Revised Statutes, is amended to
21 read:

22 36-797.43. Care and treatment of children with sickle cell
23 anemia; reimbursement

24 A. The ~~department may~~ ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
25 ADMINISTRATION, through the children's rehabilitative services, MAY develop
26 and operate, either directly or by contracting with public or private
27 providers, programs for the diagnosis, care and treatment of children
28 suffering from sickle cell anemia.

29 B. The programs developed and operated pursuant to this section are
30 part of the children's rehabilitative services provided by the ~~department~~
31 ADMINISTRATION pursuant to section 36-261.

32 C. The parent or other responsible person, agency or third party payor
33 shall reimburse the ~~department~~ ADMINISTRATION for part or all of the costs of
34 services rendered to a child pursuant to this section according to a scale of
35 rates and charges established by the ~~department~~ ADMINISTRATION and based on
36 the cost of services provided and the ability of the parent or responsible
37 person to pay for ~~such~~ THESE services.

38 Sec. 9. Section 36-797.44, Arizona Revised Statutes, is amended to
39 read:

40 36-797.44. Care and treatment of adults with sickle cell
41 anemia; reimbursement

42 A. The ~~department may~~ ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM
43 ADMINISTRATION, through the children's rehabilitative services, MAY develop
44 and operate, either directly or by contracting with public or private

1 providers, programs for the diagnosis, care and treatment of adults suffering
2 from sickle cell anemia.

3 B. The adult or other responsible person, agency or third party payor
4 shall reimburse the ~~department~~ ADMINISTRATION for part or all of the costs of
5 services rendered to an adult pursuant to this section according to a scale
6 of rates and charges established by the ~~department~~ ADMINISTRATION and based
7 on the cost of services provided and the ability of the adult or other
8 responsible person to pay for ~~such~~ THESE services.

9 Sec. 10. Section 36-2903.01, Arizona Revised Statutes, is amended to
10 read:

11 36-2903.01. Additional powers and duties; report

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

18 B. The director shall:

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

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

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

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

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

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

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

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

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

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

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

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

42 5. Apply for and accept federal funds available under title XIX of the
43 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section
44 1396 (1980)) in support of the system. The application made by the director
45 pursuant to this paragraph shall be designed to qualify for federal funding

1 primarily on a prepaid capitated basis. Such funds may be used only for the
2 support of persons defined as eligible pursuant to title XIX of the social
3 security act or the approved section 1115 waiver.

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

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

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

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

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

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

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

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

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

43 4. Notwithstanding any other law, require persons eligible pursuant to
44 section 36-2901, paragraph 6, subdivision (a), section 36-2931 and section
45 36-2981, paragraph 6 to be financially responsible for any cost sharing

1 requirements established in a state plan or a section 1115 waiver and
2 approved by the centers for medicare and medicaid services. Cost sharing
3 requirements may include copayments, coinsurance, deductibles, enrollment
4 fees and monthly premiums for enrolled members, including households with
5 children enrolled in the Arizona long-term care system.

6 E. The director shall adopt rules that further specify the medical
7 care and hospital services that are covered by the system pursuant to section
8 36-2907.

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

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

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

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

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

26 (c) The schedule of rates and charges for a hospital that became
27 effective after May 31, 1984 but before July 2, 1984, limited to five per
28 cent over the hospital's previous rate schedule, and if the hospital's
29 previous rate schedule became effective on or after April 30, 1983 but before
30 October 1, 1983.

31 For the purposes of this paragraph, "constant" means equal to or lower than.

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

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

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

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

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

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

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

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

20 1. For inpatient hospital stays, the administration shall use a
21 prospective tiered per diem methodology, using hospital peer groups if
22 analysis shows that cost differences can be attributed to independently
23 definable features that hospitals within a peer group share. In peer
24 grouping the administration may consider such factors as length of stay
25 differences and labor market variations. If there are no cost differences,
26 the administration shall implement a stop loss-stop gain or similar
27 mechanism. Any stop loss-stop gain or similar mechanism shall ensure that
28 the tiered per diem rates assigned to a hospital do not represent less than
29 ninety per cent of its 1990 base year costs or more than one hundred ten per
30 cent of its 1990 base year costs, adjusted by an audit factor, during the
31 period of March 1, 1993 through September 30, 1994. The tiered per diem
32 rates set for hospitals shall represent no less than eighty-seven and
33 one-half per cent or more than one hundred twelve and one-half per cent of
34 its 1990 base year costs, adjusted by an audit factor, from October 1, 1994
35 through September 30, 1995 and no less than eighty-five per cent or more than
36 one hundred fifteen per cent of its 1990 base year costs, adjusted by an
37 audit factor, from October 1, 1995 through September 30, 1996. For the
38 periods after September 30, 1996 no stop loss-stop gain or similar mechanisms
39 shall be in effect. An adjustment in the stop loss-stop gain percentage may
40 be made to ensure that total payments do not increase as a result of this
41 provision. If peer groups are used the administration shall establish
42 initial peer group designations for each hospital before implementation of
43 the per diem system. The administration may also use a negotiated rate
44 methodology. The tiered per diem methodology may include separate
45 consideration for specialty hospitals that limit their provision of services

1 to specific patient populations, such as rehabilitative patients or children.
2 The initial per diem rates shall be based on hospital claims and encounter
3 data for dates of service November 1, 1990 through October 31, 1991 and
4 processed through May of 1992.

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

11 3. Through June 30, 2004, for outpatient hospital services, the
12 administration shall reimburse a hospital by applying a hospital specific
13 outpatient cost-to-charge ratio to the covered charges. Beginning on July 1,
14 2004 through June 30, 2005, the administration shall reimburse a hospital by
15 applying a hospital specific outpatient cost-to-charge ratio to covered
16 charges. If the hospital increases its charges for outpatient services filed
17 with the Arizona department of health services pursuant to chapter 4, article
18 3 of this title, by more than 4.7 per cent for dates of service effective on
19 or after July 1, 2004, the hospital specific cost-to-charge ratio will be
20 reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7
21 per cent, the effective date of the increased charges will be the effective
22 date of the adjusted Arizona health care cost containment system
23 cost-to-charge ratio. The administration shall develop the methodology for a
24 capped fee-for-service schedule and a statewide cost-to-charge ratio. Any
25 covered outpatient service not included in the capped fee-for-service
26 schedule shall be reimbursed by applying the statewide cost-to-charge ratio
27 that is based on the services not included in the capped fee-for-service
28 schedule. Beginning on July 1, 2005, the administration shall reimburse
29 clean claims with dates of service on or after July 1, 2005, based on the
30 capped fee-for-service schedule or the statewide cost-to-charge ratio
31 established pursuant to this paragraph. The administration may make
32 additional adjustments to the outpatient hospital rates established pursuant
33 to this section based on other factors, including the number of beds in the
34 hospital, specialty services available to patients and the geographic
35 location of the hospital.

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

- 40 (a) An admission face sheet.
- 41 (b) An itemized statement.
- 42 (c) An admission history and physical.
- 43 (d) A discharge summary or an interim summary if the claim is split.
- 44 (e) An emergency record, if admission was through the emergency room.
- 45 (f) Operative reports, if applicable.

1 (g) A labor and delivery room report, if applicable.
2 Payment received by a hospital from the administration pursuant to this
3 subsection or from a contractor either by contract or pursuant to section
4 36-2904, subsection I is considered payment by the administration or the
5 contractor of the administration's or contractor's liability for the hospital
6 bill. A hospital may collect any unpaid portion of its bill from other third
7 party payors or in situations covered by title 33, chapter 7, article 3.

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

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

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

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

22 6. In developing the reimbursement methodology, if a review of the
23 reports filed by a hospital pursuant to section 36-125.04 indicates that
24 further investigation is considered necessary to verify the accuracy of the
25 information in the reports, the administration may examine the hospital's
26 records and accounts related to the reporting requirements of section
27 36-125.04. The administration shall bear the cost incurred in connection
28 with this examination unless the administration finds that the records
29 examined are significantly deficient or incorrect, in which case the
30 administration may charge the cost of the investigation to the hospital
31 examined.

32 7. Except for privileged medical information, the administration shall
33 make available for public inspection the cost and charge data and the
34 calculations used by the administration to determine payments under the
35 tiered per diem system, provided that individual hospitals are not identified
36 by name. The administration shall make the data and calculations available
37 for public inspection during regular business hours and shall provide copies
38 of the data and calculations to individuals requesting such copies within
39 thirty days of receipt of a written request. The administration may charge a
40 reasonable fee for the provision of the data or information.

41 8. The prospective tiered per diem payment methodology for inpatient
42 hospital services shall include a mechanism for the prospective payment of
43 inpatient hospital capital related costs. The capital payment shall include
44 hospital specific and statewide average amounts. For tiered per diem rates
45 beginning on October 1, 1999, the capital related cost component is frozen at

1 the blended rate of forty per cent of the hospital specific capital cost and
2 sixty per cent of the statewide average capital cost in effect as of
3 January 1, 1999 and as further adjusted by the calculation of tier rates for
4 maternity and nursery as prescribed by law. The administration shall adjust
5 the capital related cost component by the data resources incorporated market
6 basket index for prospective payment system hospitals.

7 9. For graduate medical education programs:

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

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

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

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

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

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

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

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

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

28 (f) Local, county and tribal governments and any university under the
29 jurisdiction of the Arizona board of regents may provide monies in addition
30 to any state general fund monies appropriated for graduate medical education
31 in order to qualify for additional matching federal monies for providers,
32 programs or positions in a specific locality and costs incurred pursuant to a
33 specific contract between the administration and providers or other entities
34 to provide graduate medical education services as an administrative
35 activity. Payments by the administration pursuant to this subdivision may be
36 limited to those providers designated by the funding entity and may be based
37 on any methodology deemed appropriate by the administration, including
38 replacing any payments that might otherwise have been paid pursuant to
39 subdivision (a), (b) or (c) of this paragraph had sufficient state general
40 fund monies or other monies been appropriated to fully fund those payments.
41 These programs, positions, payment methodologies and administrative graduate
42 medical education services must be approved by the administration and the
43 centers for medicare and medicaid services. The administration shall report
44 to the president of the senate, the speaker of the house of representatives
45 and the director of the joint legislative budget committee on or before July

1 1 of each year on the amount of money contributed and number of residency
2 positions funded by local, county and tribal governments, including the
3 amount of federal matching monies used.

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

8 10. The prospective tiered per diem payment methodology for inpatient
9 hospital services shall include a mechanism for the payment of claims with
10 extraordinary operating costs per day. For tiered per diem rates effective
11 beginning on October 1, 1999, outlier cost thresholds are frozen at the
12 levels in effect on January 1, 1999 and adjusted annually by the
13 administration by the global insight hospital market basket index for
14 prospective payment system hospitals. Beginning with dates of service on or
15 after October 1, 2007, the administration shall phase in the use of the most
16 recent statewide urban and statewide rural average medicare cost-to-charge
17 ratios or centers for medicare and medicaid services approved cost-to-charge
18 ratios to qualify and pay extraordinary operating costs. Cost-to-charge
19 ratios shall be updated annually. Routine maternity charges are not eligible
20 for outlier reimbursement. The administration shall complete full
21 implementation of the phase-in on or before October 1, 2009. FOR DATES OF
22 SERVICE ON AND AFTER OCTOBER 1, 2011 AND FOR EACH SUBSEQUENT CONTRACT YEAR,
23 THE ADMINISTRATION SHALL USE NINETY-FIVE PER CENT OF THE STATEWIDE URBAN AND
24 STATEWIDE RURAL AVERAGE MEDICARE COST-TO-CHARGE RATIOS IN EFFECT ON THE
25 PRECEDING JULY 1 OR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES APPROVED
26 COST-TO-CHARGE RATIOS TO QUALIFY AND PAY EXTRAORDINARY OPERATING COSTS.

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

30 12. FOR INPATIENT HOSPITAL SERVICES RENDERED ON OR AFTER OCTOBER 1,
31 2011, THE PROSPECTIVE TIERED PER DIEM PAYMENT RATES ARE PERMANENTLY RESET TO
32 THE AMOUNTS PAYABLE FOR THOSE SERVICES AS OF SEPTEMBER 30, 2011 PURSUANT TO
33 THIS SUBSECTION.

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

41 J. The administration may make direct payments to hospitals for
42 hospitalization and medical care provided to a member in accordance with this
43 article and rules. The director may adopt rules to establish the procedures
44 by which the administration shall pay hospitals pursuant to this subsection
45 if a contractor fails to make timely payment to a hospital. Such payment

1 shall be at a level determined pursuant to section 36-2904, subsection H
2 or I. The director may withhold payment due to a contractor in the amount of
3 any payment made directly to a hospital by the administration on behalf of a
4 contractor pursuant to this subsection.

5 K. The director shall establish a special unit within the
6 administration for the purpose of monitoring the third party payment
7 collections required by contractors and noncontracting providers pursuant to
8 section 36-2903, subsection B, paragraph 10 and subsection F and section
9 36-2915, subsection E. The director shall determine by rule:

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

12 2. The percentage of third party payments that is collected by a
13 contractor or noncontracting provider and that the contractor or
14 noncontracting provider may keep and the percentage of such payments that the
15 contractor or noncontracting provider may be required to pay to the
16 administration. Contractors and noncontracting providers must pay to the
17 administration one hundred per cent of all third party payments that are
18 collected and that duplicate administration fee-for-service payments. A
19 contractor that contracts with the administration pursuant to section
20 36-2904, subsection A may be entitled to retain a percentage of third party
21 payments if the payments collected and retained by a contractor are reflected
22 in reduced capitation rates. A contractor may be required to pay the
23 administration a percentage of third party payments that are collected by a
24 contractor and that are not reflected in reduced capitation rates.

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

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

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

42 (a) Notify the collection agency and request that all attempts to
43 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 apply 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 other law, 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. For the purposes of this
14 subsection, "disproportionate share payment" means a payment to a hospital
15 that serves a disproportionate share of low-income patients as described by
16 42 United States Code section 1396r-4.

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

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

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

27 T. IN ADDITION TO ANY REQUIREMENTS ADOPTED PURSUANT TO SUBSECTION D,
28 PARAGRAPH 4 OF THIS SECTION, NOTWITHSTANDING ANY OTHER LAW, BEGINNING JULY 1,
29 2011, MEMBERS ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 6, SUBDIVISION
30 (a), SECTION 36-2931 AND SECTION 36-2981, PARAGRAPH 6 SHALL PAY THE
31 FOLLOWING:

- 32 1. A MONTHLY PREMIUM OF FIFTEEN DOLLARS, EXCEPT THAT THE TOTAL MONTHLY
33 PREMIUM FOR AN ENTIRE HOUSEHOLD SHALL NOT EXCEED SIXTY DOLLARS.
- 34 2. A COPAYMENT OF FIVE DOLLARS FOR EACH PHYSICIAN OFFICE VISIT.
- 35 3. A COPAYMENT OF TEN DOLLARS FOR EACH URGENT CARE VISIT.
- 36 4. A COPAYMENT OF THIRTY DOLLARS FOR EACH EMERGENCY DEPARTMENT VISIT.

37 Sec. 11. Section 36-2906, Arizona Revised Statutes, is amended to
38 read:

39 36-2906. Qualified plan health services contracts; proposals;
40 administration

- 41 A. The administration shall:
 - 42 1. Supervise the administrator.
 - 43 2. Review the proposals.
 - 44 3. Award contracts.

1 B. The director shall prepare and issue a request for proposal,
2 including a proposed contract format, in each of the counties of this state,
3 at least once every five years, to qualified group disability insurers,
4 hospital and medical service corporations, health care services organizations
5 and any other qualified public or private persons, including county-owned and
6 operated health care facilities. The contracts shall specify the
7 administrative requirements, the delivery of medically necessary services and
8 the subcontracting requirements.

9 C. The director shall adopt rules regarding the request for proposal
10 process that provide:

11 1. For definition of proposals in the following categories subject to
12 the following conditions:

13 (a) Inpatient hospital services.

14 (b) Outpatient services, including emergency dental care, and early
15 and periodic health screening and diagnostic services for children.

16 (c) Pharmacy services.

17 (d) Laboratory, x-ray and related diagnostic medical services and
18 appliances.

19 2. Allowance for the adjustment of such categories by expansion,
20 deletion, segregation or combination in order to secure the most financially
21 advantageous proposals for the system.

22 3. An allowance for limitations on the number of high risk persons
23 that must be included in any proposal.

24 4. For analysis of the proposals for each geographic service area as
25 defined by the director to ensure the provision of health and medical
26 services that are required to be provided throughout the geographic service
27 area pursuant to section 36-2907.

28 5. For the submittal of proposals by a group disability insurer,
29 hospital and medical service corporation, health care services organization
30 or any other qualified public or private person intending to submit a
31 proposal pursuant to this section. Each qualified proposal shall be entered
32 with separate categories for the distinct groups of persons to be covered by
33 the proposed contracts, as set forth in the request for proposal.

34 6. For the procurement of reinsurance for expenses incurred by any
35 contractor or member or the system in providing services in excess of amounts
36 specified by the director in any contract year. The director shall adopt
37 rules to provide that the administrator may specify guidelines on a case by
38 case basis for the types of care and services that may be provided to a
39 person whose care is covered by reinsurance. The rules shall provide that if
40 a contractor does not follow specified guidelines for care or services and if
41 the care or services could be provided pursuant to the guidelines at a lower
42 cost the contractor is entitled to reimbursement as if the care or services
43 specified in the guidelines had been provided.

1 7. For the awarding of contracts to contractors with qualified
2 proposals determined to be the most advantageous to the state for each of the
3 counties in this state. A contract may be awarded that provides services
4 only to persons defined as eligible pursuant to section 36-2901, paragraph 6,
5 subdivision (b), (c), (d) or (e). The director may provide by rule a second
6 round competitive proposal procedure for the director to request voluntary
7 price reduction of proposals from only those that have been tentatively
8 selected for award, before the final award or rejection of proposals.

9 8. For the requirement that any proposal in a geographic service area
10 provide for the full range of system covered services.

11 9. For the option of the administration to waive the requirement in
12 any request for proposal or in any contract awarded pursuant to a request for
13 proposal for a subcontract with a hospital for good cause in a county or area
14 including but not limited to situations when such hospital is the only
15 hospital in the health service area. In any situation where the subcontract
16 requirement is waived, no hospital may refuse to treat members of the system
17 admitted by primary care physicians or primary care practitioners with
18 hospital privileges in that hospital. In the absence of a subcontract, the
19 reimbursement level shall be at the levels specified in section 36-2904,
20 subsection H or I.

21 D. Reinsurance may be obtained against expenses in excess of a
22 specified amount on behalf of any individual for system covered emergency or
23 inpatient services either through the purchase of a reinsurance policy or
24 through a system self-insurance program as determined by the director.
25 Reinsurance ~~may~~, subject to the approval of the director, **MAY** be obtained
26 against expenses in excess of a specified amount on behalf of any individual
27 for outpatient services either through the purchase of a reinsurance policy
28 or through a system self-insurance program as determined by the director.

29 E. Notwithstanding the other provisions of this section, the ~~system~~
30 **ADMINISTRATION** may procure, provide or coordinate system covered services by
31 interagency agreement with authorized agencies of this state or with a
32 federal agency for distinct groups of eligible persons, including persons
33 eligible for children's rehabilitative services ~~through the department of~~
34 ~~health services~~ and persons eligible for comprehensive medical and dental
35 program services through the department **OF ECONOMIC SECURITY**.

36 F. Contracts shall be awarded as otherwise provided by law, except
37 that in no event may a contract be awarded to any respondent that will cause
38 the system to lose any federal monies to which it is otherwise entitled.

39 G. After contracts are awarded pursuant to this section, the director
40 may negotiate with any successful proposal respondent for the expansion or
41 contraction of services or service areas if there are unnecessary gaps or
42 duplications in services or service areas.

1 Sec. 12. Section 36-2907, Arizona Revised Statutes, is amended to
2 read:

3 36-2907. Covered health and medical services; modifications;
4 related delivery of service requirements; definition

5 A. Subject to the limitations and exclusions specified in this
6 section, contractors shall provide the following medically necessary health
7 and medical services:

8 1. Inpatient hospital services that are ordinarily furnished by a
9 hospital for the care and treatment of inpatients and that are provided under
10 the direction of a physician or a primary care practitioner. For the
11 purposes of this section, inpatient hospital services exclude services in an
12 institution for tuberculosis or mental diseases unless authorized under an
13 approved section 1115 waiver.

14 2. Outpatient health services that are ordinarily provided in
15 hospitals, clinics, offices and other health care facilities by licensed
16 health care providers. Outpatient health services include services provided
17 by or under the direction of a physician or a primary care practitioner.

18 3. Other laboratory and x-ray services ordered by a physician or a
19 primary care practitioner.

20 4. Medications that are ordered on prescription by a physician or a
21 dentist licensed pursuant to title 32, chapter 11. ~~Beginning January 1,~~
22 ~~2006,~~ Persons who are dually eligible for title XVIII and title XIX services
23 must obtain available medications through a medicare licensed or certified
24 medicare advantage prescription drug plan, a medicare prescription drug plan
25 or any other entity authorized by medicare to provide a medicare part D
26 prescription drug benefit.

27 5. Medical supplies, durable medical equipment and prosthetic devices
28 ordered by a physician or a primary care practitioner. Suppliers of durable
29 medical equipment shall provide the administration with complete information
30 about the identity of each person who has an ownership or controlling
31 interest in their business and shall comply with federal bonding requirements
32 in a manner prescribed by the administration.

33 6. For persons who are at least twenty-one years of age, treatment of
34 medical conditions of the eye, excluding eye examinations for prescriptive
35 lenses and the provision of prescriptive lenses.

36 7. Early and periodic health screening and diagnostic services as
37 required by section 1905(r) of title XIX of the social security act for
38 members who are under twenty-one years of age.

39 8. Family planning services that do not include abortion or abortion
40 counseling. If a contractor elects not to provide family planning services,
41 this election does not disqualify the contractor from delivering all other
42 covered health and medical services under this chapter. In that event, the
43 administration may contract directly with another contractor, including an
44 outpatient surgical center or a noncontracting provider, to deliver family

1 planning services to a member who is enrolled with the contractor that elects
2 not to provide family planning services.

3 9. Podiatry services ordered by a primary care physician or primary
4 care practitioner.

5 10. Nonexperimental transplants approved for title XIX reimbursement.

6 11. Ambulance and nonambulance transportation, except as provided in
7 subsection G of this section.

8 B. The limitations and exclusions for health and medical services
9 provided under this section are as follows:

10 1. ~~Beginning on October 1, 2002,~~ Circumcision of newborn males is not
11 a covered health and medical service.

12 2. For eligible persons who are at least twenty-one years of age:

13 (a) Outpatient health services do not include occupational therapy or
14 speech therapy.

15 (b) Prosthetic devices do not include hearing aids, dentures, bone
16 anchored hearing aids or cochlear implants. Prosthetic devices, except
17 prosthetic implants, may be limited to twelve thousand ~~five-hundred~~ FIVE
18 HUNDRED dollars per contract year.

19 (c) Insulin pumps, percussive vests and orthotics are not covered
20 health and medical services.

21 (d) Durable medical equipment is limited to items covered by medicare.

22 (e) Podiatry services do not include services performed by a
23 podiatrist.

24 (f) Nonexperimental transplants do not include the following:

25 (i) Pancreas only transplants.

26 (ii) Pancreas after kidney transplants.

27 (iii) Lung transplants.

28 (iv) Hemopoetic cell allogenic unrelated transplants.

29 (v) Heart transplants for non-ischemic cardiomyopathy.

30 (vi) Liver transplants for diagnosis of hepatitis C.

31 (g) Beginning October 1, 2011, bariatric surgery procedures, including
32 laparoscopic and open gastric bypass and restrictive procedures, are not
33 covered health and medical services.

34 (h) Well exams are not a covered health and medical service, except
35 mammograms, pap smears and colonoscopies.

36 C. The system shall pay noncontracting providers only for health and
37 medical services as prescribed in subsection A of this section and as
38 prescribed by rule.

39 D. The director shall adopt rules necessary to limit, to the extent
40 possible, the scope, duration and amount of services, including maximum
41 limitations for inpatient services that are consistent with federal
42 regulations under title XIX of the social security act (P.L. 89-97; 79 Stat.
43 344; 42 United States Code section 1396 (1980)). To the extent possible and
44 practicable, these rules shall provide for the prior approval of medically
45 necessary services provided pursuant to this chapter.

1 E. The director shall make available home health services in lieu of
2 hospitalization pursuant to contracts awarded under this article. For the
3 purposes of this subsection, "home health services" means the provision of
4 nursing services, home health aide services or medical supplies, equipment
5 and appliances, which are provided on a part-time or intermittent basis by a
6 licensed home health agency within a member's residence based on the orders
7 of a physician or a primary care practitioner. Home health agencies shall
8 comply with the federal bonding requirements in a manner prescribed by the
9 administration.

10 F. The director shall adopt rules for the coverage of behavioral
11 health services for persons who are eligible under section 36-2901, paragraph
12 6, subdivision (a). The administration shall contract with the department of
13 health services for the delivery of all medically necessary behavioral health
14 services to persons who are eligible under rules adopted pursuant to this
15 subsection. The division of behavioral health in the department of health
16 services shall establish a diagnostic and evaluation program to which other
17 state agencies shall refer children who are not already enrolled pursuant to
18 this chapter and who may be in need of behavioral health services. In
19 addition to an evaluation, the division of behavioral health shall also
20 identify children who may be eligible under section 36-2901, paragraph 6,
21 subdivision (a) or section 36-2931, paragraph 5 and shall refer the children
22 to the appropriate agency responsible for making the final eligibility
23 determination.

24 G. The director shall adopt rules for the provision of transportation
25 services and rules providing for copayment by members for transportation for
26 other than emergency purposes. ~~Subject to approval by the centers for~~
27 ~~medicare and medicaid services,~~ Nonemergency medical transportation shall not
28 be provided ~~to persons who are eligible pursuant to sections 36-2901.01 and~~
29 ~~36-2901.04 and who reside in a county with a population of more than five~~
30 ~~hundred thousand persons.~~ Prior authorization is not required for medically
31 necessary ambulance transportation services rendered to members or eligible
32 persons initiated by dialing telephone number 911 or other designated
33 emergency response systems.

34 H. The director may adopt rules to allow the administration, at the
35 director's discretion, to use a second opinion procedure under which surgery
36 may not be eligible for coverage pursuant to this chapter without
37 documentation as to need by at least two physicians or primary care
38 practitioners.

39 I. If the director does not receive bids within the amounts budgeted
40 or if at any time the amount remaining in the Arizona health care cost
41 containment system fund is insufficient to pay for full contract services for
42 the remainder of the contract term, the administration, on notification to
43 system contractors at least thirty days in advance, may modify the list of
44 services required under subsection A of this section for persons defined as
45 eligible other than those persons defined pursuant to section 36-2901,

1 paragraph 6, subdivision (a). The director may also suspend services or may
2 limit categories of expense for services defined as optional pursuant to
3 title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United
4 States Code section 1396 (1980)) for persons defined pursuant to section
5 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not
6 apply to the continuity of care for persons already receiving these services.

7 J. Additional, reduced or modified hospitalization and medical care
8 benefits may be provided under the system to enrolled members who are
9 eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d)
10 or (e).

11 K. All health and medical services provided under this article shall
12 be provided in the geographic service area of the member, except:

13 1. Emergency services and specialty services provided pursuant to
14 section 36-2908.

15 2. That the director may permit the delivery of health and medical
16 services in other than the geographic service area in this state or in an
17 adjoining state if the director determines that medical practice patterns
18 justify the delivery of services or a net reduction in transportation costs
19 can reasonably be expected. Notwithstanding the definition of physician as
20 prescribed in section 36-2901, if services are procured from a physician or
21 primary care practitioner in an adjoining state, the physician or primary
22 care practitioner shall be licensed to practice in that state pursuant to
23 licensing statutes in that state similar to title 32, chapter 13, 15, 17 or
24 25 and shall complete a provider agreement for this state.

25 L. Covered outpatient services shall be subcontracted by a primary
26 care physician or primary care practitioner to other licensed health care
27 providers to the extent practicable for purposes including, but not limited
28 to, making health care services available to underserved areas, reducing
29 costs of providing medical care and reducing transportation costs.

30 M. The director shall adopt rules that prescribe the coordination of
31 medical care for persons who are eligible for system services. The rules
32 shall include provisions for the transfer of patients, the transfer of
33 medical records and the initiation of medical care.

34 N. For the purposes of this section, "ambulance" has the same meaning
35 prescribed in section 36-2201.

36 Sec. 13. Title 36, chapter 29, article 1, Arizona Revised Statutes, is
37 amended by adding section 36-2930, to read:

38 36-2930. Prescription drug rebate fund; exemption; definition

39 A. THE PRESCRIPTION DRUG REBATE FUND IS ESTABLISHED CONSISTING OF
40 PRESCRIPTION DRUG REBATE COLLECTIONS, INTEREST FROM PRESCRIPTION DRUG REBATE
41 LATE PAYMENTS AND FEDERAL MONIES MADE AVAILABLE TO THIS STATE FOR THE
42 OPERATION OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM PRESCRIPTION
43 DRUG REBATE PROGRAM. THE ADMINISTRATION SHALL ADMINISTER THE FUND.
44 NONFEDERAL MONIES IN THE FUND ARE SUBJECT TO ANNUAL LEGISLATIVE
45 APPROPRIATION. FEDERAL MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED AND

1 ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190 RELATING TO THE LAPSING OF
2 APPROPRIATIONS.

3 B. MONIES IN THE FUND SHALL BE USED TO RETURN THE FEDERAL SHARE OF
4 PRESCRIPTION DRUG REBATE COLLECTIONS AND INTEREST FROM LATE PAYMENTS TO THE
5 CENTERS FOR MEDICARE AND MEDICAID SERVICES BY OFFSETTING FUTURE FEDERAL
6 DRAWS, TO PAY FOR THE ADMINISTRATIVE COSTS OF THE PRESCRIPTION DRUG REBATE
7 PROGRAM AND AS THE NONFEDERAL SHARE FOR PAYMENTS TO CONTRACTORS OR PROVIDERS
8 IN THE ADMINISTRATION'S MEDICAL SERVICES PROGRAMS. THE NONFEDERAL SHARE OF
9 PRESCRIPTION DRUG REBATE COLLECTIONS AND INTEREST FROM LATE PAYMENTS INCLUDE
10 REBATES RELATING TO PROGRAMS ADMINISTERED BY THE DEPARTMENT OF ECONOMIC
11 SECURITY, THE DEPARTMENT OF HEALTH SERVICES AND OTHER GOVERNMENTAL ENTITIES
12 THAT CONTRIBUTE TO THE NONFEDERAL SHARE FOR PRESCRIPTION DRUGS.

13 C. FOR THE PURPOSES OF THIS SECTION, "ADMINISTRATIVE COSTS OF THE
14 PRESCRIPTION DRUG REBATE PROGRAM" INCLUDES PAYMENTS TO THE PRESCRIPTION DRUG
15 REBATE VENDOR TO PROCESS, INVOICE, RESOLVE DISPUTES AND REPORT TO THE
16 ADMINISTRATION ALL MEDICAID FEE-FOR-SERVICE AND MANAGED CARE DRUG REBATES AND
17 SUPPLEMENTAL REBATES ON A QUARTERLY BASIS ACCORDING TO THE CENTERS FOR
18 MEDICARE AND MEDICAID SERVICES GUIDELINES AND REQUIRED TIMELINES, INCLUDING
19 REBATES RELATING TO PROGRAMS ADMINISTERED BY THE DEPARTMENT OF ECONOMIC
20 SECURITY, THE DEPARTMENT OF HEALTH SERVICES AND OTHER GOVERNMENTAL ENTITIES
21 THAT CONTRIBUTE TO THE NONFEDERAL SHARE FOR PRESCRIPTION DRUGS.

22 Sec. 14. Section 36-2988, Arizona Revised Statutes, is amended to
23 read:

24 36-2988. Delivery of services; health plans; requirements

25 A. To the extent possible, the administration shall use contractors
26 that have a contract with the administration pursuant to article 1 of this
27 chapter or qualifying plans to provide services to members who qualify for
28 the program.

29 B. The administration has full authority to amend existing contracts
30 awarded pursuant to article 1 of this chapter.

31 C. As determined by the director, reinsurance may be provided against
32 expenses in excess of a specified amount on behalf of any member for covered
33 emergency services, inpatient services or outpatient services in the same
34 manner as reinsurance provided under article 1 of this chapter. Subject to
35 the approval of the director, reinsurance may be obtained against expenses in
36 excess of a specified amount on behalf of any member.

37 D. Notwithstanding any other law, the administration may procure,
38 provide or coordinate covered services by interagency agreement with
39 authorized agencies of this state for distinct groups of members, including
40 persons eligible for children's rehabilitative services ~~through the~~
41 ~~department of health services~~ and members eligible for comprehensive medical
42 and dental benefits through the department of economic security.

43 E. After contracts are awarded pursuant to this section, the director
44 may negotiate with any successful bidder for the expansion or contraction of
45 services or service areas.

1 F. Payments to contractors shall be made monthly and may be subject to
2 contract provisions requiring the retention of a specified percentage of the
3 payment by the director, a reserve fund or any other contract provisions by
4 which adjustments to the payments are made based on utilization efficiency,
5 including incentives for maintaining quality care and minimizing unnecessary
6 inpatient services. Reserve monies withheld from contractors shall be
7 distributed to providers who meet performance standards established by the
8 director. Any reserve fund established pursuant to this subsection shall be
9 established as a separate account within the Arizona health care cost
10 containment system.

11 G. The director may negotiate at any time with a hospital on behalf of
12 a contractor for inpatient hospital services and outpatient hospital services
13 provided pursuant to the requirements specified in section 36-2904.

14 H. A contractor may require that subcontracting providers or
15 noncontracting providers be paid for covered services, other than hospital
16 services, according to the capped fee-for-service schedule adopted by the
17 administration or at lower rates as may be negotiated by the contractor.

18 I. A school district may perform outreach and information activities
19 that relate to this article, with permission of the school principal and
20 school district. The administration and contractors may collaborate with
21 entities such as community based organizations, faith based organizations,
22 schools and school districts for outreach and information activities related
23 to this article. Outreach and information activities shall not include
24 delivery of services, screening activities, eligibility determination or
25 enrollment related to this article. Outreach and information activities
26 include promotion of health care coverage, participation in school events and
27 distribution of applications and materials to pupils and their families.
28 Outreach and information activities performed by the administration,
29 contractors or a school district shall not reduce or interfere with classroom
30 instruction time.

31 J. The administration is exempt from the procurement code pursuant to
32 section 41-2501.

33 Sec. 15. Section 38-654, Arizona Revised Statutes, is amended to read:
34 38-654. Special employee health insurance trust fund; purpose;
35 investment of monies; use of monies; exemption from
36 lapsing; annual report

37 A. There is established a special employee health insurance trust fund
38 for the purpose of administering the state employee health insurance benefit
39 plans. The fund shall consist of legislative appropriations, monies
40 collected from the employer and employees for the health insurance benefit
41 plans and investment earnings on monies collected from employees. The fund
42 shall be administered by the director of the department of administration.
43 Monies in the fund that are determined by the legislature to be for
44 administrative expenses of the department of administration, including monies

1 authorized by subsection ~~D~~ C, paragraph 4 of this section, are subject to
2 legislative appropriation.

3 B. On notice from the department of administration, the state
4 treasurer shall invest and divest monies in the fund as provided by section
5 35-313, and monies earned from investment shall be credited to the fund.
6 There shall be a separate accounting of monies contributed by the employer,
7 monies collected from state employees and investment earnings on monies
8 collected from employees. Monies collected from state employees for health
9 insurance benefit plans shall be expended ~~prior to~~ BEFORE expenditure of
10 monies contributed by the employer.

11 ~~C. The director of the department of administration may authorize the
12 employer health insurance contributions by fund to be payable in advance
13 whether the budget unit is funded in whole or in part by state monies. By
14 July 15 each year, the joint legislative budget committee staff shall
15 determine the amount appropriated for employer health insurance
16 contributions. The department of administration may transfer to the special
17 employee health insurance trust fund in whole or in part the amount
18 appropriated to budget units for employer health insurance contributions as
19 deemed necessary.~~

20 ~~D~~ C. Monies in the fund shall be used by the department of
21 administration for the following purposes for the benefit of officers and
22 employees who participate in a health insurance benefit plan pursuant to this
23 article:

24 1. To administer a health insurance benefit program for state officers
25 and employees.

26 2. To pay health insurance premiums, claims costs and related
27 administrative expenses.

28 3. To apply against future premiums, claims costs and related
29 administrative expenses.

30 4. To apply the equivalent of not more than one dollar fifty cents for
31 each employee for each month to administer applicable federal and state laws
32 relating to health insurance benefit programs and to design, implement and
33 administer improvements to the employee health insurance or benefit program.

34 ~~E~~ D. Subsection ~~D~~ C of this section shall not be construed to
35 require that all monies in the special employee health insurance trust fund
36 shall be used within any one or more fiscal years. Any person who is no
37 longer a state employee or an employee who is no longer a participant in a
38 health insurance plan under contract with the department of administration
39 shall have no claim ~~upon~~ ON monies in the fund.

40 ~~F~~ E. Monies deposited in or credited to the fund are exempt from the
41 provisions of section 35-190 relating to lapsing of appropriations.

42 ~~G~~ F. Claims for services rendered ~~prior to~~ BEFORE July 1, 1989 shall
43 not be paid from the special employee health insurance trust fund.

44 ~~H~~ G. The department of administration shall submit an annual report
45 on the financial status of the special employee insurance trust fund to the

1 governor, the president of the senate, the speaker of the house of
2 representatives, the chairpersons of the house and senate appropriations
3 committees and the joint legislative budget committee staff by March 1. The
4 report shall include:

5 1. The actuarial assumptions and a description of the methodology used
6 to set premiums and reserve balance targets for the health insurance benefit
7 program for the current plan year.

8 2. An analysis of the actuarial soundness of the health insurance
9 benefit program for the previous plan year.

10 3. An analysis of the actuarial soundness of the health insurance
11 benefit program for the current plan year, based on both year-to-date
12 experience and total expected experience.

13 4. A preliminary estimate of the premiums and reserve balance targets
14 for the next plan year, including the actuarial assumptions and a description
15 of the methodology used.

16 ~~I~~ H. The department shall submit a report to the joint legislative
17 budget committee detailing any changes to the type of benefits offered under
18 the plan and associated costs at least forty-five days before making the
19 change. The report shall include:

20 1. An estimate of the cost or saving associated with the change.

21 2. An explanation of why the change was implemented before the next
22 plan year.

23 Sec. 16. Section 43-1088, Arizona Revised Statutes, is amended to
24 read:

25 43-1088. Credit for contribution to qualifying charitable
26 organizations; definitions

27 A. A credit is allowed against the taxes imposed by this title for
28 voluntary cash contributions by the taxpayer or on the taxpayer's behalf
29 pursuant to section 43-401, subsection ~~H~~ I during the taxable year to a
30 qualifying charitable organization not to exceed:

31 1. Two hundred dollars in any taxable year for a single individual or
32 a head of household.

33 2. Four hundred dollars in any taxable year for a married couple
34 filing a joint return.

35 B. A husband and wife who file separate returns for a taxable year in
36 which they could have filed a joint return may each claim only one-half of
37 the tax credit that would have been allowed for a joint return.

38 C. If the allowable tax credit exceeds the taxes otherwise due under
39 this title on the claimant's income, or if there are no taxes due under this
40 title, the taxpayer may carry forward the amount of the claim not used to
41 offset the taxes under this title for not more than five consecutive taxable
42 years' income tax liability.

43 D. The credit allowed by this section:

44 1. Is allowed only if the taxpayer itemizes deductions pursuant to
45 section 43-1042 for the taxable year.

1 2. Is in lieu of a deduction pursuant to section 170 of the internal
2 revenue code and taken for state tax purposes.

3 E. Taxpayers taking a credit authorized by this section shall provide
4 the name of the qualifying charitable organization and the amount of the
5 contribution to the department of revenue on forms provided by the
6 department.

7 F. A qualifying charitable organization shall provide the department
8 of revenue with a written certification that it meets all criteria to be
9 considered a qualifying charitable organization. The organization shall also
10 notify the department of any changes that may affect the qualifications under
11 this section.

12 G. The charitable organization's written certification must be signed
13 by an officer of the organization under penalty of perjury. The written
14 certification must include the following:

15 1. Verification of the organization's status under section 501(c)(3)
16 of the internal revenue code or verification that the organization is a
17 designated community action agency that receives community services block
18 grant program monies pursuant to 42 United States Code section 9901.

19 2. Financial data indicating the organization's budget for the
20 organization's prior operating year and the amount of that budget spent on
21 services to residents of this state who either:

22 (a) Receive temporary assistance for needy families benefits.

23 (b) Are low income residents of this state.

24 (c) Are chronically ill or physically disabled children.

25 3. A statement that the organization plans to continue spending at
26 least fifty per cent of its budget on services to residents of this state who
27 receive temporary assistance for needy families benefits, who are low income
28 residents of this state or who are chronically ill or physically disabled
29 children.

30 H. The department shall review each written certification and
31 determine whether the organization meets all the criteria to be considered a
32 qualifying charitable organization and notify the organization of its
33 determination. The department may also periodically request recertification
34 from the organization. The department shall compile and make available to
35 the public a list of the qualifying charitable organizations.

36 I. For the purposes of this section:

37 1. "Chronically ill or physically disabled children" has the same
38 meaning prescribed in section ~~36-262~~ 36-260.

39 2. "Low income residents" means persons whose household income is less
40 than one hundred fifty per cent of the federal poverty level.

41 3. "Qualifying charitable organization" means a charitable
42 organization that is exempt from federal income taxation under section
43 501(c)(3) of the internal revenue code or is a designated community action
44 agency that receives community services block grant program monies pursuant
45 to 42 United States Code section 9901. The organization must spend at least

1 fifty per cent of its budget on services to residents of this state who
 2 receive temporary assistance for needy families benefits or low income
 3 residents of this state and their households or to chronically ill or
 4 physically disabled children who are residents of this state. Taxpayers
 5 choosing to make donations through an umbrella charitable organization that
 6 collects donations on behalf of member charities shall designate that the
 7 donation be directed to a member charitable organization that would qualify
 8 under this section on a stand-alone basis.

9 4. "Services" means cash assistance, medical care, child care, food,
 10 clothing, shelter, job placement and job training services or any other
 11 assistance that is reasonably necessary to meet immediate basic needs and
 12 that is provided and used in this state.

13 Sec. 17. Laws 2010, chapter 232, section 13 is amended to read:

14 Sec. 13. ALTCs; county contributions; fiscal year 2010-2011

15 A. If the federal government extends the enhanced federal match rate
 16 through June 30, 2011, notwithstanding Laws 2010, seventh special session,
 17 chapter 10, section 15 and section 11-292, Arizona Revised Statutes, county
 18 contributions for the Arizona long-term care system for fiscal year 2010-2011
 19 are as follows:

20	1. Apache	\$ 469,400
21		\$ 485,000
22	2. Cochise	\$ 4,023,400
23		\$ 4,140,300
24	3. Coconino	\$ 1,408,800
25		\$ 1,455,400
26	4. Gila	\$ 1,623,600
27		\$ 1,670,700
28	5. Graham	\$ 1,072,900
29		\$ 1,098,000
30	6. Greenlee	\$ 122,200
31		\$ 124,600
32	7. La Paz	\$ 619,700
33		\$ 636,800
34	8. Maricopa	\$115,295,400
35		\$118,573,200
36	9. Mohave	\$ 5,479,700
37		\$ 5,629,100
38	10. Navajo	\$ 1,942,400
39		\$ 2,006,700
40	11. Pima	\$ 29,839,700
41		\$ 30,705,400
42	12. Pinal	\$ 11,132,800
43		\$ 11,455,700
44	13. Santa Cruz	\$ 1,434,600
45		\$ 1,476,300

1	14. Yavapai	\$ 7,024,400
2		\$ 7,228,300
3	15. Yuma	\$ 6,018,000
4		\$ 6,192,500

5 B. The amounts specified in subsection A of this section reflect
6 ~~\$76,014,400~~ \$57,757,000 in decreases in county contributions for the Arizona
7 long-term care system.

8 C. The amounts specified in subsection A of this section reflect
9 ~~\$4,390,700~~ \$3,629,200 in decreases in county contributions for the Arizona
10 long-term care system for medicare clawback savings.

11 D. The county contributions for the Arizona long-term care system
12 would have otherwise totaled ~~\$267,912,100~~ \$250,635,000 in fiscal year
13 2010-2011.

14 Sec. 18. ALTCs; county contributions; fiscal year 2011-2012

15 Notwithstanding section 11-292, Arizona Revised Statutes, county
16 contributions for the Arizona long-term care system for fiscal year 2011-2012
17 are as follows:

18	1. Apache	\$ 631,800
19	2. Cochise	\$ 5,309,100
20	3. Coconino	\$ 1,896,300
21	4. Gila	\$ 2,113,600
22	5. Graham	\$ 1,430,800
23	6. Greenlee	\$ 162,300
24	7. La Paz	\$ 827,500
25	8. Maricopa	\$154,518,900
26	9. Mohave	\$ 7,335,500
27	10. Navajo	\$ 2,614,500
28	11. Pima	\$ 39,653,400
29	12. Pinal	\$ 15,702,000
30	13. Santa Cruz	\$ 1,933,300
31	14. Yavapai	\$ 9,586,200
32	15. Yuma	\$ 8,017,700

33 Sec. 19. Sexually violent persons; county reimbursement; fiscal
34 year 2011-2012; deposit; tax withholding

35 A. Notwithstanding any other law, if this state pays the costs of a
36 commitment of an individual determined to be sexually violent by the court,
37 the county shall reimburse the department of health services for fifty per
38 cent of these costs for fiscal year 2011-2012.

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

43 C. Each county shall make the reimbursements for these costs as
44 specified in subsection A of this section within thirty days after a request
45 by the department of health services. If the county does not make the

1 reimbursement, the superintendent of the Arizona state hospital shall notify
2 the state treasurer of the amount owed and the treasurer shall withhold the
3 amount, including any additional interest as provided in section 42-1123,
4 Arizona Revised Statutes, from any transaction privilege tax distributions to
5 the county. The treasurer shall deposit the withholdings, pursuant to
6 sections 35-146 and 35-147, Arizona Revised Statutes, in the Arizona state
7 hospital fund established by section 36-545.08, Arizona Revised Statutes.

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

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

14 Sec. 20. Competency restoration treatment; city and county
15 reimbursement; fiscal year 2011-2012; deposit; tax
16 withholding

17 A. Notwithstanding section 13-4512, Arizona Revised Statutes, if this
18 state pays the costs of a defendant's inpatient competency restoration
19 treatment pursuant to section 13-4512, Arizona Revised Statutes, the city or
20 county shall reimburse the department of health services for one hundred per
21 cent of these costs for fiscal year 2011-2012.

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

26 C. Each city and county shall make the reimbursements for these costs
27 as specified in subsection A of this section within thirty days after a
28 request by the department of health services. If the city or county does not
29 make the reimbursement, the superintendent of the Arizona state hospital
30 shall notify the state treasurer of the amount owed and the treasurer shall
31 withhold the amount, including any additional interest as provided in section
32 42-1123, Arizona Revised Statutes, from any transaction privilege tax
33 distributions to the city or county. The treasurer shall deposit the
34 withholdings, pursuant to sections 35-146 and 35-147, Arizona Revised
35 Statutes, in the Arizona state hospital fund established by section
36 36-545.08, Arizona Revised Statutes.

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

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

1 Sec. 21. State employee health benefits

2 For fiscal year 2011-2012, the department of administration shall not
3 implement a differentiated health insurance premium based on the integrated
4 or nonintegrated status of a health insurance provider available through the
5 state employee health insurance program.

6 Sec. 22. AHCCCS: disproportionate share payments

7 A. Disproportionate share payments for fiscal year 2011-2012 made
8 pursuant to section 36-2903.01, subsection P, Arizona Revised Statutes,
9 include:

10 1. \$55,507,900 for a qualifying nonstate operated public hospital.
11 The Maricopa county special health care district shall provide a certified
12 public expense form for the amount of qualifying disproportionate share
13 hospital expenditures made on behalf of this state to the administration on
14 or before May 1, 2012 for all state plan years as required by the Arizona
15 health care cost containment system 1115 waiver standard terms and
16 conditions. The administration shall assist the district in determining the
17 amount of qualifying disproportionate share hospital expenditures. Once the
18 administration files a claim with the federal government and receives federal
19 funds participation based on the amount certified by the Maricopa county
20 special health care district, if the certification is equal to or greater
21 than \$55,507,900, the administration shall distribute \$4,202,300 to the
22 Maricopa county special health care district and deposit the balance of the
23 federal funds participation in the state general fund. If the certification
24 provided is for an amount less than \$55,507,900, and the administration
25 determines that the revised amount is correct pursuant to the methodology
26 used by the administration pursuant to section 36-2903.01, Arizona Revised
27 Statutes, the administration shall notify the governor, the president of the
28 senate and the speaker of the house of representatives, shall distribute
29 \$4,202,300 to the Maricopa county special health care district and shall
30 deposit the balance of the federal funds participation in the state general
31 fund. If the certification provided is for an amount less than \$55,507,900
32 and the administration determines that the revised amount is not correct
33 pursuant to the methodology used by the administration pursuant to section
34 36-2903.01, Arizona Revised Statutes, the administration shall notify the
35 governor, the president of the senate and the speaker of the house of
36 representatives and shall deposit the total amount of the federal funds
37 participation in the state general fund.

38 2. \$28,474,900 for the Arizona state hospital. The Arizona state
39 hospital shall provide a certified public expense form for the amount of
40 qualifying disproportionate share hospital expenditures made on behalf of the
41 state to the administration on or before March 31, 2012. The administration
42 shall assist the Arizona state hospital in determining the amount of
43 qualifying disproportionate share hospital expenditures. Once the
44 administration files a claim with the federal government and receives federal
45 funds participation based on the amount certified by the Arizona state

1 hospital, the administration shall distribute the entire amount of federal
2 financial participation to the state general fund. If the certification
3 provided is for an amount less than \$28,474,900, the administration shall
4 notify the governor, the president of the senate and the speaker of the house
5 of representatives and shall distribute the entire amount of federal
6 financial participation to the state general fund. The certified public
7 expense form provided by the Arizona state hospital shall contain both the
8 total amount of qualifying disproportionate share hospital expenditures and
9 the amount limited by section 1923(g) of the social security act.

10 3. \$9,284,800 for private qualifying disproportionate share hospitals.
11 The Arizona health care cost containment system administration shall make
12 payments to hospitals consistent with this appropriation and the terms of the
13 section 1115 waiver, however, payments shall be limited to those hospitals
14 that either:

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

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

19 B. Disproportionate share payments in fiscal years 2010-2011 and
20 2011-2012 made pursuant to section 36-2903.01, subsection D, Arizona Revised
21 Statutes, include amounts for disproportionate share hospitals designated by
22 political subdivisions of this state, tribal governments and any university
23 under the jurisdiction of the Arizona board of regents. Contingent on
24 approval by the administration and the centers for medicare and Medicaid
25 services any amount of federal funding allotted to this state pursuant to
26 section 1923(f) of the social security act and not otherwise expended under
27 subsection A, paragraph 1, 2 or 3 of this section shall be made available for
28 distribution pursuant to this subsection. Political subdivisions of this
29 state, tribal governments and any university under the jurisdiction of the
30 Arizona board of regents may designate hospitals eligible to receive
31 disproportionate share funds in an amount up to the limit prescribed in
32 section 1923(g) of the social security act if those political subdivisions,
33 tribal governments or universities provide sufficient monies to qualify for
34 the matching federal monies for the disproportionate share payments.

35 Sec. 23. AHCCCS transfer; counties; federal monies

36 On or before December 31, 2012, notwithstanding any other law, for
37 fiscal year 2011-2012 the Arizona health care cost containment system
38 administration shall transfer to the counties such portion, if any, as may be
39 necessary to comply with section 10201(c)(6) of the patient protection and
40 affordable care act (P.L. 111-148), regarding the counties' proportional
41 share of the state's contribution.

1 that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona
2 Revised Statutes, plus interest on that amount pursuant to section 44-1201,
3 Arizona Revised Statutes, retroactive to the first day the funding was due.
4 If the monies the state treasurer withholds are insufficient to meet that
5 county's funding requirements as specified in subsection A of this section,
6 the state treasurer shall withhold from any other monies payable to that
7 county from whatever state funding source is available an amount necessary to
8 fulfill that county's requirement. The state treasurer shall not withhold
9 distributions from the highway user revenue fund pursuant to title 28,
10 chapter 18, article 2, Arizona Revised Statutes.

11 C. Payment of an amount equal to one-twelfth of the total amount
12 determined pursuant to subsection A of this section shall be made to the
13 state treasurer on or before the fifth day of each month. On request from
14 the director of the Arizona health care cost containment system
15 administration, the state treasurer shall require that up to three months'
16 payments be made in advance, if necessary.

17 D. The state treasurer shall deposit the amounts paid pursuant to
18 subsection C of this section and amounts withheld pursuant to subsection B of
19 this section in the Arizona health care cost containment system fund and the
20 long-term care system fund established by section 36-2913, Arizona Revised
21 Statutes.

22 E. If payments made pursuant to subsection C of this section exceed
23 the amount required to meet the costs incurred by the Arizona health care
24 cost containment system for the hospitalization and medical care of those
25 persons defined as an eligible person pursuant to section 36-2901, paragraph
26 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of
27 the Arizona health care cost containment system administration may instruct
28 the state treasurer either to reduce remaining payments to be paid pursuant
29 to this section by a specified amount or to provide to the counties specified
30 amounts from the Arizona health care cost containment system fund and the
31 long-term care system fund.

32 F. It is the intent of the legislature that the Maricopa county
33 contribution pursuant to subsection A of this section be reduced in each
34 subsequent year according to the changes in the GDP price deflator. For the
35 purposes of this subsection, "GDP price deflator" has the same meaning
36 prescribed in section 41-563, Arizona Revised Statutes.

37 Sec. 26. Hospitalization and medical care contribution; fiscal
38 year 2011-2012

39 A. Notwithstanding any other law, for fiscal year 2011-2012, beginning
40 with the second monthly distribution of transaction privilege tax revenues,
41 the state treasurer shall withhold one-eleventh of the following amounts from
42 state transaction privilege tax revenues otherwise distributable, after any
43 amounts withheld for the county long-term care contribution or the county
44 administration contribution pursuant to section 11-292, subsection 0, Arizona
45 Revised Statutes, for deposit in the Arizona health care cost containment

1 system fund established by section 36-2913, Arizona Revised Statutes, for the
2 provision of hospitalization and medical care:

3	1. Apache	\$ 87,300
4	2. Cochise	\$ 162,700
5	3. Coconino	\$ 160,500
6	4. Gila	\$ 65,900
7	5. Graham	\$ 46,800
8	6. Greenlee	\$ 12,000
9	7. La Paz	\$ 24,900
10	8. Mohave	\$ 187,400
11	9. Navajo	\$ 122,800
12	10. Pima	\$1,115,900
13	11. Pinal	\$ 218,300
14	12. Santa Cruz	\$ 51,600
15	13. Yavapai	\$ 206,200
16	14. Yuma	\$ 183,900

17 B. If the monies the state treasurer withholds are insufficient to
18 meet that county's funding requirement as specified in subsection A of this
19 section, the state treasurer shall withhold from any other monies payable to
20 that county from whatever state funding source is available an amount
21 necessary to fulfill that county's requirement. The state treasurer shall
22 not withhold distributions from the highway user revenue fund pursuant to
23 title 28, chapter 18, article 2, Arizona Revised Statutes.

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

27 D. In fiscal year 2011-2012, the sum of \$2,646,200 withheld pursuant
28 to subsection A of this section is allocated for the county acute care
29 contribution for the provision of hospitalization and medical care services
30 administered by the Arizona health care cost containment system
31 administration.

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

34 Sec. 27. Proposition 204 administration; county expenditure
35 limitation

36 County contributions for the administrative costs of implementing
37 sections 36-2901.01 and 36-2901.04, Arizona Revised Statutes, that are made
38 pursuant to section 11-292, subsection 0, Arizona Revised Statutes, are
39 excluded from the county expenditure limitations.

40 Sec. 28. AHCCCS; ambulance rates; fiscal year 2011-2012;
41 retroactivity

42 A. For fiscal year 2011-2012, section 36-2239, subsections D, F, G and
43 H, Arizona Revised Statutes, do not apply to a remuneration made pursuant to
44 the Arizona health care cost containment system.

1 B. This section is effective retroactively to from and after June 30,
2 2011.

3 Sec. 29. AHCCCS; risk contingency rate setting

4 Notwithstanding any other law, for the contract year beginning
5 October 1, 2011 and ending September 30, 2012, the Arizona health care cost
6 containment system administration may continue the risk contingency rate
7 setting for all managed care organizations and the funding for all managed
8 care organizations administrative funding levels that was imposed for the
9 contract year beginning October 1, 2010 and ending September 30, 2011.

10 Sec. 30. AHCCCS; hospital reimbursement inflation adjustment
11 freeze

12 For the contract year beginning October 1, 2011:

13 1. Notwithstanding section 36-2903.01, subsection H, paragraph 2,
14 Arizona Revised Statutes, and any rules adopted to implement that provision,
15 the Arizona health care cost containment system administration shall not
16 adjust tiered per diem payments for inpatient hospital care by the 2011 data
17 resources incorporated market basket index for prospective payment system
18 hospitals.

19 2. Notwithstanding section 36-2903.01, subsection H, paragraph 3,
20 Arizona Revised Statutes, and any rules adopted to implement that provision,
21 the Arizona health care cost containment system administration shall not
22 adjust outpatient hospital fee schedule rates by any inflation index.

23 3. Notwithstanding section 36-2903.01, subsection H, paragraph 10,
24 Arizona Revised Statutes, and any rules adopted to implement that provision,
25 the Arizona health care cost containment system administration shall not
26 adjust outlier cost thresholds by the global insight hospital market basket
27 index for prospective payment system hospitals.

28 Sec. 31. AHCCCS; hospital rates; reduction authority

29 Notwithstanding any other law, for rates effective October 1, 2011
30 through September 30, 2012, the Arizona health care cost containment system
31 administration may reduce payments for institutional and noninstitutional
32 services up to five per cent.

33 Sec. 32. Exemption from rule making; Arizona health care cost
34 containment system

35 A. The Arizona health care cost containment system is exempt from the
36 rule making requirements of title 41, chapter 6, Arizona Revised Statutes,
37 for two years after the effective date of this act, to establish and maintain
38 rules regarding standards, methods and procedures for determining eligibility
39 necessary to implement a program within the available appropriation. The
40 agency shall provide public notice and an opportunity for public comment on
41 proposed rules at least thirty days before rules are adopted or amended
42 pursuant to this section.

43 B. The Arizona health care cost containment system administration is
44 exempt from the rule making requirements of title 41, chapter 6, Arizona
45 Revised Statutes, for one year after the effective date of this act, to

1 implement the requirements of section 36-2903.01, subsection H, Arizona
2 Revised Statutes, as amended by this act.

3 Sec. 33. Exemption from rule making; department of health
4 services

5 The department of health services is exempt from the rule making
6 requirements of title 41, chapter 6, Arizona Revised Statutes, for two years
7 after the effective date of this act for the purpose of establishing fees
8 pursuant to section 36-341, Arizona Revised Statutes, as amended by this act.

9 Sec. 34. Intent; false claims act; savings

10 It is the intent of the legislature that the Arizona health care cost
11 containment system administration comply with the federal false claims act
12 and maximize savings in, and continue to consider best available technologies
13 in detecting fraud in, the administration's programs.

14 Sec. 35. Intent; vital records fees

15 It is the intent of the legislature that the fees collected pursuant to
16 section 36-341, subsection A, Arizona Revised Statutes, as amended by this
17 act, shall not exceed \$4,539,000 in fiscal year 2011-2012.

18 Sec. 36. Transfer of powers; effect

19 A. The Arizona health care cost containment system administration
20 succeeds to the powers and duties of the department of health services
21 relating to children's rehabilitative services prescribed pursuant to title
22 36, chapter 2, article 3, Arizona Revised Statutes.

23 B. All matters, including contracts, orders and judicial or
24 quasi-judicial actions, whether completed or pending, of the department of
25 health services relating to children's rehabilitative services are
26 transferred on the effective date of this act, and maintain the same status
27 with the Arizona health care cost containment system administration.

28 C. Rules adopted by the department of health services relating to
29 children's rehabilitative services are effective until superseded by rules
30 adopted by the Arizona health care cost containment system administration.

31 D. All personnel, property and records, all data and investigative
32 findings and all appropriated monies remaining unspent and unencumbered of
33 the department of health services relating to children's rehabilitative
34 services are transferred to the Arizona health care cost containment system
35 administration and may be used for the purposes prescribed in title 36,
36 chapter 2, article 3, Arizona Revised Statutes.

37 Sec. 37. Retroactivity

38 Section 36-2930, Arizona Revised Statutes, as added by this act, is
39 effective retroactively to March 1, 2011.

40 Sec. 38. Effective date

41 Section 36-260, Arizona Revised Statutes, as added by this act, and
42 sections 36-261, 36-262, 36-263, 36-264, 36-797.43, 36-797.44, 36-2903.01,
43 36-2988 and 43-1088, Arizona Revised Statutes, as amended by this act, are
44 effective from and after June 30, 2011.