Conference Engrossed

State of Arizona
House of Representatives
Fifty-first Legislature
First Regular Session
2013

CHAPTER 202

HOUSE BILL 2045

AN ACT

AMENDING TITLE 32, CHAPTER 32, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 32-3216; AMENDING TITLE 36, CHAPTER 4, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-437; AMENDING SECTION 36-2903.01, ARIZONA REVISED STATUTES; PROVIDING FOR THE DELAYED REPEAL OF SECTIONS 32-3216 AND 36-437, ARIZONA REVISED STATUTES, AS ADDED BY THIS ACT; RELATING TO HEALTH CARE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Title 32, chapter 32, article 1, Arizona Revised Statutes, is amended by adding section 32-3216, to read:

32-3216. Health care providers; charges; public availability; direct payment; notice; definitions

A. A HEALTH CARE PROVIDER MUST MAKE AVAILABLE ON REQUEST OR ONLINE THE DIRECT PAY PRICE FOR AT LEAST THE TWENTY-FIVE MOST COMMONLY PROVIDED SERVICES, IF APPLICABLE, FOR THE HEALTH CARE PROVIDER. THE SERVICES MAY BE IDENTIFIED BY A COMMON PROCEDURAL TERMINOLOGY CODE OR BY A PLAIN-ENGLISH DESCRIPTION. THE DIRECT PAY PRICES MUST BE UPDATED AT LEAST ANNUALLY AND MUST BE BASED ON THE SERVICES FROM A TWELVE-MONTH PERIOD THAT OCCURRED WITHIN THE EIGHTEEN-MONTH PERIOD PRECEDING THE ANNUAL UPDATE. THE DIRECT PAY PRICE MUST BE FOR THE STANDARD TREATMENT PROVIDED FOR THE SERVICE AND MAY INCLUDE THE COST OF TREATMENT FOR COMPLICATIONS OR EXCEPTIONAL TREATMENT. HEALTH CARE PROVIDERS WHO ARE OWNERS OR EMPLOYEES OF A LEGAL ENTITY WITH FEWER THAN THREE LICENSED HEALTH CARE PROVIDERS ARE EXEMPT FROM THE REQUIREMENTS OF THIS SUBSECTION.

B. SUBSECTION A OF THIS SECTION DOES NOT APPLY TO EMERGENCY SERVICES.

C. THE HEALTH CARE SERVICES PROVIDED BY HEALTH CARE PROVIDERS IN VETERANS ADMINISTRATION FACILITIES, HEALTH FACILITIES ON MILITARY BASES, INDIAN HEALTH SERVICES HOSPITALS AND OTHER INDIAN HEALTH SERVICE FACILITIES, TRIBAL OWNED CLINICS, THE ARIZONA STATE HOSPITAL AND ANY HEALTH CARE FACILITY DETERMINED TO BE EXEMPT PURSUANT TO SECTION 36-437, SUBSECTION D, ARE EXEMPT FROM THE REQUIREMENTS AND PROVISIONS OF THIS SECTION.

D. SUBSECTION A OF THIS SECTION DOES NOT PREVENT A HEALTH CARE PROVIDER FROM OFFERING EITHER ADDITIONAL DISCOUNTS OR ADDITIONAL LAWFUL HEALTH CARE SERVICES FOR AN ADDITIONAL COST TO A PERSON OR AN EMPLOYER PAYING DIRECTLY.

E. A HEALTH CARE PROVIDER IS NOT REQUIRED TO REPORT THE DIRECT PAY PRICES TO A GOVERNMENT AGENCY OR DEPARTMENT OR TO A GOVERNMENT-AUTHORIZED OR GOVERNMENT-CREATED ENTITY FOR REVIEW OR FILING. A GOVERNMENT AGENCY OR DEPARTMENT OR GOVERNMENT-AUTHORIZED OR GOVERNMENT-CREATED ENTITY MAY NOT APPROVE, DISAPPROVE OR LIMIT A HEALTH CARE PROVIDER'S DIRECT PAY PRICE FOR SERVICES. A GOVERNMENT AGENCY OR DEPARTMENT OR GOVERNMENT-AUTHORIZED OR GOVERNMENT-CREATED ENTITY MAY NOT APPROVE, DISAPPROVE OR LIMIT A HEALTH CARE PROVIDER'S ABILITY TO CHANGE THE PUBLISHED OR POSTED DIRECT PAY PRICE FOR SERVICES.

F. A HEALTH CARE SYSTEM MAY NOT PUNISH A PERSON OR EMPLOYER FOR PAYING DIRECTLY FOR LAWFUL HEALTH CARE SERVICES OR A HEALTH CARE PROVIDER FOR ACCEPTING DIRECT PAYMENT FROM A PERSON OR EMPLOYER FOR LAWFUL HEALTH CARE SERVICES.

G. EXCEPT AS PROVIDED IN SUBSECTION J OF THIS SECTION, A HEALTH CARE PROVIDER WHO RECEIVES DIRECT PAYMENT FROM A PERSON OR EMPLOYER FOR A LAWFUL HEALTH CARE SERVICE IS DEEMED PAID IN FULL IF THE ENTIRE FEE FOR THE SERVICE IS PAID AND SHALL NOT SUBMIT A CLAIM FOR PAYMENT OR REIMBURSEMENT FOR THE SERVICE TO ANY HEALTH CARE SYSTEM. THIS SUBSECTION DOES NOT PREVENT A HEALTH

CARE PROVIDER FROM PURSUING A HEALTH CARE LIEN FOR CUSTOMARY CHARGES PURSUANT TO TITLE 33. THIS SUBSECTION DOES NOT AFFECT THE ABILITY OF A HEALTH CARE PROVIDER TO SUBMIT CLAIMS FOR THE SAME SERVICE PROVIDED ON OTHER OCCASIONS TO THE SAME OR A DIFFERENT PERSON IF NO DIRECT PAYMENT OCCURS. THIS SUBSECTION DOES NOT REQUIRE A HEALTH CARE PROVIDER TO REFUND OR ADJUST ANY CAPITATED PAYMENT, BUNDLED PAYMENT OR OTHER FORM OF PREPAYMENT OR GLOBAL PAYMENT MADE BY A HEALTH CARE SYSTEM TO THE HEALTH CARE PROVIDER FOR LAWFUL HEALTH CARE SERVICES TO BE PROVIDED BY THE HEALTH CARE PROVIDER FOR THE PERSON WHO MAKES, OR ON WHOSE BEHALF AN EMPLOYER MAKES, DIRECT PAYMENT TO THE HEALTH CARE PROVIDER.

H. BEFORE A HEALTH CARE PROVIDER WHO IS CONTRACTED AS A NETWORK PROVIDER FOR A HEALTH CARE SYSTEM ACCEPTS DIRECT PAYMENT FROM A PERSON OR AN EMPLOYER, AND THE PERSON IS AN ENROLLEE OF THE SAME HEALTH CARE SYSTEM, THE HEALTH CARE PROVIDER SHALL OBTAIN THE PERSON'S OR EMPLOYER'S SIGNATURE ON A NOTICE IN A FORM THAT IS SUBSTANTIALLY SIMILAR TO THE FOLLOWING:

IMPORTANT NOTICE ABOUT DIRECT PAYMENT
FOR YOUR HEALTH CARE SERVICES

THE ARIZONA CONSTITUTION PERMITS YOU TO PAY A HEALTH CARE PROVIDER DIRECTLY FOR HEALTH CARE SERVICES. BEFORE YOU MAKE ANY AGREEMENT TO DO SO, PLEASE READ THE FOLLOWING IMPORTANT INFORMATION:

IF YOU ARE AN ENROLLEE OF A HEALTH CARE SYSTEM (MORE COMMONLY REFERRED TO AS A HEALTH INSURANCE PLAN) AND YOUR HEALTH CARE PROVIDER IS CONTRACTED WITH THE HEALTH INSURANCE PLAN, THE FOLLOWING APPLY:

1. YOU MAY NOT BE REQUIRED TO PAY THE HEALTH CARE PROVIDER DIRECTLY FOR THE SERVICES COVERED BY YOUR PLAN, EXCEPT FOR COST SHARE AMOUNTS THAT YOU ARE OBLIGATED TO PAY UNDER YOUR PLAN, SUCH AS COPAYMENTS, COINSURANCE AND DEDUCTIBLE AMOUNTS.

2. YOUR PROVIDER'S AGREEMENT WITH THE HEALTH INSURANCE PLAN MAY PREVENT THE HEALTH CARE PROVIDER FROM BILLING YOU FOR THE DIFFERENCE BETWEEN THE PROVIDER'S BILLED CHARGES AND THE AMOUNT ALLOWED BY YOUR HEALTH INSURANCE PLAN FOR COVERED SERVICES.

3. IF YOU PAY DIRECTLY FOR A HEALTH CARE SERVICE, YOUR HEALTH CARE PROVIDER WILL NOT BE RESPONSIBLE FOR SUBMITTING CLAIM DOCUMENTATION TO YOUR HEALTH INSURANCE PLAN FOR THAT CLAIM. BEFORE PAYING YOUR CLAIM, YOUR HEALTH INSURANCE PLAN MAY REQUIRE YOU TO PROVIDE INFORMATION AND SUBMIT DOCUMENTATION NECESSARY TO DETERMINE WHETHER THE SERVICES ARE COVERED UNDER YOUR PLAN.

4. IF YOU DO NOT PAY DIRECTLY FOR A HEALTH CARE SERVICE, YOUR HEALTH CARE PROVIDER MAY BE RESPONSIBLE FOR SUBMITTING CLAIM DOCUMENTATION TO YOUR HEALTH INSURANCE PLAN FOR THE HEALTH CARE SERVICE.

YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU RECEIVED THIS NOTICE BEFORE PAYING DIRECTLY FOR A HEALTH CARE SERVICE.

I. A HEALTH CARE PROVIDER WHO RECEIVES DIRECT PAYMENT FOR A LAWFUL HEALTH CARE SERVICE AND WHO COMPLIES WITH SUBSECTION H OF THIS SECTION IS NOT RESPONSIBLE FOR SUBMITTING DOCUMENTATION OF ANY KIND FOR PURPOSES OF REIMBURSEMENT TO ANY HEALTH CARE SYSTEM FOR THAT CLAIM IF THE FAILURE TO SUBMIT SUCH DOCUMENTATION DOES NOT CONFLICT WITH THE TERMS OF ANY FEDERAL OR STATE CONTRACTS TO WHICH THE HEALTH CARE SYSTEM IS A PARTY AND THE HEALTH CARE PROVIDER HAS AGREED TO SERVE PATIENTS UNDER OR WITH APPLICABLE STATE OR FEDERAL PROGRAMS IN WHICH A HEALTH CARE PROVIDER AND HEALTH CARE SYSTEM PARTICIPATE.

J. THIS SECTION DOES NOT IMPAIR THE PROVISIONS OF A HEALTH CARE SYSTEM'S PRIVATE HEALTH CARE NETWORK PROVIDER CONTRACT, EXCEPT THAT A HEALTH CARE PROVIDER MAY ACCEPT DIRECT PAYMENT FROM A PERSON OR EMPLOYER OR MAY DECLINE TO BILL THE HEALTH CARE SYSTEM DIRECTLY FOR SERVICES PAID DIRECTLY BY A PERSON OR EMPLOYER IF THE HEALTH CARE PROVIDER HAS COMPLIED WITH SUBSECTION H OF THIS SECTION AND THE HEALTH CARE PROVIDER'S RECEIPT OF DIRECT PAYMENT AND THE DECLINATION TO BILL THE HEALTH CARE SYSTEM DO NOT CONFLICT WITH THE TERMS OF ANY FEDERAL OR STATE CONTRACT TO WHICH THE HEALTH CARE SYSTEM IS A PARTY AND THE HEALTH CARE PROVIDER HAS AGREED TO SERVE PATIENTS UNDER OR WITH APPLICABLE STATE OR FEDERAL PROGRAMS IN WHICH BOTH A HEALTH CARE PROVIDER AND HEALTH CARE SYSTEM PARTICIPATE.

K. A HEALTH CARE PROVIDER WHO DOES NOT COMPLY WITH THE REQUIREMENTS OF THIS SECTION COMMITS UNPROFESSIONAL CONDUCT. ANY DISCIPLINARY ACTION TAKEN BY THE HEALTH PROFESSIONAL'S LICENSING BOARD MAY NOT INCLUDE REVOCATION OF THE HEALTH CARE PROVIDER'S LICENSE.

L. FOR THE PURPOSES OF THIS SECTION:

1. "DIRECT PAY PRICE" MEANS THE PRICE THAT WILL BE CHARGED BY A HEALTH CARE PROVIDER FOR A LAWFUL HEALTH CARE SERVICE, REGARDLESS OF THE HEALTH INSURANCE STATUS OF THE PERSON, IF THE ENTIRE FEE FOR THE SERVICE IS PAID IN FULL DIRECTLY TO A HEALTH CARE PROVIDER BY THE PERSON, INCLUDING THE PERSON'S HEALTH SAVINGS ACCOUNT, OR BY THE PERSON'S EMPLOYER AND THAT DOES NOT PROHIBIT A PROVIDER FROM ESTABLISHING A PAYMENT PLAN WITH THE PERSON PAYING DIRECTLY FOR SERVICES.

2. "EMERGENCY SERVICES" MEANS LAWFUL HEALTH CARE SERVICES NEEDED TO EVALUATE AND STABILIZE AN EMERGENCY MEDICAL CONDITION AS DEFINED IN 42 UNITED STATES CODE SECTION 1396u-2(b)(2)(C).

3. "ENROLLEE" MEANS A PERSON WHO IS ENROLLED IN A HEALTH CARE PLAN PROVIDED BY A HEALTH INSURER.

4. "HEALTH CARE PLAN" MEANS A POLICY, CONTRACT OR EVIDENCE OF COVERAGE ISSUED TO AN ENROLLEE. HEALTH CARE PLAN DOES NOT INCLUDE LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137.

5. "HEALTH CARE PROVIDER" MEANS A PERSON WHO IS LICENSED PURSUANT TO CHAPTER 7, 8, 13, 16, 17, 19 OR 34 OF THIS TITLE.

6. "HEALTH CARE SYSTEM" MEANS A PUBLIC OR PRIVATE ENTITY WHOSE FUNCTION OR PURPOSE IS THE MANAGEMENT, PROCESSING OR ENROLLMENT OF INDIVIDUALS OR THE PAYMENT, IN FULL OR IN PART, OF HEALTH CARE SERVICES.

7. "HEALTH INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION, HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR HOSPITAL AND MEDICAL SERVICE CORPORATION AS DEFINED IN TITLE 20.

8. "LAWFUL HEALTH CARE SERVICES" MEANS ANY HEALTH-RELATED SERVICE OR TREATMENT, TO THE EXTENT THAT THE SERVICE OR TREATMENT IS PERMITTED OR NOT PROHIBITED BY LAW OR REGULATION, THAT MAY BE PROVIDED BY PERSONS OR BUSINESSES OTHERWISE PERMITTED TO OFFER THE SERVICES OR TREATMENTS.

9. "PUNISH" MEANS TO IMPOSE ANY PENALTY, SURCHARGE OR NAMED FEE WITH A SIMILAR EFFECT THAT IS USED TO DISCOURAGE THE EXERCISE OF RIGHTS UNDER THIS SECTION.

Sec. 2. Title 36, chapter 4, article 3, Arizona Revised Statutes, is amended by adding section 36-437, to read:

36-437. <u>Health care facilities; charges; public availability; direct payment; notice; definitions</u>

A. A HEALTH CARE FACILITY WITH MORE THAN FIFTY INPATIENT BEDS MUST MAKE AVAILABLE ON REQUEST OR ONLINE THE DIRECT PAY PRICE FOR AT LEAST THE FIFTY MOST USED DIAGNOSIS-RELATED GROUP CODES, IF APPLICABLE, FOR THE FACILITY AND AT LEAST THE FIFTY MOST USED OUTPATIENT SERVICE CODES, IF APPLICABLE, FOR THE FACILITY. THE SERVICES MAY BE IDENTIFIED BY A COMMON PROCEDURAL TERMINOLOGY CODE OR BY A PLAIN-ENGLISH DESCRIPTION. THE HEALTH CARE FACILITY MUST UPDATE THE DIRECT PAY PRICES AT LEAST ANNUALLY BASED ON THE SERVICES FROM A TWELVE-MONTH PERIOD THAT OCCURRED WITHIN THE EIGHTEEN-MONTH PERIOD PRECEDING THE ANNUAL UPDATE. THE DIRECT PAY PRICE MUST BE FOR THE STANDARD TREATMENT PROVIDED FOR THE SERVICE AND MAY INCLUDE THE COST OF TREATMENT FOR COMPLICATIONS OR EXCEPTIONAL TREATMENT.

B. A HEALTH CARE FACILITY WITH FIFTY OR FEWER INPATIENT BEDS MUST MAKE AVAILABLE ON REQUEST OR ONLINE THE DIRECT PAY PRICE FOR AT LEAST THE THIRTY-FIVE MOST USED DIAGNOSIS-RELATED GROUP CODES, IF APPLICABLE, FOR THE FACILITY AND AT LEAST THE THIRTY-FIVE MOST USED OUTPATIENT SERVICE CODES IF APPLICABLE, FOR THE FACILITY. THE SERVICES MAY BE IDENTIFIED BY A COMMON PROCEDURAL TERMINOLOGY CODE OR BY A PLAIN-ENGLISH DESCRIPTION. THE HEALTH CARE FACILITY MUST UPDATE THE DIRECT PAY PRICES AT LEAST ANNUALLY BASED ON THE SERVICES FROM A TWELVE-MONTH PERIOD THAT OCCURRED WITHIN THE EIGHTEEN-MONTH PERIOD PRECEDING THE ANNUAL UPDATE. THE DIRECT PAY PRICE MUST BE FOR THE STANDARD TREATMENT PROVIDED FOR THE SERVICE AND MAY INCLUDE THE COST OF TREATMENT FOR COMPLICATIONS OR EXCEPTIONAL TREATMENT.

C. SUBSECTIONS A AND B OF THIS SECTION DO NOT APPLY IF A DISCUSSION OF THE DIRECT PAY PRICE WOULD BE A VIOLATION OF THE FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT.

D. VETERANS ADMINISTRATION FACILITIES, HEALTH FACILITIES ON MILITARY BASES, INDIAN HEALTH SERVICES HOSPITALS AND OTHER INDIAN HEALTH SERVICES FACILITIES, TRIBAL OWNED CLINICS AND THE ARIZONA STATE HOSPITAL ARE EXEMPT

FROM THE REQUIREMENTS AND PROVISIONS OF THIS SECTION. IF THE DIRECTOR OF THE ARIZONA DEPARTMENT OF HEALTH SERVICES DETERMINES THAT A HEALTH CARE FACILITY DOES NOT SERVE THE GENERAL PUBLIC, THE HEALTH CARE FACILITY SHALL BE EXEMPT FROM THE REQUIREMENTS AND PROVISIONS OF THIS SECTION IF THE FACILITY DOES NOT SERVE THE GENERAL PUBLIC.

E. SUBSECTIONS A AND B OF THIS SECTION DO NOT PREVENT A HEALTH CARE FACILITY FROM OFFERING EITHER ADDITIONAL DISCOUNTS OR ADDITIONAL LAWFUL HEALTH CARE SERVICES FOR AN ADDITIONAL COST TO A PERSON OR AN EMPLOYER PAYING DIRECTLY.

F. A HEALTH CARE FACILITY IS NOT REQUIRED TO REPORT THE DIRECT PAY PRICES TO A GOVERNMENT AGENCY OR DEPARTMENT OR TO A GOVERNMENT-AUTHORIZED OR GOVERNMENT-CREATED ENTITY FOR REVIEW. A GOVERNMENT AGENCY OR DEPARTMENT OR GOVERNMENT-AUTHORIZED OR GOVERNMENT-CREATED ENTITY MAY NOT APPROVE, DISAPPROVE OR LIMIT A HEALTH CARE FACILITY'S DIRECT PAY PRICE FOR SERVICES. A GOVERNMENT AGENCY OR DEPARTMENT OR GOVERNMENT-AUTHORIZED OR GOVERNMENT-CREATED ENTITY MAY NOT APPROVE, DISAPPROVE OR LIMIT A HEALTH CARE FACILITY'S ABILITY TO CHANGE THE PUBLISHED OR POSTED DIRECT PAY PRICE FOR SERVICES.

G. A HEALTH CARE SYSTEM MAY NOT PUNISH A PERSON OR EMPLOYER FOR PAYING DIRECTLY FOR LAWFUL HEALTH CARE SERVICES OR A HEALTH CARE FACILITY FOR ACCEPTING DIRECT PAYMENT FROM A PERSON OR EMPLOYER FOR LAWFUL HEALTH CARE SERVICES.

H. EXCEPT AS PROVIDED IN SUBSECTION K OF THIS SECTION, A HEALTH CARE FACILITY THAT RECEIVES DIRECT PAYMENT FROM A PERSON OR EMPLOYER FOR A LAWFUL HEALTH CARE SERVICE IS DEEMED PAID IN FULL IF THE ENTIRE FEE FOR THE SERVICE IS PAID AND SHALL NOT SUBMIT A CLAIM FOR PAYMENT OR REIMBURSEMENT FOR THE SERVICE TO ANY HEALTH CARE SYSTEM. THIS SUBSECTION DOES NOT PREVENT A HEALTH CARE FACILITY FROM PURSUING A HEALTH CARE LIEN FOR CUSTOMARY CHARGES PURSUANT TO TITLE 33. THIS SUBSECTION DOES NOT AFFECT THE ABILITY OF A HEALTH CARE FACILITY TO SUBMIT CLAIMS FOR THE SAME SERVICE PROVIDED ON OTHER OCCASIONS TO THE SAME OR A DIFFERENT PERSON IF NO DIRECT PAYMENT OCCURS. THIS SUBSECTION DOES NOT REQUIRE A HEALTH CARE FACILITY TO REFUND OR ADJUST ANY CAPITATED PAYMENT, BUNDLED PAYMENT OR ANY OTHER FORM OF PREPAYMENT OR GLOBAL PAYMENT MADE BY A HEALTH CARE SYSTEM TO THE HEALTH CARE FACILITY FOR LAWFUL HEALTH CARE SERVICES TO BE PROVIDED BY THE HEALTH CARE FACILITY FOR THE PERSON WHO MAKES, OR ON WHOSE BEHALF AN EMPLOYER MAKES, DIRECT PAYMENT TO THE HEALTH CARE FACILITY.

I. BEFORE A HEALTH CARE FACILITY THAT IS CONTRACTED AS A NETWORK PROVIDER FOR A HEALTH CARE SYSTEM ACCEPTS DIRECT PAYMENT FROM A PERSON OR AN EMPLOYER, AND THE PERSON IS AN ENROLLEE OF THE SAME HEALTH CARE SYSTEM, THE HEALTH CARE FACILITY SHALL OBTAIN THE PERSON'S OR EMPLOYER'S SIGNATURE ON A NOTICE IN A FORM THAT IS SUBSTANTIALLY SIMILAR TO THE FOLLOWING:

IMPORTANT NOTICE ABOUT DIRECT PAYMENT
FOR YOUR HEALTH CARE SERVICES

THE ARIZONA CONSTITUTION PERMITS YOU TO PAY A HEALTH CARE FACILITY DIRECTLY FOR HEALTH CARE SERVICES. BEFORE YOU MAKE ANY

AGREEMENT TO DO SO, PLEASE READ THE FOLLOWING IMPORTANT INFORMATION:

IF YOU ARE AN ENROLLEE OF A HEALTH CARE SYSTEM (MORE COMMONLY REFERRED TO AS A HEALTH INSURANCE PLAN) AND YOUR HEALTH CARE FACILITY IS CONTRACTED WITH THE HEALTH INSURANCE PLAN, THE FOLLOWING APPLY:

1. YOU MAY NOT BE REQUIRED TO PAY THE HEALTH CARE FACILITY DIRECTLY FOR THE SERVICES COVERED BY YOUR PLAN, EXCEPT FOR COST SHARE AMOUNTS THAT YOU ARE OBLIGATED TO PAY UNDER YOUR PLAN, SUCH AS COPAYMENTS, COINSURANCE AND DEDUCTIBLE AMOUNTS.

2. YOUR PROVIDER'S AGREEMENT WITH THE HEALTH INSURANCE PLAN MAY PREVENT THE HEALTH CARE FACILITY FROM BILLING YOU FOR THE DIFFERENCE BETWEEN THE FACILITY'S BILLED CHARGES AND THE AMOUNT ALLOWED BY YOUR HEALTH INSURANCE PLAN FOR COVERED SERVICES.

3. IF YOU PAY DIRECTLY FOR A HEALTH CARE SERVICE, YOUR HEALTH CARE FACILITY WILL NOT BE RESPONSIBLE FOR SUBMITTING CLAIM DOCUMENTATION TO YOUR HEALTH INSURANCE PLAN FOR THAT CLAIM. BEFORE PAYING YOUR CLAIM, YOUR HEALTH INSURANCE PLAN MAY REQUIRE YOU TO PROVIDE INFORMATION AND SUBMIT DOCUMENTATION NECESSARY TO DETERMINE WHETHER THE SERVICES ARE COVERED UNDER YOUR PLAN.

4. IF YOU DO NOT PAY DIRECTLY FOR A HEALTH CARE SERVICE, YOUR HEALTH CARE FACILITY MAY BE RESPONSIBLE FOR SUBMITTING CLAIM DOCUMENTATION TO YOUR HEALTH INSURANCE PLAN FOR THE HEALTH CARE SERVICE.

YOUR SIGNATURE BELOW ACKNOWLEDGES THAT YOU RECEIVED THIS NOTICE BEFORE PAYING DIRECTLY FOR A HEALTH CARE SERVICE.

J. A HEALTH CARE FACILITY THAT RECEIVES DIRECT PAYMENT FOR A LAWFUL HEALTH CARE SERVICE AND THAT COMPLIES WITH SUBSECTION I OF THIS SECTION IS NOT RESPONSIBLE FOR SUBMITTING DOCUMENTATION OF ANY KIND FOR PURPOSES OF REIMBURSEMENT TO ANY HEALTH CARE SYSTEM FOR THAT CLAIM IF THE FAILURE TO SUBMIT SUCH DOCUMENTATION DOES NOT CONFLICT WITH THE TERMS OF ANY FEDERAL OR STATE CONTRACTS TO WHICH THE HEALTH CARE SYSTEM IS A PARTY AND THE HEALTH CARE FACILITY HAS AGREED TO SERVE PATIENTS UNDER OR WITH APPLICABLE STATE OR FEDERAL PROGRAMS IN WHICH A HEALTH CARE FACILITY AND HEALTH CARE SYSTEM PARTICIPATE.

K. THIS SECTION DOES NOT IMPAIR THE PROVISIONS OF A HEALTH CARE SYSTEM'S PRIVATE HEALTH CARE NETWORK PROVIDER CONTRACT, EXCEPT THAT A HEALTH CARE FACILITY MAY ACCEPT DIRECT PAYMENT FROM A PERSON OR EMPLOYER OR MAY DECLINE TO BILL THE HEALTH CARE SYSTEM DIRECTLY FOR SERVICES PAID DIRECTLY BY A PERSON OR EMPLOYER IF THE HEALTH CARE FACILITY HAS COMPLIED WITH SUBSECTION I OF THIS SECTION AND THE HEALTH CARE FACILITY'S RECEIPT OF DIRECT PAYMENT AND THE DECLINATION TO BILL THE HEALTH CARE SYSTEM DO NOT CONFLICT WITH THE TERMS OF ANY FEDERAL OR STATE CONTRACT TO WHICH THE HEALTH CARE SYSTEM IS A PARTY AND THE HEALTH CARE FACILITY HAS AGREED TO SERVE PATIENTS UNDER OR WITH

APPLICABLE STATE OR FEDERAL PROGRAMS IN WHICH A HEALTH CARE FACILITY AND HEALTH CARE SYSTEM PARTICIPATE.

L. THIS SECTION MAY NOT PREVENT THE ARIZONA DEPARTMENT OF HEALTH SERVICES FROM PERFORMING AN INVESTIGATION OF A HEALTH CARE FACILITY UNDER THE DEPARTMENT'S POWERS AND DUTIES AS DEFINED IN TITLE 36. IF A HEALTH CARE FACILITY FAILS TO COMPLY WITH THIS SECTION, THE PENALTY SHALL NOT INCLUDE THE REVOCATION OF THE LICENSE TO DELIVER HEALTH CARE SERVICES.

M. FOR THE PURPOSES OF THIS SECTION:

1. "DIRECT PAY PRICE" MEANS THE ENTIRE PRICE THAT WILL BE CHARGED BY A HEALTH CARE FACILITY FOR A LAWFUL HEALTH CARE SERVICE, REGARDLESS OF THE HEALTH INSURANCE STATUS OF THE PERSON, IF THE ENTIRE FEE FOR THE SERVICE IS PAID IN FULL DIRECTLY TO A HEALTH CARE FACILITY BY THE PERSON, INCLUDING THE PERSON'S HEALTH SAVINGS ACCOUNT, OR BY THE PERSON'S EMPLOYER AND THAT DOES NOT PROHIBIT A FACILITY FROM ESTABLISHING A PAYMENT PLAN WITH THE PERSON PAYING DIRECTLY FOR SERVICES.

2. "ENROLLEE" MEANS A PERSON WHO IS ENROLLED IN A HEALTH CARE PLAN PROVIDED BY A HEALTH INSURER.

3. "HEALTH CARE FACILITY" MEANS A HOSPITAL, OUTPATIENT SURGICAL CENTER, HEALTH CARE LABORATORY, DIAGNOSTIC IMAGING CENTER OR URGENT CARE CENTER.

4. "HEALTH CARE PLAN" MEANS A POLICY, CONTRACT OR EVIDENCE OF COVERAGE ISSUED TO AN ENROLLEE. HEALTH CARE PLAN DOES NOT INCLUDE LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137.

5. "HEALTH CARE PROVIDER" MEANS A PERSON WHO IS LICENSED PURSUANT TO CHAPTER 7, 8, 13, 16, 17, 19 OR 34 OF TITLE 32.

6. "HEALTH CARE SYSTEM" MEANS A PUBLIC OR PRIVATE ENTITY WHOSE FUNCTION OR PURPOSE IS THE MANAGEMENT, PROCESSING OR ENROLLMENT OF INDIVIDUALS OR THE PAYMENT, IN FULL OR IN PART, OF HEALTH CARE SERVICES.

7. "HEALTH INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION, HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR HOSPITAL AND MEDICAL SERVICE CORPORATION AS DEFINED IN TITLE 20.

8. "LAWFUL HEALTH CARE SERVICES" MEANS ANY HEALTH-RELATED SERVICE OR TREATMENT, TO THE EXTENT THAT THE SERVICE OR TREATMENT IS PERMITTED OR NOT PROHIBITED BY LAW OR REGULATION, THAT MAY BE PROVIDED BY PERSONS OR BUSINESSES OTHERWISE PERMITTED TO OFFER THE SERVICES OR TREATMENTS.

9. "PUNISH" MEANS TO IMPOSE ANY PENALTY, SURCHARGE OR NAMED FEE WITH A SIMILAR EFFECT THAT IS USED TO DISCOURAGE THE EXERCISE OF RIGHTS UNDER THIS SECTION.

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

36-2903.01. <u>Additional powers and duties; report</u>

A. The director of the Arizona health care cost containment system administration may adopt rules that provide that the system may withhold or forfeit payments to be made to a noncontracting provider by the system if the noncontracting provider fails to comply with this article, the provider

agreement or rules that are adopted pursuant to this article and that relate to the specific services rendered for which a claim for payment is made.

B. The director shall:

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

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

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

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

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

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

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

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

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

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

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

4. By rule establish a procedure and time frames for the intake of grievances and requests for hearings, for the continuation of benefits and services during the appeal process and for a grievance process at the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. For inpatient hospital stays from March 1, 1993 through September 30, ~~2013~~ 2014, the administration shall use a prospective tiered per diem

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

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

3. Through June 30, 2004, for outpatient hospital services, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to the covered charges. Beginning on July 1, 2004 through June 30, 2005, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona department of health services pursuant to chapter 4, article 3 of this title, by more than 4.7 per cent for dates of service effective on or after July 1, 2004, the hospital specific cost-to-charge ratio will be

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

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

(a) An admission face sheet.

(b) An itemized statement.

(c) An admission history and physical.

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

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

(f) Operative reports, if applicable.

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

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

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

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

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

(c) If the hospital's bill is paid any time after sixty days of the date the bill was received, the administration shall pay one hundred per cent of the rate plus a fee of one per cent per month for each month or portion of

a month following the sixtieth day of receipt of the bill until the date of payment.

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

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

8. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the prospective payment of inpatient hospital capital related costs. The capital payment shall include hospital specific and statewide average amounts. For tiered per diem rates beginning on October 1, 1999, the capital related cost component is frozen at the blended rate of forty per cent of the hospital specific capital cost and sixty per cent of the statewide average capital cost in effect as of January 1, 1999 and as further adjusted by the calculation of tier rates for maternity and nursery as prescribed by law. Through September 30, 2011, the administration shall adjust the capital related cost component by the data resources incorporated market basket index for prospective payment system hospitals.

9. For graduate medical education programs:

(a) Beginning September 30, 1997, the administration shall establish a separate graduate medical education program to reimburse hospitals that had graduate medical education programs that were approved by the administration as of October 1, 1999. The administration shall separately account for monies for the graduate medical education program based on the total reimbursement for graduate medical education reimbursed to hospitals by the system in federal fiscal year 1995-1996 pursuant to the tiered per diem methodology specified in this section. The graduate medical education program reimbursement shall be adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Subject to legislative appropriation, on an annual basis, each qualified hospital shall receive a single payment from

the graduate medical education program that is equal to the same percentage of graduate medical education reimbursement that was paid by the system in federal fiscal year 1995-1996. Any reimbursement for graduate medical education made by the administration shall not be subject to future settlements or appeals by the hospitals to the administration. The monies available under this subdivision shall not exceed the fiscal year 2005-2006 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement, except for monies distributed for expansions pursuant to subdivision (b) of this paragraph.

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

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

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

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

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

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

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

(e) Each graduate medical education program that receives funding pursuant to subdivision (b) or (c) of this paragraph shall identify and report to the administration the number of new residency positions created by the funding provided in this paragraph, including positions in rural areas.

The program shall also report information related to the number of funded residency positions that resulted in physicians locating their practice in this state. The administration shall report to the joint legislative budget committee by February 1 of each year on the number of new residency positions as reported by the graduate medical education programs.

(f) Local, county and tribal governments and any university under the jurisdiction of the Arizona board of regents may provide monies in addition to any state general fund monies appropriated for graduate medical education in order to qualify for additional matching federal monies for providers, programs or positions in a specific locality and costs incurred pursuant to a specific contract between the administration and providers or other entities to provide graduate medical education services as an administrative activity. Payments by the administration pursuant to this subdivision may be limited to those providers designated by the funding entity and may be based on any methodology deemed appropriate by the administration, including replacing any payments that might otherwise have been paid pursuant to subdivision (a), (b) or (c) of this paragraph had sufficient state general fund monies or other monies been appropriated to fully fund those payments. These programs, positions, payment methodologies and administrative graduate medical education services must be approved by the administration and the centers for medicare and medicaid services. The administration shall report to the president of the senate, the speaker of the house of representatives and the director of the joint legislative budget committee on or before July 1 of each year on the amount of money contributed and number of residency positions funded by local, county and tribal governments, including the amount of federal matching monies used.

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

10. Notwithstanding section 41-1005, subsection A, paragraph 9, the administration shall adopt rules pursuant to title 41, chapter 6 establishing the methodology for determining the prospective tiered per diem payments that are in effect through September 30, ~~2013~~ 2014.

11. For inpatient hospital services rendered on or after October 1, 2011, the prospective tiered per diem payment rates are permanently reset to the amounts payable for those services as of ~~September 30~~ OCTOBER 1, 2011 pursuant to this subsection.

12. The administration shall ~~obtain legislative approval before adopting~~ ADOPT a DIAGNOSIS-RELATED GROUP BASED hospital reimbursement methodology consistent with title XIX of the social security act for inpatient dates of service on and after October 1, ~~2013~~ 2014. THE ADMINISTRATION MAY MAKE ADDITIONAL ADJUSTMENTS TO THE INPATIENT HOSPITAL RATES ESTABLISHED PURSUANT TO THIS SECTION FOR HOSPITALS THAT ARE PUBLICLY OPERATED OR BASED ON OTHER FACTORS, INCLUDING THE NUMBER OF BEDS IN THE HOSPITAL, THE SPECIALTY SERVICES AVAILABLE TO PATIENTS, THE GEOGRAPHIC

LOCATION AND DIAGNOSIS-RELATED GROUP CODES THAT ARE MADE PUBLICLY AVAILABLE BY THE HOSPITAL PURSUANT TO SECTION 36-437. THE ADMINISTRATION MAY ALSO PROVIDE ADDITIONAL REIMBURSEMENT FOR EXTRAORDINARILY HIGH COST CASES THAT EXCEED A THRESHOLD ABOVE THE STANDARD PAYMENT. THE ADMINISTRATION MAY ALSO ESTABLISH A SEPARATE PAYMENT METHODOLOGY FOR SPECIFIC SERVICES OR HOSPITALS SERVING UNIQUE POPULATIONS.

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

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

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

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

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

K. The administration shall establish procedures to apply to the following if a provider that has a contract with a contractor or noncontracting provider seeks to collect from an individual or financially

1 responsible relative or representative a claim that exceeds the amount that
2 is reimbursed or should be reimbursed by the system:
3 1. On written notice from the administration or oral or written notice
4 from a member that a claim for covered services may be in violation of this
5 section, the provider that has a contract with a contractor or noncontracting
6 provider shall investigate the inquiry and verify whether the person was
7 eligible for services at the time that covered services were provided. If
8 the claim was paid or should have been paid by the system, the provider that
9 has a contract with a contractor or noncontracting provider shall not
10 continue billing the member.
11 2. If the claim was paid or should have been paid by the system and
12 the disputed claim has been referred for collection to a collection agency or
13 referred to a credit reporting bureau, the provider that has a contract with
14 a contractor or noncontracting provider shall:
15 (a) Notify the collection agency and request that all attempts to
16 collect this specific charge be terminated immediately.
17 (b) Advise all credit reporting bureaus that the reported delinquency
18 was in error and request that the affected credit report be corrected to
19 remove any notation about this specific delinquency.
20 (c) Notify the administration and the member that the request for
21 payment was in error and that the collection agency and credit reporting
22 bureaus have been notified.
23 3. If the administration determines that a provider that has a
24 contract with a contractor or noncontracting provider has billed a member for
25 charges that were paid or should have been paid by the administration, the
26 administration shall send written notification by certified mail or other
27 service with proof of delivery to the provider that has a contract with a
28 contractor or noncontracting provider stating that this billing is in
29 violation of federal and state law. If, twenty-one days or more after
30 receiving the notification, a provider that has a contract with a contractor
31 or noncontracting provider knowingly continues billing a member for charges
32 that were paid or should have been paid by the system, the administration may
33 assess a civil penalty in an amount equal to three times the amount of the
34 billing and reduce payment to the provider that has a contract with a
35 contractor or noncontracting provider accordingly. Receipt of delivery
36 signed by the addressee or the addressee's employee is prima facie evidence
37 of knowledge. Civil penalties collected pursuant to this subsection shall be
38 deposited in the state general fund. Section 36-2918, subsections C, D and
39 F, relating to the imposition, collection and enforcement of civil penalties,
40 apply to civil penalties imposed pursuant to this paragraph.
41 L. The administration may conduct postpayment review of all claims
42 paid by the administration and may recoup any monies erroneously paid. The
43 director may adopt rules that specify procedures for conducting postpayment
44 review. A contractor may conduct a postpayment review of all claims paid by
45 the contractor and may recoup monies that are erroneously paid.

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

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

O. Notwithstanding any other law, on federal approval the administration may make disproportionate share payments to private hospitals, county operated hospitals, including hospitals owned or leased by a special health care district, and state operated institutions for mental disease beginning October 1, 1991 in accordance with federal law and subject to legislative appropriation. If at any time the administration receives written notification from federal authorities of any change or difference in the actual or estimated amount of federal funds available for disproportionate share payments from the amount reflected in the legislative appropriation for such purposes, the administration shall provide written notification of such change or difference to the president and the minority leader of the senate, the speaker and the minority leader of the house of representatives, the director of the joint legislative budget committee, the legislative committee of reference and any hospital trade association within this state, within three working days not including weekends after receipt of the notice of the change or difference. In calculating disproportionate share payments as prescribed in this section, the administration may use either a methodology based on claims and encounter data that is submitted to the administration from contractors or a methodology based on data that is reported to the administration by private hospitals and state operated institutions for mental disease. The selected methodology applies to all private hospitals and state operated institutions for mental disease qualifying for disproportionate share payments. For the purposes of this subsection, "disproportionate share payment" means a payment to a hospital that serves a disproportionate share of low-income patients as described by 42 United States Code section 1396r-4.

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

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

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

S. In addition to any requirements adopted pursuant to subsection D, paragraph 4 of this section, notwithstanding any other law, subject to approval by the centers for medicare and medicaid services, beginning July 1, 2011, members eligible pursuant to section 36-2901, paragraph 6, subdivision

(a), section 36-2931 and section 36-2981, paragraph 6 shall pay the following:

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

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

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

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

Sec. 4. Reimbursement methodology; budget neutrality

It is the intent of the legislature that the reimbursement methodology developed by the Arizona health care cost containment system administration pursuant to this act be budget neutral in the aggregate. The administration may consider the unique financial characteristics of particular hospitals, including low patient volume of rural hospitals, when developing the payment methodology.

Sec. 5. Payment methodology report

For contract years 2015 through 2019, the Arizona health care cost containment system administration is required to report on the implementation of the new payment methodology authorized by this act, including any concerns raised by hospitals and any realized costs savings. The administration is required to submit its report by October 1 of each year to the governor, the president of the senate and the speaker of the house of representatives, together with the chairpersons of the house and senate health committees.

Sec. 6. Prospective changes; payment methodology

Prior to changing the type of payment methodology the Arizona health care cost containment system administration utilizes to reimburse hospitals for inpatient services beyond those authorized by this act, the administration is required to obtain legislative authorization. This section is not intended to preclude the administration from making necessary adjustments for the implementation and ongoing administration of the diagnosis-related group based payment methodology as authorized by this act.

Sec. 7. Delayed repeal

Sections 32-3216 and 36-437, Arizona Revised Statutes, as added by this act, are repealed from and after December 31, 2021.

Sec. 8. Effective date

Sections 32-3216 and 36-437, Arizona Revised Statutes, as added by this act, are effective from and after December 31, 2013.

Sec. 9. Severability

If any provision or clause of sections 32-3216 and 36-437, Arizona Revised Statutes, as added by this act, or the application of these sections to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of sections 32-3216 and 36-437, Arizona Revised Statutes, as added by this act, that can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

APPROVED BY THE GOVERNOR JUNE 19, 2013.

FILED IN THE OFFICE OF THE SECRETARY OF STATE JUNE 19, 2013.