

State of Arizona
House of Representatives
Forty-eighth Legislature
Second Regular Session
2008

HOUSE BILL 2208

AN ACT

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

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

4 36-2903.01. Additional powers and duties; report

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

11 B. The director shall:

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

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

25 3. Enter into an intergovernmental agreement with the department to:
26 (a) Establish an expedited eligibility and enrollment process for all
27 persons who are hospitalized at the time of application.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

39 9. For graduate medical education programs:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

26 K. The director shall establish a special unit within the
27 administration for the purpose of monitoring the third party payment
28 collections required by contractors and noncontracting providers pursuant to
29 section 36-2903, subsection B, paragraph 10 and subsection F and section
30 36-2915, subsection E. The director shall determine by rule:

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

33 2. The percentage of third party payments that is collected by a
34 contractor or noncontracting provider and that the contractor or
35 noncontracting provider may keep and the percentage of such payments that the
36 contractor or noncontracting provider may be required to pay to the
37 administration. Contractors and noncontracting providers must pay to the
38 administration one hundred per cent of all third party payments that are
39 collected and that duplicate administration fee-for-service payments. A
40 contractor that contracts with the administration pursuant to section
41 36-2904, subsection A may be entitled to retain a percentage of third party
42 payments if the payments collected and retained by a contractor are reflected
43 in reduced capitation rates. A contractor may be required to pay the
44 administration a percentage of third party payments that are collected by a
45 contractor and that are not reflected in reduced capitation rates.

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

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

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

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

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

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

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

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

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

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

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

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

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

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