

State of Arizona
Senate
Forty-fifth Legislature
First Regular Session
2001

CHAPTER 344

SENATE BILL 1577

AN ACT

AMENDING SECTIONS 1-215, 8-114.01, 8-142.01, 8-512, 11-251, 11-291, 11-292, 11-293, 11-1431, 11-1434, 20-282, 20-283, 20-291, 20-826 AND 20-934, ARIZONA REVISED STATUTES; AMENDING SECTION 20-1057, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2000, CHAPTER 37, SECTION 15 AND CHAPTER 282, SECTION 3; AMENDING SECTION 20-1342, ARIZONA REVISED STATUTES; AMENDING SECTION 20-1379, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2000, CHAPTER 355, SECTION 10; AMENDING SECTIONS 20-1402 AND 20-1404, ARIZONA REVISED STATUTES; AMENDING SECTION 20-2301, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2000, CHAPTER 355, SECTION 11; AMENDING SECTIONS 20-2321, 28-907, 36-183.01, 36-210, 36-263, 36-551, 36-774, 36-2901, 36-2902.02, 36-2903, 36-2903.01, 36-2903.02, 36-2903.03, 36-2903.04, 36-2904, 36-2905.04, 36-2905.06, 36-2906, 36-2906.01, 36-2907, 36-2907.04, 36-2907.06, 36-2907.08, 36-2907.10, 36-2907.11, 36-2907.12, 36-2908, 36-2909, 36-2910, 36-2911, 36-2912, 36-2912.04, 36-2913, 36-2915, 36-2917, 36-2918, 36-2918.01, 36-2920, 36-2921, 36-2922, 36-2923, 36-2934, 36-2935, 36-2939, 36-2971, 36-2972, 36-2973, 36-2974, 36-2975, 36-2976, 36-2982, 36-2983, 36-2986, 36-2987, 36-2989, 36-3408, 36-3411, 36-3414, 41-1377, 41-1378, 41-1954, 41-2501, 42-11101 AND 46-134, ARIZONA REVISED STATUTES; AMENDING LAWS 1999, FIRST SPECIAL SESSION, CHAPTER 1, SECTION 7; AMENDING LAWS 1999, CHAPTER 176, SECTION 14; AMENDING LAWS 2001, CHAPTER 236, SECTION 7; REPEALING LAWS 2001, CHAPTER 232, SECTION 20; REPEALING SECTIONS 11-290, 11-291.01, 11-297, 11-297.01, 11-297.02, 11-297.03, 11-297.04, 11-297.05, 11-297.06, 11-298, 11-300, 36-2905, 36-2905.01, 36-2905.02, 36-2905.03, 36-2905.05 AND 36-2997, ARIZONA REVISED

STATUTES; REPEALING SECTION 20-1057, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2000, CHAPTER 355, SECTION 5; AMENDING TITLE 11, CHAPTER 2, ARTICLE 4, ARIZONA REVISED STATUTES, BY ADDING SECTION 11-254.03; AMENDING TITLE 11, CHAPTER 2, ARTICLE 7, ARIZONA REVISED STATUTES, BY ADDING NEW SECTIONS 11-297 AND 11-300; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 36-2901.03, 36-2901.04 AND 36-2928; MAKING APPROPRIATIONS; BLENDING MULTIPLE ENACTMENTS; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Section 1-215, Arizona Revised Statutes, is amended to
3 read:

4 1-215. Definitions

5 In the statutes and laws of the state, unless the context otherwise
6 requires:

7 1. "Action" includes any matter or proceeding in a court, civil or
8 criminal.

9 2. "Adopted rule" means a final rule as defined in section 41-1001.

10 3. "Adult" means a person who has attained the age of eighteen years.

11 4. "Alternative fuel" means:

12 (a) Electricity.

13 (b) Solar energy.

14 (c) Liquefied petroleum gas, natural gas, hydrogen or a blend of
15 hydrogen with liquefied petroleum or natural gas that complies with either
16 of the following:

17 (i) Is used in an engine that is certified to meet at a minimum the
18 United States environmental protection agency low emission vehicle standard
19 pursuant to 40 Code of Federal Regulations section 88.104-94 or 88.105-94.

20 (ii) Is used in an engine that is certified by the engine modifier to
21 meet the addendum to memorandum 1-A of the United States environmental
22 protection agency.

23 (d) Only for vehicles that use alcohol fuels before August 21, 1998,
24 alcohol fuels that contain not less than eighty-five per cent alcohol by
25 volume.

26 (e) A combination of at least seventy per cent alternative fuel and
27 no more than thirty per cent petroleum based fuel and that operates in an
28 engine that meets the United States environmental protection agency low
29 emission vehicle standard pursuant to 40 Code of Federal Regulations section
30 88.104-94 or 88.105-94 and is certified by the engine manufacturer to consume
31 at least seventy per cent alternative fuel during normal vehicle operations.

32 5. "Bribe" signifies anything of value or advantage, present or
33 prospective, asked, offered, given, accepted or promised with a corrupt
34 intent to influence, unlawfully, the person to whom it is given in his THAT
35 PERSON'S action, vote or opinion, in any public or official capacity.

36 6. "Child" or "children" as used in reference to age of persons means
37 persons under the age of eighteen years.

38 7. "Clean burning fuel" means:

39 (a) An emulsion of water-phased hydrocarbon fuel that contains not
40 less than twenty per cent water by volume and that complies with any of the
41 following:

42 (i) Is used in an engine that is certified to meet at a minimum the
43 United States environmental protection agency low emission vehicle standard
44 pursuant to 40 Code of Federal Regulations section 88.104-94 or 88.105-94.

1 (ii) Is used in an engine that is certified by the engine modifier to
2 meet the addendum to memorandum 1-A of the United States environmental
3 protection agency.

4 (iii) Is used in an engine that is the subject of a waiver for that
5 specific engine application from the United States environmental protection
6 agency's memorandum 1-A addendum requirements and that waiver is documented
7 to the reasonable satisfaction of the department of commerce energy office.

8 (b) A diesel fuel substitute that is produced from nonpetroleum
9 renewable resources if the qualifying volume of the nonpetroleum renewable
10 resources meets the standards for California diesel fuel as adopted by the
11 California air resources board pursuant to 13 California code of regulations
12 sections 2281 and 2282 in effect on January 1, 2000, and the diesel fuel
13 substitute meets the registration requirement for fuels and additives
14 established by the environmental protection agency pursuant to section 211
15 of the clean air act as defined in section 49-401.01 and the use of the
16 diesel fuel substitute complies with the requirements listed in 10 Code of
17 Federal Regulations part 490, as printed in the federal register, volume 64,
18 number 96, May 19, 1999.

19 8. "Corruptly" imports a wrongful design to acquire or cause some
20 pecuniary or other advantage to the person guilty of the act or omission
21 referred to, or to some other person.

22 9. "Daytime" means the period between sunrise and sunset.

23 10. "Depose" includes every manner of written statement under oath or
24 affirmation.

25 11. "FEDERAL POVERTY GUIDELINES" MEANS THE GUIDELINES AS UPDATED
26 ANNUALLY IN THE FEDERAL REGISTER BY THE UNITED STATES DEPARTMENT OF HEALTH
27 AND HUMAN SERVICES.

28 ~~11.~~ 12. "Grantee" includes every person to whom an estate or interest
29 in real property passes, in or by a deed.

30 ~~12.~~ 13. "Grantor" includes every person from or by whom an estate or
31 interest in real property passes, in or by a deed.

32 ~~13.~~ 14. "Includes" or "including" means not limited to and is not a
33 term of exclusion.

34 ~~14.~~ 15. "Inhabitant" means a resident of a city, town, village,
35 district, county or precinct.

36 ~~15.~~ 16. "Issue" as used in connection with descent of estates includes
37 all lawful, lineal descendants of the ancestor.

38 ~~16.~~ 17. "Knowingly" imports only a knowledge that the facts exist
39 which THAT bring the act or omission within the provisions of the statute
40 using such word. It does not require any knowledge of the unlawfulness of
41 the act or omission.

42 ~~17.~~ 18. "Magistrate" means an officer having power to issue a warrant
43 for the arrest of a person charged with a public offense and includes the

1 chief justice and judges of the supreme court, judges of the superior court,
2 justices of the peace and police magistrates in cities and towns.

3 ~~18.~~ 19. "Majority" or "age of majority" as used in reference to age
4 of persons means the age of eighteen years or more.

5 ~~19.~~ 20. "Malice" and "maliciously" import a wish to vex, annoy or
6 injure another person, or an intent to do a wrongful act, established either
7 by proof or presumption of law.

8 ~~20.~~ 21. "Mentally ill person" includes an idiot, an insane person, a
9 lunatic or a person non compos.

10 ~~21.~~ 22. "Minor" means a person under the age of eighteen years.

11 ~~22.~~ 23. "Minor children" means persons under the age of eighteen
12 years.

13 ~~23.~~ 24. "Month" means a calendar month unless otherwise expressed.

14 ~~24.~~ 25. "Neglect," "negligence," "negligent" and "negligently" import
15 a want of such attention to the nature or probable consequence of the act or
16 omission as a prudent man ordinarily bestows in acting in his own concerns.

17 ~~25.~~ 26. "Nighttime" means the period between sunset and sunrise.

18 ~~26.~~ 27. "Oath" includes affirmation or declaration.

19 ~~27.~~ 28. "Peace officers" means sheriffs of counties, constables,
20 marshals, policemen of cities and towns, commissioned personnel of the
21 department of public safety, peace officers who are appointed by a
22 multi-county water conservation district and who have received a certificate
23 from the Arizona peace officer standards and training board, police officers
24 who are appointed by community college district governing boards and who have
25 received a certificate from the Arizona peace officer standards and training
26 board and police officers who are appointed by the Arizona board of regents
27 and who have received a certificate from the Arizona peace officer standards
28 and training board.

29 ~~28.~~ 29. "Person" includes a corporation, company, partnership, firm,
30 association or society, as well as a natural person. When the word "person"
31 is used to designate the party whose property may be the subject of a
32 criminal or public offense, the term includes the United States, this state,
33 or any territory, state or country, or any political subdivision of this
34 state which THAT may lawfully own any property, or a public or private
35 corporation, or partnership or association. When the word "person" is used
36 to designate the violator or offender of any law, it includes corporation,
37 partnership or any association of persons.

38 ~~29.~~ 30. "Personal property" includes money, goods, chattels, dogs,
39 things in action and evidences of debt.

40 ~~30.~~ 31. "Population" means the population according to the most recent
41 United States decennial census.

42 ~~31.~~ 32. "Process" means a citation, writ or summons issued in the
43 course of judicial proceedings.

44 ~~32.~~ 33. "Property" includes both real and personal property.

1 33. 34. "Real property" is coextensive with lands, tenements and
2 hereditaments.

3 34. 35. "Registered mail" includes certified mail.

4 35. 36. "Seal" as used in reference to a paper issuing from a court
5 or public office to which the seal of such court or office is required to be
6 affixed means the impression on that paper and the impression of the seal
7 affixed to that paper by a wafer or wax.

8 36. 37. "Signature" or "subscription" includes mark, if a person
9 cannot write, with the person's name written near it and witnessed by a
10 person who writes the person's own name as witness.

11 37. 38. "State" as applied to the different parts of the United
12 States, includes the District of Columbia, this state and the territories.

13 38. 39. "Testify" includes every manner of oral statement under oath
14 or affirmation.

15 39. 40. "United States" includes the District of Columbia and the
16 territories.

17 40. 41. "Vessel", as used in reference to shipping, includes ships of
18 all kinds, steamboats, steamships, barges, canal boats and every structure
19 adapted to navigation from place to place for the transportation of persons
20 or property.

21 41. 42. "Wilfully" means, with respect to conduct or to a circumstance
22 described by a statute defining an offense, that a person is aware or
23 believes that the person's conduct is of that nature or that the circumstance
24 exists.

25 42. 43. "Will" includes codicils.

26 43. 44. "Workers' compensation" means workmen's compensation as used
27 in article XVIII, section 8, Constitution of Arizona.

28 44. 45. "Writ" signifies an order or precept in writing issued in the
29 name of the state or by a court or judicial officer.

30 45. 46. "Writing" includes printing.

31 Sec. 2. Section 8-114.01, Arizona Revised Statutes, is amended to
32 read:

33 8-114.01. Monies paid to or for parent; interstate adoption
34 placements

35 A. A sending agency located in this state or an attorney licensed to
36 practice in this state assisting in a direct placement adoption, not more
37 than thirty days after a petition to adopt a child is heard, shall provide
38 to the ~~interstate compact on the placement of children~~ SENDING AGENCY under
39 chapter 5, article 4 of this title a verified accounting, in a form specified
40 by court rules, of all payments, disbursements or commitments of anything of
41 value made or agreed to be made by the prospective adoptive parent to or for
42 the benefit of the birth parent in connection with the adoption. The
43 accounting shall include costs for medical and hospital care, examinations
44 for the mother and child, counseling fees, legal fees and agency fees. If

1 the mother and child have received medical services pursuant to title 36,
2 chapter 29, not including services made available to persons defined as
3 eligible under section 36-2901, paragraph 4-6, subdivisions ~~(d), (e), (f)~~
4 and ~~(g)~~ (b), (c), (d) AND (e), the sending agency or an attorney licensed to
5 practice in this state assisting in a direct placement adoption shall include
6 this information in its verified accounting.

7 B. The interstate compact on the placement of children under chapter
8 5, article 4 of this title shall notify the state bar of noncompliance with
9 subsection A of this section on the part of an attorney licensed to practice
10 in this state assisting in a direct placement adoption.

11 C. This section does not apply to placements or adoptions made by the
12 division.

13 Sec. 3. Section 8-142.01, Arizona Revised Statutes, is amended to
14 read:

15 8-142.01. Adoption subsidy program; hospital reimbursement

16 A. Notwithstanding section 8-144, subsection B, for inpatient hospital
17 admissions and outpatient hospital services on or after March 1, 1993, the
18 department shall reimburse a hospital according to the tiered per diem rates
19 and outpatient cost-to-charge ratios established by the Arizona health care
20 cost containment system pursuant to section 36-2903.01, subsection ~~J~~ H.

21 B. The department shall use the Arizona health care cost containment
22 system rates as identified in subsection A of this section for any child
23 enrolled in the adoption subsidy program. This requirement shall not be
24 construed to expand the liability of the adoption subsidy program beyond
25 eligible preexisting conditions on an adoption subsidy agreement entered into
26 between the department and the adoptive parent.

27 C. A hospital bill is considered received for purposes of subsection
28 E of this section upon initial receipt of the legible, error-free claim form
29 by the department if the claim includes the following error-free
30 documentation in legible form:

- 31 1. An admission face sheet.
- 32 2. An itemized statement.
- 33 3. An admission history and physical.
- 34 4. A discharge summary or an interim summary if the claim is split.
- 35 5. An emergency record, if admission was through the emergency room.
- 36 6. Operative reports, if applicable.
- 37 7. A labor and delivery room report, if applicable.

38 D. The department shall require that the hospital pursue other third
39 party payors prior to BEFORE submitting a claim to the department. Payment
40 received by a hospital from the department pursuant to this section is
41 considered payment by the department of the department's liability for the
42 hospital bill. A hospital may collect any unpaid portion of its bill from
43 other third party payors or in situations covered by title 33, chapter 7,
44 article 3.

1 E. For inpatient hospital admissions and outpatient hospital services
2 rendered on and after October 1, 1997, if the department receives the claim
3 directly from the hospital for services rendered, the department shall pay
4 a hospital's rate established according to this section subject to the
5 following:

6 1. If the hospital's bill is paid within thirty days of the date the
7 bill was received, the department shall pay ninety-nine per cent of the rate.

8 2. If the hospital's bill is paid after thirty days but within sixty
9 days of the date the bill was received, the department shall pay one hundred
10 per cent of the rate.

11 3. If the hospital's bill is paid any time after sixty days of the
12 date the bill was received, the department shall pay one hundred per cent of
13 the rate plus a fee of one per cent per month for each month or portion of
14 a month following the sixtieth day of receipt of the bill until the date of
15 payment.

16 F. For medical services other than those for which a rate has been
17 established pursuant to section 36-2903.01, subsection J-H, the department
18 shall pay according to the Arizona health care cost containment system capped
19 fee-for-service schedule adopted pursuant to section 36-2904, subsection M-
20 L.

21 G. For any hospital or medical claims not covered under subsection A
22 or F of this section, the department shall establish and adopt a schedule
23 setting out maximum allowable fees which THAT the department deems reasonable
24 for such services after appropriate study and analysis of usual and customary
25 fees charged by providers.

26 Sec. 4. Section 8-512, Arizona Revised Statutes, is amended to read:

27 8-512. Comprehensive medical and dental care; guidelines

28 A. The department shall provide comprehensive medical and dental care,
29 as prescribed by rules of the department, for each child:

30 1. Placed in a foster home.

31 2. In the custody of the department and placed with a relative.

32 3. In the custody of the department and placed in a certified adoptive
33 home prior to BEFORE the entry of the final order of adoption.

34 4. In the custody of the department and in an independent living
35 program as provided in section 8-521.

36 5. In the custody of a probation department and placed in foster
37 care. The department shall not provide this care if the cost exceeds funds
38 currently appropriated and available for that purpose.

39 B. The care may include, but is not limited to:

40 1. A program of regular health examinations and immunizations
41 including as minimums:

42 (a) Vaccinations to prevent mumps, rubella, smallpox and polio.

43 (b) Tests for anemia, coccidioidomycosis and tuberculosis.

44 (c) Urinalysis, blood count and hemoglobin tests.

1 (d) Regular examinations for general health, hearing and vision,
2 including providing corrective devices when needed.

3 2. Inpatient and outpatient hospital care.

4 3. Necessary services of physicians, surgeons, psychologists and
5 psychiatrists.

6 4. Dental care consisting of at least oral examinations including
7 diagnostic radiographs, oral prophylaxis and topical fluoride applications,
8 restoration of permanent and primary teeth, pulp therapy, extraction when
9 necessary, fixed space maintainers where needed and other services for relief
10 of pain and infection.

11 5. Drug prescription service.

12 C. The facilities of any hospital or other institution within the
13 state, public or private, may be employed by the foster parent, relative,
14 certified adoptive parent, agency or division having responsibility for the
15 care of the child.

16 D. For inpatient hospital admissions and outpatient hospital services
17 on or after March 1, 1993, the department shall reimburse a hospital
18 according to the tiered per diem rates and outpatient cost-to-charge ratios
19 established by the Arizona health care cost containment system pursuant to
20 section 36-2903.01, subsection J-H.

21 E. The department shall use the Arizona health care cost containment
22 system rates as identified in subsection D of this section for any child
23 eligible for services under this section.

24 F. A hospital bill is considered received for purposes of subsection
25 H of this section upon initial receipt of the legible, error-free claim form
26 by the department if the claim includes the following error-free
27 documentation in legible form:

28 1. An admission face sheet.

29 2. An itemized statement.

30 3. An admission history and physical.

31 4. A discharge summary or an interim summary if the claim is split.

32 5. An emergency record, if admission was through the emergency room.

33 6. Operative reports, if applicable.

34 7. A labor and delivery room report, if applicable.

35 G. The department shall require that the hospital pursue other third
36 party payors ~~prior to~~ BEFORE submitting a claim to the department. Payment
37 received by a hospital from the department is considered payment by the
38 department of the department's liability for the hospital bill. A hospital
39 may collect any unpaid portion of its bill from other third party payors or
40 in situations covered by title 33, chapter 7, article 3.

41 H. For inpatient hospital admissions and outpatient hospital services
42 rendered on and after October 1, 1997, the department shall pay a hospital's
43 rate established according to this section subject to the following:

1 1. If the hospital's bill is paid within thirty days of the date the
2 bill was received, the department shall pay ninety-nine per cent of the rate.

3 2. If the hospital's bill is paid after thirty days but within sixty
4 days of the date the bill was received, the department shall pay one hundred
5 per cent of the rate.

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

11 I. For medical services other than those for which a rate has been
12 established pursuant to section 36-2903.01, subsection ~~J~~ H, the department
13 shall pay according to the Arizona health care cost containment system capped
14 fee -for -service schedule adopted pursuant to section 36-2904,
15 subsection ~~M~~ L.

16 J. For any hospital or medical claims not covered under subsection D
17 or I of this section, the department shall establish and adopt a schedule
18 setting out maximum allowable fees which THAT the department deems reasonable
19 for such services after appropriate study and analysis of usual and customary
20 fees charged by providers. The department shall not pay to any plan or
21 intermediary that portion of the cost of any service provided which THAT
22 exceeds allowable charges prescribed by the department pursuant to this
23 subsection.

24 K. The department shall not pay claims for services pursuant to this
25 section which THAT are submitted more than one hundred eighty days after the
26 date of the service for which the payment is claimed.

27 L. The department may provide for payment through an insurance plan,
28 hospital service plan, medical service plan, or any other health service plan
29 authorized to do business in this state, fiscal intermediary or a combination
30 of such plans or methods. The state shall not be liable for and the
31 department shall not pay to any plan or intermediary any portion of the cost
32 of comprehensive medical and dental care in excess of funds appropriated and
33 available for such purpose at the time the plan or intermediary incurs the
34 expense for such care.

35 M. The total amount of state monies that may be spent in any fiscal
36 year by the department for comprehensive medical and dental care shall not
37 exceed the amount appropriated or authorized by section 35-173 for that
38 purpose. This section shall not be construed to impose a duty on an officer,
39 agent or employee of this state to discharge a responsibility or to create
40 any right in a person or group if the discharge or right would require an
41 expenditure of state monies in excess of the expenditure authorized by
42 legislative appropriation for that specific purpose.

1 Sec. 5. Section 11-251, Arizona Revised Statutes, is amended to read:
2 11-251. Powers of board

3 The board of supervisors, under such limitations and restrictions as
4 are prescribed by law, may:

5 1. Supervise the official conduct of all county officers and officers
6 of all districts and other subdivisions of the county charged with assessing,
7 collecting, safekeeping, managing or disbursing the public revenues, see that
8 such officers faithfully perform their duties and direct prosecutions for
9 delinquencies, and, when necessary, require the officers to renew their
10 official bonds, make reports and present their books and accounts for
11 inspection.

12 2. Divide the counties into such districts or precincts as required
13 by law, change them and create others as convenience requires.

14 3. Establish, abolish and change election precincts, appoint
15 inspectors and judges of elections, canvass election returns, declare the
16 result and issue certificates thereof.

17 4. Lay out, maintain, control and manage public roads, ferries and
18 bridges within the county and levy such tax therefor FOR THAT PURPOSE as may
19 be authorized by law.

20 5. Provide for the care and maintenance of the indigent sick of the
21 county, erect and maintain hospitals therefor FOR THAT PURPOSE and, in its
22 discretion, provide a farm in connection with the county hospital and adopt
23 ordinances for working the farm.

24 6. Provide suitable rooms for county purposes.

25 7. Purchase, receive by donation or lease real or personal property
26 necessary for the use of the county prison and take care of, manage and
27 control the property, but no purchase of real property shall be made unless
28 the value has been previously estimated by three disinterested citizens of
29 the county, appointed by the board for that purpose, and no more than the
30 appraised value shall be paid therefor FOR THE PROPERTY.

31 8. Cause to be erected and furnished a courthouse, jail and hospital
32 and such other buildings as necessary, and construct and establish a branch
33 jail, when necessary, at a point distant from the county seat.

34 9. Sell at public auction, after thirty days' previous notice given
35 by publication in a newspaper of the county, stating the time and place of
36 the auction, and convey to the highest bidder, for cash or contract of
37 purchase extending not more than ten years from the date of sale and upon
38 such terms and conditions and for such consideration as the board shall
39 prescribe, any property belonging to the county which THAT the board deems
40 advantageous for the county to sell, or which the board deems unnecessary for
41 use by the county, and shall pay the proceeds thereof into the county
42 treasury for use of the county, except that personal property need not be
43 sold but may be used as a trade-in on the purchase of personal property when
44 the board deems this disposition of the personal property to be in the best

1 interests of the county. When the property for sale is real property, the
2 board shall have such property appraised by a qualified independent fee
3 appraiser who has an office located in this state. The appraiser shall
4 establish a minimum price, which shall ~~in no instance~~ NOT be less than ninety
5 per cent of the appraised value. The notice regarding the sale of real
6 property shall be published in the county where the property is situated and
7 may be published in one or more other counties, and shall contain, among
8 other things, the appraised value, the minimum acceptable sale price, and the
9 common and legal description of the real property. Notwithstanding the
10 requirement for a sale at public auction prescribed in this paragraph, a
11 county may with unanimous consent of the board, without a public auction,
12 sell or lease any county property to any other duly constituted governmental
13 entity, including the state, cities, towns and other counties. A county may
14 with unanimous consent of the board, without public auction, sell or lease
15 any county property for a specific use to any solely charitable, social or
16 benevolent nonprofit organization incorporated or operating in this state. A
17 county may dispose of surplus equipment and materials that have little or no
18 value or are unauctionable in any manner authorized by the board.

19 10. Examine and exhibit the accounts of all officers having the care,
20 management, collection or disbursement of money belonging to the county or
21 appropriated by law or otherwise for the use and benefit of the county.

22 11. Examine, settle and allow all accounts legally chargeable against
23 the county, order warrants to be drawn on the county treasurer therefor FOR
24 THAT PURPOSE and provide for issuing the warrants.

25 12. Levy such tax annually on the taxable property of the county as may
26 be necessary to defray the general current expenses thereof, including
27 salaries otherwise unprovided for, and levy such other taxes as are required
28 to be levied by law.

29 13. Equalize assessments.

30 14. Direct and control the prosecution and defense of all actions to
31 which the county is a party, and compromise them.

32 15. Insure the county buildings in the name of and for the benefit of
33 the county.

34 16. Fill by appointment all vacancies occurring in county or precinct
35 offices.

36 17. Adopt provisions necessary to preserve the health of the county,
37 and provide for the expenses thereof.

38 18. With the approval of the department of health services, contract
39 with any qualified person to provide all or part of the health services,
40 funded through the department of health services with federal or state
41 monies, that the board in its discretion extends to residents of the county.

42 19. Contract for county printing and advertising, and provide books and
43 stationery for county officers.

1 20. Provide for rebinding county records, or, if necessary, the
2 transcribing of county records.

3 21. Make and enforce necessary rules and regulations for the government
4 of its body, the preservation of order and the transaction of business.

5 22. Adopt a seal for the board, a description and impression of which
6 shall be filed by the clerk in the office of the county recorder and the
7 secretary of state.

8 23. Establish, maintain and conduct or aid in establishing, maintaining
9 and conducting public aviation fields, purchase, receive by donation or lease
10 any property necessary therefor FOR THAT PURPOSE, lease, at a nominal rental
11 if desired, sell such aviation fields or property to the United States or any
12 department thereof, or sell or lease such aviation fields to a city, exchange
13 lands acquired pursuant to this section for other lands, or act in
14 conjunction with the United States in maintaining, managing and conducting
15 all thereof, and, when SUCH PROPERTY. IF any such property or part thereof
16 OF THAT PROPERTY is not needed for the THESE purposes herein mentioned, it
17 shall be sold by the board and the proceeds SHALL BE paid into the general
18 fund of the county.

19 24. Acquire and hold property for the use of county fairs, and conduct,
20 take care of and manage them.

21 25. Authorize the sheriff to offer a reward, not exceeding ten thousand
22 dollars in one case, for information leading to the arrest and conviction of
23 persons charged with crime.

24 26. Contract for the transportation of insane persons to the state
25 hospital or direct the sheriff to transport such persons. The county is
26 responsible for such expense to the extent the expense is not covered by any
27 third party payor.

28 27. Provide for the reasonable expenses of burial for deceased
29 indigents as provided in section 36-831 and maintain a permanent register of
30 deceased indigents including name, age and date of death, and when burial
31 occurs, the board shall mark the grave with a permanent marker giving the
32 name, age, and date of birth, if known.

33 28. Sell or grant to the United States the title or interest of the
34 county in any toll road or toll train in or partly within a national park,
35 upon such terms and consideration as may be agreed upon by the board and the
36 secretary of the interior of the United States.

37 29. Enter into agreements for acquiring rights-of-way, construction,
38 reconstruction or maintenance of highways in their respective counties,
39 including highways which THAT pass through Indian reservations, with the
40 government of the United States, acting through its duly authorized officers
41 or agents pursuant to any act of Congress, except that the governing body of
42 any Indian tribe whose lands are affected must consent to the use of its
43 land, and any such agreements entered into prior to BEFORE June 26, 1952 are
44 validated and confirmed.

1 30. Do and perform all other acts and things necessary to the full
2 discharge of its duties as the legislative authority of the county
3 government.

4 31. Make and enforce all local, police, sanitary and other regulations
5 not in conflict with general law.

6 32. Budget for funds for foster home care during the school week for
7 mentally retarded and otherwise handicapped children who reside within the
8 county and attend a school for the handicapped in a city or town within such
9 county.

10 33. Do and perform all acts necessary to enable the county to
11 participate in the "economic opportunity act of 1964" (P.L. 88-452; 78 Stat.
12 508), as amended.

13 34. Provide a plan or plans for its employees which THAT provide tax
14 deferred annuity and deferred compensation plans as authorized pursuant to
15 title 26, United States Code annotated. Such plans shall allow voluntary
16 participation by all employees of the county. Participating employees shall
17 authorize the board to make reductions in their remuneration as provided in
18 an executed deferred compensation agreement.

19 35. Adopt and enforce standards for shielding and filtration of
20 commercial or public outdoor portable or permanent light fixtures in
21 proximity to astronomical or meteorological laboratories.

22 36. Subject to the prohibitions, restrictions and limitations as set
23 forth in section 11-830, adopt and enforce standards for excavation, landfill
24 and grading to prevent unnecessary loss from erosion, flooding and
25 landslides.

26 37. Make and enforce necessary ordinances for the operation and
27 licensing of any establishment not in the limits of an incorporated city or
28 town in which is carried on the business of providing baths, showers or other
29 forms of hydrotherapy or any service of manual massage of the human body.

30 38. Provide pecuniary compensation as salary or wages for overtime work
31 performed by county employees, including those employees covered by the
32 provisions of title 23, chapter 2, article 9. In so providing, the board may
33 establish salary and wage plans incorporating classifications and conditions
34 prescribed by the federal fair labor standards act.

35 39. Establish, maintain and operate medical clinics as defined in title
36 36, chapter 24, article 1.

37 40. Enact ordinances under its police authority prescribing reasonable
38 curfews in the entire unincorporated area or any area less than the entire
39 unincorporated area of the county for minors and fines not to exceed the fine
40 for a petty offense for violation of such ordinances. Nothing in this
41 paragraph shall be construed to require a request from an association or a
42 majority of the residents of an area before the board may enact an ordinance
43 applicable to the entire or any portion of the unincorporated area. An
44 ordinance enacted pursuant to this paragraph shall provide that a minor is

1 not violating a curfew if the minor is accompanied by a parent, a guardian
2 or an adult having supervisory custody, is on an emergency errand or has
3 been specifically directed to the location on reasonable, legitimate business
4 or some other activity by the parent, guardian or adult having supervisory
5 custody. If no curfew ordinance is applicable to a particular unincorporated
6 area of the county, the board may adopt a curfew ordinance on the request or
7 petition of either:

8 (a) A homeowners' association which THAT represents a majority of the
9 homeowners in the area covered by the association and to which the curfew
10 would apply.

11 (b) A majority of the residents of the area to which the curfew would
12 apply.

13 41. Lease or sublease personal property owned by the county to other
14 political subdivisions of this state to be used for a public purpose.

15 42. In addition to the agreements authorized by section 11-651, enter
16 into long-term agreements for the purchase of personal property, provided
17 that the board may cancel any such agreement at the end of a fiscal year, at
18 which time the seller may repossess the property and the agreement shall be
19 deemed terminated.

20 43. Make and enforce necessary ordinances not in conflict with the laws
21 of this state to regulate off-road recreational motor vehicles which THAT are
22 operated within the county on public lands without lawful authority or on
23 private lands without the consent of the lawful owner or which THAT generate
24 air pollution. For purposes of this paragraph, "off-road recreational motor
25 vehicle" means three and four wheel vehicles manufactured for recreational
26 nonhighway all terrain travel.

27 44. Acquire land for roads, drainage ways and other public purposes by
28 exchange without public auction, except that notice shall be published thirty
29 days before the exchange listing the property ownership and descriptions.

30 45. Purchase real property for public purposes, provided that final
31 payment shall be made not later than five years after the date of purchase.

32 46. Lease purchase real property and improvements for real property for
33 public purposes, provided that final payment shall be made not later than
34 twenty-five years after the date of purchase. Any increase in the final
35 payment date from fifteen years up to the maximum of twenty-five years shall
36 be made only on unanimous approval by the board of supervisors.

37 47. Make and enforce ordinances for the protection and disposition of
38 domestic animals subject to inhumane, unhealthful or dangerous conditions or
39 circumstances. An ordinance enacted pursuant to this paragraph shall not
40 restrict or limit the authority of the game and fish commission to regulate
41 the taking of wildlife. For the purposes of this paragraph, "domestic
42 animal" means an animal kept as a pet and not primarily for economic
43 purposes.

1 48. If a part of a parcel of land is to be taken for roads, drainage,
2 flood control or other public purposes and the board and the affected
3 property owner determine that the remainder will be left in such a condition
4 as to give rise to a claim or litigation concerning severance or other
5 damage, acquire the whole parcel by purchase, donation, dedication, exchange,
6 condemnation or other lawful means and the remainder may be sold or exchanged
7 for other properties needed for any public purpose.

8 49. Make and enforce necessary rules providing for the reimbursement
9 of travel and subsistence expenses of members of county boards, commissions
10 and advisory committees when acting in the performance of their duties, if
11 the board, commission or advisory committee is authorized or required by
12 federal or state law or county ordinance, and the members serve without
13 compensation.

14 50. Provide a plan or plans for county employee benefits which THAT
15 allow for participation in a cafeteria plan that meets the requirements of
16 the United States internal revenue code of 1986.

17 51. Provide for fringe benefits for county employees, including sick
18 leave, personal leave, vacation and holiday pay and jury duty pay.

19 52. Make and enforce ordinances which THAT are more restrictive than
20 state requirements to reduce or encourage the reduction of carbon monoxide
21 and ozone levels, provided an ordinance does not establish a standard for
22 vehicular emissions, including ordinances to reduce or encourage the
23 reduction of the commuter use of motor vehicles by employees of the county
24 and employees whose place of employment is in unincorporated areas of the
25 county.

26 53. Make and enforce ordinances to provide for the reimbursement of up
27 to one hundred per cent of the cost to county employees of public bus or van
28 pool transportation to and from their place of employment.

29 54. Lease for public purposes any real property, improvements for real
30 property and personal property under the same terms and conditions, to the
31 extent applicable, as are specified in sections 11-651 and 11-653 for lease
32 purchases.

33 55. Enact ordinances prescribing regulation of alarm systems and
34 providing for civil penalties to reduce the incidence of false alarms at
35 business and residential structures relating to burglary, robbery, fire and
36 other emergencies not within the limits of an incorporated city or town.

37 56. In addition to the provisions of paragraph 9 of this section, and
38 notwithstanding the provisions of section 23-504, sell or dispose of, at no
39 less than fair market value, county personal property which THAT the board
40 deems no longer useful or necessary through a retail outlet or to another
41 government entity if the personal property has a fair market value of no more
42 than one thousand dollars, or by retail sale or private bid, if the personal
43 property has a fair market value of no more than fifteen thousand dollars.
44 Notice of sales in excess of one thousand dollars shall include a description

1 and sale price of each item and shall be published in a newspaper of general
2 circulation in the county and for thirty days after notice other bids may be
3 submitted that exceed the sale price by at least five per cent. The county
4 shall select the highest bid received at the end of the thirty day period.

5 57. Sell services, souvenirs, sundry items or informational
6 publications that are uniquely prepared for use by the public and by
7 employees and license and sell information systems and intellectual property
8 developed from county resources that the county is not obligated to provide
9 as a public record.

10 58. On unanimous consent of the board of supervisors, license, lease
11 or sell any county property pursuant to paragraphs 55 and 56 of this section
12 at less than fair market value to any other governmental entity, including
13 this state, cities, towns, public improvement districts or other counties
14 within or outside of this state, or for a specific purpose to any charitable,
15 social or benevolent nonprofit organization incorporated or operating in this
16 state.

17 59. On unanimous consent of the board of supervisors, provide technical
18 assistance and related services to a fire district pursuant to an
19 intergovernmental agreement.

20 60. Adopt contracting procedures for the operation of a county health
21 system pursuant to section 11-291. ~~Prior to~~ BEFORE the adoption of
22 contracting procedures the board shall hold a public hearing. The board
23 shall publish one notification in a newspaper of general circulation in the
24 county seat at least fifteen days ~~prior to~~ BEFORE the hearing.

25 Sec. 6. Title 11, chapter 2, article 4, Arizona Revised Statutes, is
26 amended by adding section 11-254.03, to read:

27 11-254.03. Board powers; hospitals

28 IN ADDITION TO THE PROVISIONS OF SECTION 11-251, PARAGRAPH 5, IF A
29 BOARD MAINTAINS A HOSPITAL OR HEALTH CARE FACILITY FOR THE SICK OF THE COUNTY
30 OR IF A BOARD HAS DELEGATED THIS RESPONSIBILITY TO A HOSPITAL BOARD PURSUANT
31 TO SECTION 36-183.01, THE BOARD OR COUNTY HOSPITAL BOARD MAY:

32 1. ENTER INTO AGREEMENTS WITH OTHER HEALTH CARE ENTITIES, GOVERNMENTAL
33 ENTITIES, ORGANIZATIONS, FOUNDATIONS OR PROVIDERS FOR SERVICES OR FACILITIES
34 TO PROVIDE, MAINTAIN, ESTABLISH, ENHANCE, MANAGE OR MANAGE THE RISK OF HEALTH
35 CARE SERVICES.

36 2. ACQUIRE AND OPERATE, MAINTAIN, LEASE, ENCUMBER AND DISPOSE OF REAL
37 AND PERSONAL PROPERTY, INCLUDING PROPERTY HELD IN TRUST, AND INTERESTS IN
38 THIS PROPERTY.

39 3. ADOPT ADMINISTRATIVE RULES, INCLUDING AN EMPLOYEE MERIT SYSTEM AND
40 COMPETITIVE PROCUREMENT PROCESS, NECESSARY TO ADMINISTER AND OPERATE THE
41 HOSPITAL'S OR HEALTH CARE FACILITY'S PROGRAMS AND ANY PROPERTY UNDER THE
42 AUTHORITY OF EITHER.

43 4. ESTABLISH OR ACQUIRE FOUNDATIONS OR CHARITABLE ORGANIZATIONS TO
44 SOLICIT DONATIONS, FINANCIAL CONTRIBUTIONS, REAL OR PERSONAL PROPERTY OR

1 SERVICES FOR USE SOLELY TO PERFORM THE DUTIES AND OBLIGATIONS IN FURTHERANCE
2 OF THE PROVISION OF HEALTH CARE SERVICES.

3 5. DELEGATE TO THE CHIEF EXECUTIVE OFFICER OF THE HOSPITAL THE
4 AUTHORITY TO COMPROMISE CLAIMS FOR SERVICES PROVIDED OR DEBTS INCURRED, UP
5 TO TWENTY-FIVE THOUSAND DOLLARS PER CLAIM OR DEBT.

6 6. DISCLOSE AND MAKE AVAILABLE RECORDS AND OTHER MATTERS IN THE SAME
7 MANNER AS IS REQUIRED OF A PUBLIC BODY PURSUANT TO TITLE 39, CHAPTER 1,
8 EXCEPT THAT IT IS NOT REQUIRED TO DISCLOSE OR MAKE AVAILABLE ANY RECORDS OR
9 OTHER MATTERS THAT:

10 (a) IDENTIFY THE CARE OR TREATMENT OF A PATIENT WHO RECEIVES SERVICES,
11 INCLUDING BILLING INFORMATION, UNLESS THE PATIENT OR THE PATIENT'S
12 REPRESENTATIVE CONSENTS TO THE DISCLOSURE IN WRITING OR UNLESS OTHERWISE
13 PERMITTED PURSUANT TO FEDERAL OR STATE LAW.

14 (b) REVEAL PROPRIETARY INFORMATION PROVIDED TO IT BY A NONGOVERNMENTAL
15 SOURCE. FOR THE PURPOSES OF THIS SUBDIVISION, "NONGOVERNMENTAL" MEANS AN
16 ENTITY OTHER THAN THE UNITED STATES GOVERNMENT, AN AGENCY OR INSTRUMENTALITY
17 OF THE UNITED STATES GOVERNMENT OR A PUBLIC BODY AS DEFINED IN SECTION
18 39-121.01.

19 (c) WOULD CAUSE DEMONSTRABLE AND MATERIAL HARM AND WOULD PLACE IT AT
20 A COMPETITIVE DISADVANTAGE IN THE MARKETPLACE.

21 (d) WOULD VIOLATE ANY EXCEPTION, PRIVILEGE OR CONFIDENTIALITY GRANTED
22 OR IMPOSED BY STATUTE OR COMMON LAW.

23 Sec. 7. Repeal

24 Section 11-290, Arizona Revised Statutes, is repealed.

25 Sec. 8. Section 11-291, Arizona Revised Statutes, is amended to read:
26 11-291. Hospitalization and medical care of the sick

27 A. Except as provided in sections 11-293 and 36-183.01 and title 36,
28 chapter 29, the board of supervisors ~~has the sole and exclusive authority to~~
29 MAY provide for the hospitalization and medical care of the indigent sick in
30 the county, ~~including home health services, which are defined in section~~
31 ~~36-151, paragraph 3, and which are provided in lieu of hospitalization, to~~
32 ~~indigent persons and, to the extent that such expenses are not covered by a~~
33 ~~third party payor, to indigent persons under the supervision of a county~~
34 ~~corrections agency. For the purposes of this subsection, "third party~~
35 ~~payor" does not include the Arizona health care cost containment system or~~
36 ~~the Arizona long-term care system and hospitalization and medical care does~~
37 ~~not include long-term care. For the purposes of this section, an indigent~~
38 ~~is a resident of the county who is otherwise eligible for county services~~
39 ~~and, except for emergency services provided to persons who are in fact~~
40 ~~eligible pursuant to section 36-2905.05, who meets one of the following~~
41 ~~requirements for citizenship or alien status:~~

42 1. ~~Is a citizen of the United States.~~

43 2. ~~Is a qualified alien who entered the United States on or before~~
44 ~~August 21, 1996 as prescribed in section 36-2903.03.~~

1 ~~3. Is a qualified alien who entered the United States on or after~~
2 ~~August 22, 1996 and is a member of an exception group as prescribed in~~
3 ~~section 36-2903.03.~~

4 ~~B. Counties shall not be required to provide services specified in~~
5 ~~title 36, chapter 29 to persons eligible for care under title 36, chapter 29~~
6 ~~after the persons have been determined eligible pursuant to the eligibility~~
7 ~~process. Except as provided in sections 36-2908 and 36-2909, until the final~~
8 ~~eligibility determination has been made and all applicable notice provisions~~
9 ~~have been complied with, the county shall provide services for indigent~~
10 ~~persons who are in fact eligible for care as required by section 11-291.01.~~
11 ~~A county may condition the provision of nonemergency care to a person who is~~
12 ~~otherwise eligible for county services on the completion by the person, or~~
13 ~~by a representative of the person on his behalf, of an application for~~
14 ~~eligibility for the Arizona health care cost containment system or the~~
15 ~~Arizona long-term care system pursuant to title 36, chapter 29. Beginning~~
16 ~~October 1, 1985, a county shall determine whether a person is eligible or~~
17 ~~ineligible for care provided pursuant to section 11-291.01 no later than it~~
18 ~~determines whether a person is eligible or ineligible for care pursuant to~~
19 ~~title 36, chapter 29, article 1.~~

20 ~~C. B. The board may employ physicians and other persons necessary to~~
21 ~~accomplish the purpose of this section.~~

22 ~~D. C. In carrying out the powers and duties prescribed by section~~
23 ~~11-251, paragraph 5 and subsection A of this section and for health care~~
24 ~~education purposes, the board may contract with any qualified person OR~~
25 ~~ENTITY to provide all or a part of the services required. Such contracts may~~
26 ~~be for a term of not more than ten years.~~

27 ~~E. D. The board may enter into contracts for the operation of a~~
28 ~~county health care system for a term of not more than five years pursuant to~~
29 ~~procedures adopted by the board. The procedures shall require the exercise~~
30 ~~of sound business judgment and efforts to obtain contracts that are the most~~
31 ~~advantageous to the county.~~

32 ~~F. E. The county is entitled to a lien for the charges for ANY~~
33 ~~SERVICES PROVIDED BY THE hospital or medical care and treatment of an injured~~
34 ~~person or the provision of long-term care services for which it is~~
35 ~~responsible pursuant to subsection A of this section or section 11-293, on~~
36 ~~any and all claims of liability or indemnity for damages accruing to the~~
37 ~~person to whom hospital or medical service is rendered, or to the legal~~
38 ~~representative of such person, on account of injuries giving rise to such~~
39 ~~claims and which THAT necessitated such THE hospital or medical care and~~
40 ~~treatment. Recovery of charges pursuant to this subsection shall be in a~~
41 ~~manner as nearly as possible the same as the procedures prescribed in section~~
42 ~~36-2915.~~

43 ~~G. Except as provided in sections 36-2908 and 36-2909, the county~~
44 ~~shall reimburse an ambulance company for the transportation to a hospital of~~

1 ~~a person in a medical emergency situation if that person's medical care is~~
2 ~~a county responsibility pursuant to section 11-291.01 and subsection A of~~
3 ~~this section and if such transportation is requested by a health care~~
4 ~~professional licensed under the provisions of title 32, chapter 13, 15, 17~~
5 ~~or 25, by a paramedic or emergency medical technician certified pursuant to~~
6 ~~title 36, chapter 21.1, or by a law enforcement officer or fire fighter. The~~
7 ~~county shall reimburse the ambulance company for services on a capped~~
8 ~~fee-for-service basis not to exceed the maximum amount determined by the~~
9 ~~administration pursuant to section 36-2904, subsection B.~~

10 H. F. A person who receives services pursuant to this article to that
11 extent only shall assign to the county by operation of law that person's
12 rights to all types of medical benefits to which the person is entitled,
13 including first party medical benefits under automobile insurance policies.
14 The county has a right to subrogation against any other person or firm to
15 enforce the assignment of medical benefits. The requirements of this
16 subsection control over the provisions of any insurance policy that provides
17 benefits to an eligible A person if the policy is inconsistent with this
18 subsection.

19 Sec. 9. Repeal

20 Section 11-291.01, Arizona Revised Statutes, is repealed.

21 Sec. 10. Section 11-292, Arizona Revised Statutes, is amended to read:

22 11-292. Medical care; definition

23 A. The board of supervisors shall, subject to the applicable
24 provisions of title 42, chapter 17, articles 2 and 3, SHALL include in its
25 annual budget the following:

26 1. ~~For county purposes, such amount as it deems necessary and adequate~~
27 ~~for the hospitalization, medical care and outpatient relief of the indigent~~
28 ~~sick in the county not provided for by title 36, chapter 29.~~

29 2. ~~For the purposes of title 36, chapter 29, article 1, for fiscal~~
30 ~~year:~~

31 (a) ~~1982-1983, an amount equal to forty per cent of the amount~~
32 ~~budgeted by the county board of supervisors or the amount expended, whichever~~
33 ~~is less, for the hospitalization and medical care of the indigent sick~~
34 ~~pursuant to this article for the fiscal year 1980-1981, except for Yuma and~~
35 ~~La Paz counties. The office of the auditor general shall determine the~~
36 ~~amount Yuma county would otherwise have included pursuant to this subdivision~~
37 ~~if no division had occurred and shall then determine the contribution amounts~~
38 ~~of Yuma and La Paz counties based on the proportionate share of the estimated~~
39 ~~population in such counties as of July 1, 1982. The estimated population~~
40 ~~shall be the estimates determined by the department of economic security and~~
41 ~~utilized by the economic estimates commission pursuant to section 41-563,~~
42 ~~subsection A; paragraph 2, subdivision (a).~~

43 (b) ~~1983-1984, an amount equal to fifty per cent of the amount~~
44 ~~budgeted by the county board of supervisors or the amount expended, whichever~~

1 is less, for the hospitalization and medical care of the indigent sick
2 pursuant to this article for fiscal year 1980-1981, except for Yuma and La
3 Paz counties. The contribution amounts of such counties shall be equal to the
4 amount Yuma county would have made pursuant to this subdivision if a division
5 had not occurred, apportioned between the counties in the same manner as
6 provided in subdivision (a) of this paragraph.

7 (c) 1984-1985, an amount established at that time by the legislature
8 or by the joint legislative tax committee in the absence of action by the
9 legislature based on the recommendations of the joint legislative committee
10 for the Arizona health care cost containment system which reflects the
11 nonfederal portion of the actual cost of the Arizona health care cost
12 containment system for providing health services to persons defined pursuant
13 to section 36-2901, paragraph 4, subdivisions (a), (b) and (c), who are
14 residents of the county in fiscal year 1983-1984, except that the amount
15 assessed may not exceed fifty per cent of the total expenditures of the
16 county for the hospitalization and medical care of the indigent sick pursuant
17 to this article for fiscal year 1980-1981, except that the amounts for Yuma
18 and La Paz counties shall not exceed fifty per cent of the total expenditures
19 of Yuma county for the hospitalization and medical care of the indigent sick
20 pursuant to this article for fiscal year 1980-1981 apportioned between the
21 counties in the same manner as provided in subdivision (a) of this paragraph.

22 (d) 1985-1986, and for each fiscal year thereafter, an amount equal
23 to fifty per cent of the amount budgeted by the county board of supervisors
24 or the amount expended, whichever is less, for the hospitalization and
25 medical care of the indigent sick pursuant to this article for fiscal year
26 1980-1981, except for Yuma and La Paz counties. The contribution amounts of
27 those counties shall be equal to the amount Yuma county would have made
28 pursuant to this subdivision SUBSECTION if a division had not occurred
29 apportioned between the counties in the same manner as provided in
30 subdivision (a) of this paragraph. THE OFFICE OF THE AUDITOR GENERAL SHALL
31 DETERMINE THE AMOUNT YUMA COUNTY WOULD OTHERWISE HAVE INCLUDED IF A DIVISION
32 HAD NOT OCCURRED AND SHALL THEN DETERMINE THE CONTRIBUTION AMOUNTS OF YUMA
33 AND LA PAZ COUNTIES BASED ON THE PROPORTIONATE SHARE OF THE ESTIMATED
34 POPULATION IN THESE COUNTIES AS OF JULY 1, 1982.

35 B. For fiscal year 1994-1995, and for each fiscal year thereafter, the
36 state treasurer shall withhold an amount sufficient to meet the county
37 portion of the nonfederal costs of providing long-term care system services,
38 pursuant to title 36, chapter 29, article 2, excluding services to the
39 developmentally disabled, from monies otherwise payable to the county under
40 section 42-5029, subsection D, paragraph 2. This amount and the state
41 portion of the nonfederal costs, determined pursuant to subsection C, D, E
42 or F of this section, shall be specified in the annual appropriation for the
43 maintenance and operation of the Arizona health care cost containment system.
44 For fiscal years 1994-1995, 1995-1996 and 1996-1997, monies shall be withheld

1 from each county based on the following percentages derived from a state
 2 auditor general's certified audit of fiscal year 1987-1988 county long-term
 3 care and home health care expenditures, except that amounts withheld shall
 4 be adjusted to reflect amounts paid by counties pursuant to section 36-2952:

5	1. Apache:	0.22%
6	2. Cochise:	2.49%
7	3. Coconino:	0.66%
8	4. Gila:	2.56%
9	5. Graham:	0.64%
10	6. Greenlee:	0.34%
11	7. La Paz:	0.34%
12	8. Maricopa:	56.55%
13	9. Mohave:	2.73%
14	10. Navajo:	0.91%
15	11. Pima:	20.55%
16	12. Pinal:	5.09%
17	13. Santa Cruz:	1.05%
18	14. Yavapai:	3.12%
19	15. Yuma:	2.75%

20 ~~C. In fiscal year 1997-1998, of the total amount that is specified in~~
 21 ~~the annual appropriation as the nonfederal portion of the cost of providing~~
 22 ~~long-term care services, excluding services to the developmentally disabled,~~
 23 ~~and that represents an increase from the amount that was specified in the~~
 24 ~~annual appropriation for the prior fiscal year, the state shall pay fifty per~~
 25 ~~cent of the increase. The remaining nonfederal portion of the costs shall~~
 26 ~~be apportioned among the counties according to the proportion that each~~
 27 ~~county's net nonfederal expenditures for long-term care services, excluding~~
 28 ~~services to the developmentally disabled, bears to the total nonfederal~~
 29 ~~expenditure for all counties in fiscal year 1995-1996, with the following~~
 30 ~~adjustments in the following order:~~

31 ~~1. Any county that would contribute more if the percentage withheld~~
 32 ~~were the percentage in subsection B of this section is entitled to~~
 33 ~~twenty-five per cent of the savings. Any county that would contribute less~~
 34 ~~if the percentage withheld were the percentage in subsection B of this~~
 35 ~~section shall have its increased contribution paid by the state.~~

36 ~~2. If the resulting net county contribution when expressed as an~~
 37 ~~imputed property tax rate per one hundred dollars of net assessed value~~
 38 ~~exceeds ninety cents, the county's contribution shall be reduced so that the~~
 39 ~~imputed property tax rate equals ninety cents and the difference shall be~~
 40 ~~paid by the state.~~

41 ~~D. In fiscal year 1998-1999, of the total amount that is specified in~~
 42 ~~the annual appropriation as the nonfederal portion of the cost of providing~~
 43 ~~long-term care services, excluding services to the developmentally disabled,~~
 44 ~~and that represents an increase from the amount that was specified in the~~

1 annual appropriation for the prior fiscal year, the state shall pay fifty per
2 cent of the increase. The remaining nonfederal portion of the costs shall
3 be apportioned among the counties according to the proportion that each
4 county's net nonfederal expenditures for long-term care services, excluding
5 services to the developmentally disabled, bears to the total nonfederal
6 expenditure for all counties in fiscal year 1996-1997, with the following
7 adjustments in the following order:

8 1. Any county that would contribute more if the percentage withheld
9 were the percentage in subsection B of this section is entitled to fifty per
10 cent of the savings. Any county that would contribute less if the percentage
11 withheld were the percentage in subsection B of this section shall have
12 seventy-five per cent of its increased contribution paid by the state.

13 2. If the resulting net county contribution when expressed as an
14 imputed property tax rate per one hundred dollars of net assessed value
15 exceeds ninety cents, the county's contribution shall be reduced so that the
16 imputed property tax rate equals ninety cents and the difference shall be
17 paid by the state.

18 3. Any county with a native American population that represents at
19 least twenty per cent of the county's total population according to the most
20 recent United States decennial census shall contribute an amount equal to the
21 prior fiscal year's contribution plus fifty per cent of the difference
22 between the prior year's contribution were it calculated using the percentage
23 in subsection B of this section and the current year's contribution as if its
24 share of the total nonfederal portion of the long-term care costs had been
25 calculated using the percentage prescribed in subsection B of this section
26 and the state shall pay any difference from the amount otherwise required by
27 this subsection.

28 4. If, after making the adjustments in this subsection, a county would
29 contribute more than if its contribution were calculated using the percentage
30 prescribed in subsection B of this section multiplied by the total nonfederal
31 costs of long-term care services, excluding services to the developmentally
32 disabled, the county's contribution shall be reduced to the sum of its prior
33 year's contribution plus fifty per cent of the difference between the prior
34 year's contribution were it calculated using the percentage in subsection B
35 of this section and the current year's contribution as if its share of the
36 total nonfederal portion of long-term care costs had been calculated using
37 the percentage prescribed in subsection B of this section and the state shall
38 pay any difference from the amount otherwise required by this subsection.

39 E. In fiscal year 1999-2000, of the total amount that is specified in
40 the annual appropriation as the nonfederal portion of the cost of providing
41 long-term care services, excluding services to the developmentally disabled,
42 and that represents an increase from the amount that was specified in the
43 annual appropriation for the prior fiscal year, the state shall pay fifty per
44 cent of the increase. The remaining nonfederal portion of the costs shall

1 be apportioned among the counties according to the proportion that each
2 county's net nonfederal expenditures for long-term care services, excluding
3 services to the developmentally disabled, bears to the total nonfederal
4 expenditure for all counties in fiscal year 1997-1998, with the following
5 adjustments in the following order:

6 1. Any county that would contribute more if the percentage withheld
7 were the percentage in subsection B of this section is entitled to
8 seventy-five per cent of the savings. Any county that would contribute less
9 if the percentage withheld were the percentage in subsection B of this
10 section shall have fifty per cent of its increased contribution paid by the
11 state.

12 2. If the resulting net county contribution when expressed as an
13 imputed property tax rate per one hundred dollars of net assessed value
14 exceeds ninety cents, the county's contribution shall be reduced so that the
15 imputed property tax rate equals ninety cents and the difference shall be
16 paid by the state.

17 3. Any county with a native American population that represents at
18 least twenty per cent of the county's total population according to the most
19 recent United States decennial census shall contribute an amount equal to the
20 prior fiscal year's contribution plus fifty per cent of the difference
21 between the prior year's contribution were it calculated using the percentage
22 in subsection B of this section and the current year's contribution as if its
23 share of the total nonfederal portion of the long-term care costs had been
24 calculated using the percentage prescribed in subsection B of this section
25 and the state shall pay any difference from the amount otherwise required by
26 this subsection.

27 4. If, after making the adjustments in this subsection, a county would
28 contribute more than if its contribution were calculated using the percentage
29 prescribed in subsection B of this section multiplied by the total nonfederal
30 costs of long-term care services, excluding services to the developmentally
31 disabled, the county's contribution shall be reduced to the sum of its prior
32 year's contribution plus fifty per cent of the difference between the prior
33 year's contribution were it calculated using the percentage in subsection B
34 of this section and the current year's contribution as if its share of the
35 total nonfederal portion of long-term care costs had been calculated using
36 the percentage prescribed in subsection B of this section and the state shall
37 pay any difference from the amount otherwise required by this subsection.

38 F. C. In fiscal year 2000-2001, and each fiscal year thereafter, of
39 the total amount that is specified in the annual appropriation as the
40 nonfederal portion of the cost of providing long-term care services,
41 excluding services to the developmentally disabled, and that represents an
42 increase from the amount that was specified in the annual appropriation for
43 the prior fiscal year, the state shall pay fifty per cent of the increase.
44 The remaining nonfederal portion of the costs shall be apportioned among the

1 counties according to the proportion that each county's net nonfederal
2 expenditures for long-term care services, excluding services to the
3 developmentally disabled, bears to the total nonfederal expenditure for all
4 counties two fiscal years earlier, with the following adjustments in the
5 following order:

6 1. If the resulting net county contribution when expressed as an
7 imputed property tax rate per one hundred dollars of net assessed value
8 exceeds ninety cents, the county's contribution shall be reduced so that the
9 imputed property tax rate equals ninety cents and the difference shall be
10 paid by the state.

11 2. Any county with a native American population that represents at
12 least twenty per cent of the county's total population according to the most
13 recent United States decennial census shall contribute an amount equal to the
14 prior fiscal year's contribution plus fifty per cent of the difference
15 between the prior year's contribution were it calculated using the percentage
16 in subsection B of this section and the current year's contribution as if its
17 share of the total nonfederal portion of the long-term care costs had been
18 calculated using the percentage prescribed in subsection B of this section
19 and the state shall pay any difference from the amount otherwise required by
20 this subsection.

21 3. If, after making the adjustments in this subsection, a county would
22 contribute more than if its contribution were calculated using the percentage
23 prescribed in subsection B of this section multiplied by the total nonfederal
24 costs of long-term care services, excluding services to the developmentally
25 disabled, the county's contribution shall be reduced to the sum of its prior
26 year's contribution plus fifty per cent of the difference between the prior
27 year's contribution were it calculated using the percentage in subsection B
28 of this section and the current year's contribution as if its share of the
29 total nonfederal portion of long-term care costs had been calculated using
30 the percentage prescribed in subsection B of this section and the state shall
31 pay any difference from the amount otherwise required by this subsection.

32 ~~G. Any savings accruing to a county in fiscal year 1982-1983 as a~~
33 ~~result of the transfer of a portion of the costs of providing hospitalization~~
34 ~~and medical care to the indigent sick pursuant to this article to the Arizona~~
35 ~~health care cost containment system in fiscal year 1982-1983 may be used by~~
36 ~~the county only to fund the costs of providing hospitalization and medical~~
37 ~~care to the indigent sick pursuant to this article and for no other purpose.~~

38 ~~H. The determination of those amounts to be raised pursuant to~~
39 ~~subsection A, paragraph 2 of this section shall be based on audits performed~~
40 ~~by the auditor general. The auditor general shall determine on a uniform~~
41 ~~basis the expenditures in the base fiscal year 1980-1981 made by each county~~
42 ~~for the hospitalization and medical care of the indigent sick pursuant to~~
43 ~~article 7 of this chapter. The determination of expenditures for the base~~
44 ~~fiscal year 1980-1981 shall include all direct expenditures and all essential~~

1 ~~indirect expenditures and shall additionally include expenditures made for~~
2 ~~the provision of care to persons covered by a county as the result of that~~
3 ~~county's expanded definition of indigency.~~

4 ~~I. D. The director of the Arizona health care cost containment system~~
5 ~~administration shall notify each county of the amount determined pursuant to~~
6 ~~subsection A, paragraph 2 of this section to be included in its annual budget~~
7 ~~no later than May 1 of each year.~~

8 ~~J. E. In the event that any IF A county does not provide funding as~~
9 ~~specified in subsection A of this section, the state treasurer shall subtract~~
10 ~~the amount owed to the Arizona health care cost containment system fund by~~
11 ~~the county from any payments required to be made by the state treasurer to~~
12 ~~that county pursuant to section 42-5029, subsection D, paragraph 2, plus~~
13 ~~interest on that amount pursuant to section 44-1201 retroactive to the first~~
14 ~~day the funding was due. If the monies the state treasurer withholds are~~
15 ~~insufficient to meet that county's funding requirement as specified in~~
16 ~~subsection A of this section, the state treasurer shall withhold from any~~
17 ~~other monies payable to that county from whatever state funding source is~~
18 ~~available an amount necessary to fulfill that county's requirement. The~~
19 ~~state treasurer shall not withhold distributions from the highway user~~
20 ~~revenue fund pursuant to title 28, chapter 18, article 2.~~

21 ~~K. F. Payment of the amount included in the budget pursuant to~~
22 ~~subsection A, paragraph 2 of this section shall be made to the state~~
23 ~~treasurer for the fiscal year 1982-1983, on or before the fifteenth day of~~
24 ~~each month beginning in October, 1982, in an amount equal to one-ninth of the~~
25 ~~total amount. Beginning July 15, 1983 and Each month thereafter, payment of~~
26 ~~an amount equal to one-twelfth of the total amount determined pursuant to~~
27 ~~subsection A, paragraph 2 of this section shall be made to the state~~
28 ~~treasurer. Beginning October 1, 1989, payment of this amount shall be made~~
29 ~~to the state treasurer on or before the fifth day of each month. Upon~~
30 ~~request from the director of the Arizona health care cost containment system~~
31 ~~administration, the state treasurer shall require that up to three months'~~
32 ~~payments be made in advance, if necessary.~~

33 ~~L. G. The state treasurer shall deposit the amounts paid pursuant to~~
34 ~~subsection K F of this section and amounts withheld pursuant to subsection~~
35 ~~J E of this section in the Arizona health care cost containment system fund~~
36 ~~and long-term care system fund established pursuant to section 36-2913.~~

37 ~~M. H. In the event IF payments made pursuant to subsection K F of~~
38 ~~this section exceed the amount required to meet the costs incurred by the~~
39 ~~Arizona health care cost containment system for the hospitalization and~~
40 ~~medical care of those persons A PERSON WHO IS defined AS AN ELIGIBLE PERSON~~
41 ~~pursuant to section 36-2901, paragraph 4 6, subdivisions (a), (b) and (c)~~
42 ~~SUBDIVISION (a), the director of the Arizona health care cost containment~~
43 ~~system administration may instruct the state treasurer either to reduce~~
44 ~~remaining payments to be paid pursuant to this section by a specified amount~~

1 or to provide to the counties specified amounts from the Arizona health care
2 cost containment system fund and long-term care system fund.

3 ~~N. I. Notwithstanding subsection A, paragraph 2, subdivision (d) of~~
4 ~~this section, beginning with fiscal year 1986-1987~~ The amount of the county
5 contribution to the Arizona health care cost containment system fund and
6 ~~long-term care system fund~~ established in section 36-2913 shall not exceed
7 thirty-three per cent of the amount that the system administration expended
8 in the county for fiscal year 1983-1984. For the purposes of this
9 subsection, system administration expenditures in a county for fiscal year
10 1983-1984 are the total capitation and fee for service amounts paid by the
11 system administration to providers in a county before February 1, 1986 for
12 services rendered during fiscal year 1983-1984 to persons eligible for the
13 system pursuant to ~~section 36-2901, paragraph 4, subdivision (a), (b) or~~
14 ~~(c).~~

15 ~~O. J.~~ The state treasurer shall deposit amounts withheld pursuant to
16 subsection ~~J~~ E of this section in the Arizona health care cost containment
17 system fund and long-term care system fund established in BY section 36-2913.

18 ~~P. K.~~ The state treasurer shall deposit the monies withheld from the
19 counties and contributed by the state pursuant to subsections ~~B, C, D, E and~~
20 ~~F~~ SUBSECTION B of this section in the Arizona health care cost containment
21 system fund and long-term care system fund established by section 36-2913,
22 in twelve equal monthly installments. The monthly installments shall be
23 deposited in the funds FUND by the state treasurer by the fourth working day
24 of each month.

25 ~~Q. L.~~ By July 1 or within sixty days after enactment of the annual
26 appropriation for the maintenance and operation of the Arizona health care
27 cost containment system, whichever is later, and after consulting with the
28 joint legislative budget committee and the governor's office of strategic
29 planning and budgeting, the state treasurer shall notify each county of the
30 amount to be withheld pursuant to subsections ~~B, C, D, E and F~~ SUBSECTION B
31 of this section.

32 ~~R. M.~~ If the monies deposited in the Arizona health care cost
33 containment system fund and long-term care system fund pursuant to subsection
34 ~~P~~ K of this section are insufficient to meet the funding requirement as
35 specified in the annual appropriation for the maintenance and operation of
36 the Arizona health care cost containment system pursuant to subsections ~~B,~~
37 ~~C, D, E and F~~ SUBSECTION B of this section, the state treasurer shall
38 withhold from any other monies payable to that county from any available
39 state funding source, other than the highway user revenue fund, the amount
40 required to fulfill fifty per cent of the funding requirement and shall
41 deposit the monies in the Arizona health care cost containment system fund
42 and long-term care system fund. The state shall pay the remaining fifty per
43 cent of the funding requirement.

1 ~~S.~~ N. If any monies in the funds for the purpose of title 36, chapter
2 29, article 2 remain unexpended at the end of the fiscal year, the director
3 of the Arizona health care cost containment system administration shall
4 specify to the state treasurer the amount to be withdrawn from the Arizona
5 ~~health care cost containment system fund and long-term care system fund.~~ Of
6 the amount specified, the state treasurer shall distribute fifty per cent to
7 the counties pursuant to the ~~percentages prescribed in subsections B, C, D,~~
8 ~~E and F~~ SUBSECTION B OR C of this section. The remaining fifty per cent
9 shall be distributed to the state.

10 ~~F.~~ O. The board of supervisors of a county that is a program
11 contractor pursuant to section 36-2940 shall include in its annual budget,
12 subject to the ~~provisions of~~ title 42, chapter 17, articles 2 and 3, monies
13 received from the Arizona health care cost containment system fund and
14 long-term care system fund for the purposes of title 36, chapter 29,
15 article 2.

16 P. NOTWITHSTANDING ANY LAW TO THE CONTRARY, BEGINNING IN FISCAL YEAR
17 2002-2003 AND IN EACH FISCAL YEAR THEREAFTER, THE STATE TREASURER SHALL
18 WITHHOLD A TOTAL OF FIVE MILLION DOLLARS FOR THE COUNTY CONTRIBUTION FOR THE
19 ADMINISTRATIVE COSTS OF IMPLEMENTING SECTIONS 36-2901.01 AND 36-2901.04
20 BEGINNING WITH THE SECOND MONTHLY DISTRIBUTION OF TRANSACTION PRIVILEGE TAX
21 REVENUES OTHERWISE DISTRIBUTABLE AFTER SUBTRACTING ANY AMOUNTS WITHHELD FOR
22 THE COUNTY LONG-TERM CARE CONTRIBUTION. BEGINNING IN FISCAL YEAR 2002-2003,
23 THE STATE TREASURER SHALL ADJUST THE AMOUNT WITHHELD ACCORDING TO THE ANNUAL
24 CHANGES IN THE GDP PRICE DEFLATOR AND AS CALCULATED BY THE JOINT LEGISLATIVE
25 BUDGET COMMITTEE STAFF. BEGINNING IN FISCAL YEAR 2003-2004, THE JOINT
26 LEGISLATIVE BUDGET COMMITTEE SHALL CALCULATE AN ADDITIONAL ADJUSTMENT OF THE
27 ALLOCATION REQUIRED BY THIS SUBSECTION BASED ON CHANGES IN THE POPULATION AS
28 REPORTED BY THE DEPARTMENT OF ECONOMIC SECURITY. FOR THE PURPOSES OF THIS
29 SUBSECTION "GDP PRICE DEFLATOR" HAS THE SAME MEANING PRESCRIBED IN SECTION
30 41-563. EACH COUNTY'S ANNUAL CONTRIBUTION IS AS FOLLOWS:

- 31 1. APACHE, 1.342 PER CENT.
- 32 2. COCHISE, 2.503 PER CENT.
- 33 3. COCONINO, 2.469 PER CENT.
- 34 4. GILA, 1.014 PER CENT.
- 35 5. GRAHAM, 0.721 PER CENT.
- 36 6. GREENLEE, 0.185 PER CENT.
- 37 7. LA PAZ, 0.384 PER CENT.
- 38 8. MARICOPA, 59.289 PER CENT.
- 39 9. MOHAVE, 2.882 PER CENT.
- 40 10. NAVAJO, 1.889 PER CENT.
- 41 11. PIMA, 17.167 PER CENT.
- 42 12. PINAL, 3.359 PER CENT.
- 43 13. SANTA CRUZ, 0.794 PER CENT.

1 14. YAVAPAI, 3.173 PER CENT.

2 15. YUMA, 2.829 PER CENT.

3 Q. THE STATE TREASURER SHALL DEPOSIT THE AMOUNTS PAID PURSUANT TO
4 SUBSECTION P OF THIS SECTION IN THE BUDGET NEUTRALITY COMPLIANCE FUND
5 ESTABLISHED BY SECTION 36-2928.

6 R. For the purposes of this section, "net assessed value" includes
7 the values used to determine voluntary contributions collected pursuant to
8 title 9, chapter 4, article 3 and title 48, chapter 1, article 8.

9 Sec. 11. Section 11-293, Arizona Revised Statutes, is amended to read:

10 11-293. Long-term care; counties; duties; requirements for
11 payment; home health care

12 A. From and after October 1, 1989, each county shall provide nursing
13 care institution services, supervisory care services or adult foster care
14 services for indigent persons qualified for hospitalization and medical care
15 pursuant to this article who were receiving services pursuant to this section
16 on September 30, 1989 or who had requested to be screened pursuant to
17 subsection F of this section, and who are not determined eligible for
18 long-term care pursuant to title 36, chapter 29, article 2. If a person was
19 determined ineligible under title 36, chapter 29, article 2 because that
20 person did not meet the resource requirements pursuant to section 36-2934,
21 a county may bill and collect from that person the actual cost of services
22 provided pursuant to this section until such time as the person's remaining
23 resources equal the maximum resource limit allowable under title 36, chapter
24 29, article 2. Notwithstanding any law to the contrary, a county shall not
25 reduce the eligibility standards, benefit levels and categories of services
26 in effect on March 1, 1988 for persons eligible pursuant to this section.

27 B. The standards adopted by a board of supervisors shall provide that
28 a portion of the indigent person's income allowed pursuant to this section
29 shall be retained by the person for his THE PERSON'S personal use. This
30 portion shall not be less than fifteen per cent of the maximum benefit
31 available under title XVI of the federal social security act, as amended. As
32 provided by state and federal law, counties may file a claim against a
33 person's estate to recover paid assistance. FOR THE PURPOSES OF THIS
34 ARTICLE, the counties may impose liens according to state and federal law on
35 the property of these persons.

36 C. The medical, nursing and social needs of the indigent person
37 eligible pursuant to subsection A of this section shall be evaluated annually
38 in order to provide placement of the indigent person in the least restrictive
39 health care environment possible.

40 D. A nursing care institution, supervisory care home or adult foster
41 care provider is not eligible for payment of the costs of providing health
42 care services to an indigent person pursuant to this section unless the
43 person has been determined to be eligible for placement pursuant to this
44 section.

1 E. A person shall not be placed in a supervisory care home or with an
2 adult foster care home provider pursuant to this article unless home health
3 care services and outpatient medical services, as necessary, are provided as
4 a condition of the placement.

5 F. A county shall screen members as defined in section 36-2901 or
6 persons eligible pursuant to this article within eight days, excluding
7 Saturdays and holidays, if there is a written request for such screening
8 before October 1, 1989, including a request by a provider CONTRACTOR as
9 defined in section 36-2901. The screening shall determine whether placement
10 is appropriate in a nursing care institution, ~~supervisory care home~~ or adult
11 foster care home. The county shall also determine eligibility for such
12 members or persons within this eight day period, excluding Saturdays and
13 holidays. If the county determines that placement is appropriate, it shall
14 place the person at the appropriate level of care within ten days, excluding
15 Saturdays and holidays, after the written request for screening. The
16 member's provider who contracts with the administration pursuant to section
17 36-2904, subsection A is responsible for the member's care until the county
18 screens and places the member.

19 G. If the county does not complete the eligibility determination,
20 screening and placement of a member or person determined appropriate for
21 placement in the specified time period, the county shall reimburse the
22 Arizona health care cost containment system for the medical expenses incurred
23 or paid for which the Arizona health care cost containment system would not
24 have been responsible except for the county's failure to determine
25 eligibility, screen and place the person within the specified time period.

26 H. If a dispute arises between the Arizona health care cost
27 containment system, including providers CONTRACTORS as defined in section
28 36-2901, and the county regarding the appropriateness of placement in
29 long-term care for persons eligible pursuant to subsection A of this section,
30 the dispute shall be submitted to a multidisciplinary review board designated
31 by the board of supervisors. The review board shall consist of one
32 physician, one nurse and one social worker, and two appropriate
33 representatives from the Arizona health care cost containment system
34 administration. If the review board determines that the long-term care was
35 appropriate when requested the county shall reimburse the Arizona health care
36 cost containment system for the medical expenses incurred or paid for which
37 the Arizona health care cost containment system would not have been
38 responsible except for the county's failure to determine eligibility, screen
39 and place the person within the specified time period.

40 Sec. 12. Repeal

41 Sections 11-297, 11-297.01, 11-297.02, 11-297.03, 11-297.04, 11-297.05,
42 11-297.06, 11-298 and 11-300, Arizona Revised Statutes, are repealed.

1 Sec. 13. Title 11, chapter 2, article 7, Arizona Revised Statutes, is
2 amended by adding new sections 11-297 and 11-300, to read:

3 11-297. Seriously mentally ill; county responsibility;
4 definition

5 A. NOTWITHSTANDING SECTION 11-291:

6 1. A COUNTY THAT HAS A POPULATION OF LESS THAN SIX HUNDRED THOUSAND
7 PERSONS MUST PROVIDE THE BENEFIT LEVELS AND CATEGORIES OF SERVICES FOR THE
8 BEHAVIORAL HEALTH TREATMENT, BEHAVIORAL HEALTH HOSPITALIZATION AND BEHAVIORAL
9 HEALTH MEDICAL CARE OF PERSONS WHO ARE SERIOUSLY MENTALLY ILL AS REQUIRED BY
10 LAW AS OF JANUARY 1, 2001.

11 2. A COUNTY THAT HAS A POPULATION OF MORE THAN TWO MILLION PERSONS AND
12 THAT HAS AN INTERGOVERNMENTAL AGREEMENT WITH THE DEPARTMENT OF HEALTH
13 SERVICES IN EFFECT AS OF JANUARY 1, 2001 FOR THE DELIVERY OF SERVICES TO THE
14 SERIOUSLY MENTALLY ILL MUST ANNUALLY RENEW THE AGREEMENT TO PROVIDE FOR THE
15 INTEGRATION OF THE SYSTEM AT THE SAME TERMS AND FUNDING AMOUNT AND WITH A
16 MUTUALLY AGREED ON ANNUAL ADJUSTMENT FOR INFLATION.

17 3. A COUNTY THAT HAS A POPULATION OF MORE THAN SIX HUNDRED THOUSAND
18 PERSONS BUT LESS THAN TWO MILLION PERSONS AND THAT HAS AN INTERGOVERNMENTAL
19 AGREEMENT WITH THE DEPARTMENT OF HEALTH SERVICES IN EFFECT AS OF JANUARY 1,
20 2001 FOR THE DELIVERY OF BEHAVIORAL HEALTH AND MENTAL HEALTH CARE SERVICES
21 MUST ANNUALLY RENEW THE AGREEMENT TO PROVIDE FOR THE INTEGRATION OF THE
22 SYSTEM AT THE SAME FUNDING AMOUNT, EXCEPT FOR THE FUNDING FOR COURT ORDERED
23 SCREENING AND EVALUATION PURSUANT TO TITLE 36, CHAPTER 5, ARTICLE 4.

24 B. FOR THE PURPOSES OF THIS SECTION, "SERIOUSLY MENTALLY ILL" HAS THE
25 SAME MEANING PRESCRIBED IN SECTION 36-550.

26 11-300. Tobacco settlement agreement; decreased payments;
27 county contribution

28 A. IF THE TOTAL OF THE INITIAL PAYMENT, ANNUAL PAYMENT AND STRATEGIC
29 CONTRIBUTION PAYMENT, AS THESE TERMS ARE PRESCRIBED BY SECTIONS 9B AND 9C OF
30 THE MASTER SETTLEMENT AGREEMENT ENTERED INTO ON NOVEMBER 23, 1998 BETWEEN
31 THIS STATE AND CERTAIN UNITED STATES TOBACCO PRODUCT MANUFACTURERS, IN ANY
32 FISCAL YEAR IS LESS THAN SIXTY-SIX PER CENT OF THE ORIGINAL AMOUNT IDENTIFIED
33 IN THAT AGREEMENT, AND THE STATE HAS USED ALL PREVIOUS TOBACCO SETTLEMENT
34 PAYMENTS TO ADMINISTER AND PROVIDE HEALTH CARE, IN THE FOLLOWING FISCAL YEAR
35 THE COUNTIES SHALL CONTRIBUTE AN AMOUNT THAT EQUALS THIRTY-THREE PER CENT OF
36 THE DIFFERENCE BETWEEN THE ACTUAL PAYMENT AND SIXTY-SIX PER CENT OF THAT
37 ORIGINAL AMOUNT IDENTIFIED FOR EACH YEAR OF THE MASTER SETTLEMENT AGREEMENT.
38 THE STAFF OF THE JOINT LEGISLATIVE BUDGET COMMITTEE SHALL CALCULATE THE TOTAL
39 COUNTY CONTRIBUTION PURSUANT TO THIS SUBSECTION.

40 B. THE STATE SHALL USE MONIES PAID BY THE COUNTIES PURSUANT TO
41 SUBSECTION A OF THIS SECTION TO PROVIDE INDIGENT HEALTH CARE SERVICES. IF
42 THE STATE DOES NOT USE ALL SETTLEMENT PAYMENTS FOR HEALTH CARE COSTS, THE
43 COUNTIES ARE NOT REQUIRED TO PROVIDE MONIES PURSUANT TO THIS SECTION.

1 C. A COUNTY'S SHARE OF THE PAYMENTS PRESCRIBED PURSUANT TO SUBSECTION
2 A OF THIS SECTION IS THE PERCENTAGE OF THAT COUNTY'S CURRENT POPULATION TO
3 THE STATE'S CURRENT POPULATION. THE STAFF OF THE JOINT LEGISLATIVE BUDGET
4 COMMITTEE SHALL CALCULATE EACH COUNTY'S CONTRIBUTION. FOR THE PURPOSES OF
5 THIS SUBSECTION, "CURRENT POPULATION" MEANS THE POPULATION ESTIMATED BY THE
6 DEPARTMENT OF ECONOMIC SECURITY AS OF JULY 1 OF THE CALENDAR YEAR THAT
7 PRECEDES THE BEGINNING OF A FISCAL YEAR.

8 D. THE STATE TREASURER SHALL WITHHOLD THE AMOUNT OWED BY A COUNTY FROM
9 ANY PAYMENTS REQUIRED TO BE MADE BY THE STATE TREASURER TO THAT COUNTY
10 PURSUANT TO SECTION 42-5029, SUBSECTION D, PARAGRAPH 2 AFTER ANY AMOUNTS
11 WITHHELD FOR THE COUNTY LONG-TERM CARE CONTRIBUTION OR THE COUNTY
12 ADMINISTRATION CONTRIBUTION PURSUANT TO SECTION 11-292, SUBSECTION P. IF THE
13 MONIES THE STATE TREASURER WITHHOLDS ARE INSUFFICIENT TO MEET THAT COUNTY'S
14 FUNDING REQUIREMENTS AS SPECIFIED IN THIS SECTION, THE STATE TREASURER SHALL
15 WITHHOLD FROM ANY OTHER MONIES PAYABLE TO THAT COUNTY FROM WHATEVER STATE
16 FUNDING SOURCE IS AVAILABLE AN AMOUNT NECESSARY TO FULFILL THAT COUNTY'S
17 REQUIREMENTS. THE STATE TREASURER MAY NOT WITHHOLD DISTRIBUTION FROM THE
18 HIGHWAY USER REVENUE FUND PURSUANT TO TITLE 28, CHAPTER 18, ARTICLE 2.

19 E. ON OR BEFORE THE FIFTH DAY OF EACH MONTH EACH COUNTY SHALL PAY TO
20 THE STATE TREASURER AN AMOUNT EQUAL TO ONE-TWELFTH OF THE TOTAL MONIES
21 PRESCRIBED PURSUANT TO THIS SECTION. THE STATE TREASURER SHALL DEPOSIT THESE
22 MONIES IN THE BUDGET NEUTRALITY COMPLIANCE FUND ESTABLISHED BY SECTION
23 36-2928. ON REQUEST FROM THE DIRECTOR OF THE ARIZONA HEALTH CARE COST
24 CONTAINMENT SYSTEM ADMINISTRATION, THE STATE TREASURER SHALL REQUIRE A COUNTY
25 TO MAKE UP TO THREE MONTHS' PAYMENTS IN ADVANCE.

26 Sec. 14. Section 11-1431, Arizona Revised Statutes, is amended to
27 read:

28 11-1431. Purposes of the nonprofit corporation

29 The board of supervisors may enter into an operating agreement only
30 with a nonprofit corporation with articles of incorporation or bylaws that
31 provide that the primary purposes of the corporation under this chapter are
32 to:

33 1. Provide quality, cost-effective health care services for
34 individuals, families and communities residing, employed or located, as
35 applicable, in the sponsoring county and elsewhere.

36 2. Act as a provider of health care services for compensation.

37 3. Assume the responsibility for managing, maintaining and operating
38 health system assets that are transferred to the corporation pursuant to a
39 lease agreement.

40 4. Provide health care ~~for the indigent~~ TO THE PUBLIC.

41 5. Promote public health.

42 6. Support and facilitate medical and public health research and
43 clinical education for health care professionals.

1 Sec. 15. Section 11-1434, Arizona Revised Statutes, is amended to
2 read:

3 11-1434. Operating agreement; required provisions

4 A. An operating agreement under this chapter shall include the
5 following provisions:

6 1. The nonprofit corporation's assumption of responsibility for
7 managing, maintaining and operating the health system assets that are leased
8 or transferred pursuant to the lease agreement.

9 2. The nonprofit corporation's assumption, beginning on the transfer
10 date, of responsibility for, and responsibility to defend, indemnify and hold
11 the sponsoring county harmless with respect to, all or some liabilities
12 relating to the health system assets that are leased or transferred to the
13 corporation as stated in the lease agreement. This assumption may include
14 liabilities accruing before, on or after the transfer date.

15 3. An agreement by the nonprofit corporation to continue to provide
16 health care for TO the PUBLIC, INCLUDING indigent PERSONS, as one of its
17 primary missions.

18 4. The nonprofit corporation's undertaking, covenants and
19 indemnification to the sponsoring county against all actions, activities and
20 consequences that may arise out of or relate to any actions taken by the
21 nonprofit corporation pursuant to the lease agreement.

22 B. An operating agreement under this chapter may include provisions
23 requiring the nonprofit corporation to:

24 1. Obtain the approval of the board of supervisors of any business
25 transaction by the corporation that may materially and adversely affect the
26 sponsoring county's interests. The agreement shall specify with
27 particularity the type and nature of the transactions that require prior
28 approval of the board of supervisors.

29 2. Notify the board of supervisors before amending all or part of the
30 corporation's articles of incorporation or bylaws. The articles of
31 incorporation and bylaws may not be amended to remove the requirement
32 prescribed by subsection A, paragraph 3 of this section.

33 3. Pay all or part of the costs of the board of supervisors that are
34 related to the conveyance and transition of the county health system to the
35 nonprofit corporation.

36 4. Provide or continue to provide services and programs to the
37 communities and populations served by the county health system.

38 C. The sponsoring county and nonprofit corporation may also agree in
39 writing to:

40 1. Any other arrangements, including indemnifications, that they
41 consider appropriate and prudent with respect to the transition of county
42 health system operations to the corporation.

43 2. Any other provision that is not inconsistent with this chapter or
44 the operating agreement, including contracts for the provision by the

1 sponsoring county or the nonprofit corporation of goods, services and
2 facilities in support of the community health system.

3 D. Notwithstanding any other law, at its discretion the sponsoring
4 county may agree to provide grants to the nonprofit corporation.

5 E. Section 42-17106 does not apply to any promise, undertaking,
6 covenant or agreement THAT IS contained in the operating agreement AND that
7 commits a sponsoring county to compensate the nonprofit corporation for
8 performing the county's primary function of providing health care services
9 to the indigent. Any such promise, undertaking, covenant or agreement is a
10 lawful long-term contract for all purposes of the constitution and laws of
11 this state.

12 Sec. 16. Section 20-282, Arizona Revised Statutes, is amended to read:
13 20-282. Agent defined; exception

14 A. An "agent" is an individual, firm or corporation authorized by an
15 insurer to solicit applications for insurance or annuities or to negotiate
16 insurance on its behalf and, if authorized by the insurer, to effectuate and
17 countersign insurance contracts. Notwithstanding any statement in the
18 application or policy to the contrary, in the event of any controversy
19 between the insured or the insured's beneficiary and the company, an agent
20 who acts within the scope of his THE AGENT'S authority or within the scope
21 of his THE AGENT'S apparent authority or whose actions have been previously
22 authorized or are subsequently ratified by the company is the agent of the
23 company which THAT issued the insurance.

24 B. A regular salaried officer or employee of a life insurer shall not
25 be deemed to be an agent by reason of rendering assistance to or on behalf
26 of a licensed life insurance agent, if such officer or employee devotes
27 substantially all of his THAT PERSON'S time to activities other than the
28 solicitation of applications for life or disability insurance or annuity
29 contracts and receives no commission or other compensation directly dependent
30 upon the amount of business obtained.

31 C. As used in this title, "agent" includes a bail bond agent, a person
32 authorized to act as an agent for a health plan contracted to provide
33 coverage to persons defined as eligible pursuant to section 36-2901,
34 paragraph 4- 6, subdivision (d), (e), (f) or (g) (b), (c), (d) OR (e) or a
35 rental car agent pursuant to section 20-295.01.

36 Sec. 17. Section 20-283, Arizona Revised Statutes, is amended to read:
37 20-283. "Broker" defined

38 A "broker" is an individual, firm or corporation who THAT for
39 compensation as an independent contractor in any manner solicits, negotiates
40 or procures insurance, or coverage from a health plan contracted to provide
41 coverage to persons defined as eligible pursuant to section 36-2901,
42 paragraph 4- 6, subdivision (d), (e), (f) or (g) (b), (c), (d) OR (e), or the
43 renewal or continuance thereof, on behalf of persons, insureds or prospective

1 insureds other than himself THE BROKER, and not on behalf of an insurer or
2 agent.

3 Sec. 18. Section 20-291, Arizona Revised Statutes, is amended to read:
4 20-291. Application for license

5 A. An applicant shall apply to the director for an agent or broker
6 license. As part of or in connection with the application the applicant
7 shall furnish information concerning the applicant's identity, personal
8 history, business record, experience in insurance, purposes for which the
9 license is to be used and other pertinent facts the director requires.

10 B. The application shall also show whether:

11 1. The applicant was ever previously licensed to transact any kind of
12 insurance in this state or elsewhere.

13 2. Any license was ever refused, suspended or revoked.

14 3. Any insurer or managing general agent claims the applicant is
15 indebted to it, and if so the details of the claim.

16 4. The applicant ever had an agency contract cancelled, and the facts
17 of the cancellation.

18 5. The applicant received a passing score on the required licensing
19 examination.

20 C. If a firm or corporation applies for an agent or broker license,
21 the application shall set forth the information required by subsections A and
22 B of this section with respect to the firm or corporation, and in addition
23 shall set forth the names of all members, officers and directors of the firm
24 or corporation and, except for a rental car agent as defined in section
25 20-295.01, the name of each individual who is to exercise the agent or broker
26 powers conferred on the firm or corporation by the license. Each individual
27 identified pursuant to this subsection shall furnish the information required
28 for a license as an individual.

29 D. The director may require any application to be in the applicant's
30 handwriting and under the applicant's oath.

31 E. If for an agent's license, the application shall show:

32 1. The kinds of insurance to be transacted and the name of the
33 authorized insurer the applicant is authorized to represent, if any, subject
34 to issuance of the license.

35 2. If authorized to represent a health plan contracted to provide
36 coverage to persons defined as eligible pursuant to section 36-2901,
37 paragraph 4-6, subdivision ~~(d)~~, ~~(e)~~, ~~(f)~~ or ~~(g)~~ (b), (c), (d) OR (e), the
38 name of the health plan the applicant is authorized to represent subject to
39 issuance of the license.

40 F. Wilful misrepresentation of any fact required to be disclosed in
41 any application or accompanying statement is a violation of this title.

1 Sec. 19. Section 20-826, Arizona Revised Statutes, is amended to read:

2 20-826. Subscription contracts; definitions

3 A. A contract between a corporation and its subscribers shall not be
4 issued unless the form of such contract is approved in writing by the
5 director.

6 B. Each contract shall plainly state the services to which the
7 subscriber is entitled and those to which the subscriber is not entitled
8 under the plan, and shall constitute a direct obligation of the providers of
9 services with which the corporation has contracted for hospital, medical,
10 dental or optometric services.

11 C. Each contract, except for dental services or optometric services,
12 shall be so written that the corporation shall pay benefits for each of the
13 following:

14 1. Performance of any surgical service which THAT is covered by the
15 terms of such contract, regardless of the place of service.

16 2. Any home health services which THAT are performed by a licensed
17 home health agency and which THAT a physician has prescribed in lieu of
18 hospital services, as defined by the director, providing the hospital
19 services would have been covered.

20 3. Any diagnostic service which THAT a physician has performed outside
21 a hospital in lieu of inpatient service, providing the inpatient service
22 would have been covered.

23 4. Any service performed in a hospital's outpatient department or in
24 a freestanding surgical facility, if such service would have been covered if
25 performed as an inpatient service.

26 D. Each contract for dental or optometric services shall be so written
27 that the corporation shall pay benefits for contracted dental or optometric
28 services provided by dentists or optometrists.

29 E. Any contract, except accidental death and dismemberment, applied
30 for that provides family coverage shall, as to such coverage of family
31 members, also provide that the benefits applicable for children shall be
32 payable with respect to a newly born child of the insured from the instant
33 of such child's birth, to a child adopted by the insured, regardless of the
34 age at which the child was adopted, and to a child who has been placed for
35 adoption with the insured and for whom the application and approval
36 procedures for adoption pursuant to section 8-105 or 8-108 have been
37 completed to the same extent that such coverage applies to other members of
38 the family. The coverage for newly born or adopted children or children
39 placed for adoption shall include coverage of injury or sickness including
40 necessary care and treatment of medically diagnosed congenital defects and
41 birth abnormalities. If payment of a specific premium is required to provide
42 coverage for a child, the contract may require that notification of birth,
43 adoption or adoption placement of the child and payment of the required
44 premium must be furnished to the insurer within thirty-one days after the

1 date of birth, adoption or adoption placement in order to have the coverage
2 continue beyond the thirty-one day period.

3 F. Each contract which THAT is delivered or issued for delivery in
4 this state after December 25, 1977 and which THAT provides that coverage of
5 a dependent child shall terminate upon attainment of the limiting age for
6 dependent children specified in the contract shall also provide in substance
7 that attainment of such limiting age shall not operate to terminate the
8 coverage of such child while the child is and continues to be both incapable
9 of self-sustaining employment by reason of mental retardation or physical
10 handicap and chiefly dependent upon the subscriber for support and
11 maintenance. Proof of such incapacity and dependency shall be furnished to
12 the corporation by the subscriber within thirty-one days of the child's
13 attainment of the limiting age and subsequently as may be required by the
14 corporation, but not more frequently than annually after the two-year period
15 following the child's attainment of the limiting age.

16 G. No corporation may cancel or refuse to renew any subscriber's
17 contract without giving notice of such cancellation or nonrenewal to the
18 subscriber under such contract. A notice by the corporation to the
19 subscriber of cancellation or nonrenewal of a subscription contract shall be
20 mailed to the named subscriber at least forty-five days ~~prior to~~ BEFORE the
21 effective date of such cancellation or nonrenewal. The notice shall include
22 or be accompanied by a statement in writing of the reasons for such action
23 by the corporation. Failure of the corporation to comply with the provisions
24 of this subsection shall invalidate any cancellation or nonrenewal except a
25 cancellation or nonrenewal for nonpayment of premium.

26 H. A contract that provides coverage for surgical services for a
27 mastectomy shall also provide coverage incidental to the patient's covered
28 mastectomy for surgical services for reconstruction of the breast on which
29 the mastectomy was performed, surgery and reconstruction of the other breast
30 to produce a symmetrical appearance, prostheses, treatment of physical
31 complications for all stages of the mastectomy, including lymphedemas, and
32 at least two external postoperative prostheses subject to all of the terms
33 and conditions of the policy.

34 I. A contract that provides coverage for surgical services for a
35 mastectomy shall also provide coverage for mammography screening performed
36 on dedicated equipment for diagnostic purposes on referral by a patient's
37 physician, subject to all of the terms and conditions of the policy and
38 according to the following guidelines:

39 1. A baseline mammogram for a woman from age thirty-five to
40 thirty-nine.

41 2. A mammogram for a woman from age forty to forty-nine every two
42 years or more frequently based on the recommendation of the woman's
43 physician.

44 3. A mammogram every year for a woman fifty years of age and over.

1 J. Any contract that is issued to the insured and that provides
2 coverage for maternity benefits shall also provide that the maternity
3 benefits apply to the costs of the birth of any child legally adopted by the
4 insured if all of the following are true:

5 1. The child is adopted within one year of birth.
6 2. The insured is legally obligated to pay the costs of birth.
7 3. All preexisting conditions and other limitations have been met by
8 the insured.

9 4. The insured has notified the insurer of the insured's acceptability
10 to adopt children pursuant to section 8-105, within sixty days after such
11 approval or within sixty days after a change in insurance policies, plans or
12 companies.

13 K. The coverage prescribed by subsection J of this section is excess
14 to any other coverage the natural mother may have for maternity benefits
15 except coverage made available to persons pursuant to title 36, chapter 29
16 but not including coverage made available to persons defined as eligible
17 under section 36-2901, paragraph 4-6, subdivisions ~~(d), (e), (f) and (g)~~
18 (b), (c), (d) AND (e). If such other coverage exists the agency, attorney
19 or individual arranging the adoption shall make arrangements for the
20 insurance to pay those costs that may be covered under that policy and shall
21 advise the adopting parent in writing of the existence and extent of the
22 coverage without disclosing any confidential information such as the identity
23 of the natural parent. The insured adopting parents shall notify their
24 insurer of the existence and extent of the other coverage.

25 L. The director may disapprove any contract if the benefits provided
26 in the form of such contract are unreasonable in relation to the premium
27 charged.

28 M. The director shall adopt emergency rules applicable to persons who
29 are leaving active service in the armed forces of the United States and
30 returning to civilian status including:

- 31 1. Conditions of eligibility.
- 32 2. Coverage of dependents.
- 33 3. Preexisting conditions.
- 34 4. Termination of insurance.
- 35 5. Probationary periods.
- 36 6. Limitations.
- 37 7. Exceptions.
- 38 8. Reductions.
- 39 9. Elimination periods.
- 40 10. Requirements for replacement.
- 41 11. Any other condition of subscription contracts.

42 N. Any contract that provides maternity benefits shall not restrict
43 benefits for any hospital length of stay in connection with childbirth for
44 the mother or the newborn child to less than forty-eight hours following a

1 normal vaginal delivery or ninety-six hours following a cesarean
2 section. The contract shall not require the provider to obtain authorization
3 from the corporation for prescribing the minimum length of stay required by
4 this subsection. The contract may provide that an attending provider in
5 consultation with the mother may discharge the mother or the newborn child
6 before the expiration of the minimum length of stay required by this
7 subsection. The corporation shall not:

8 1. Deny the mother or the newborn child eligibility or continued
9 eligibility to enroll or to renew coverage under the terms of the contract
10 solely for the purpose of avoiding the requirements of this subsection.

11 2. Provide monetary payments or rebates to mothers to encourage those
12 mothers to accept less than the minimum protections available pursuant to
13 this subsection.

14 3. Penalize or otherwise reduce or limit the reimbursement of an
15 attending provider because that provider provided care to any insured under
16 the contract in accordance with this subsection.

17 4. Provide monetary or other incentives to an attending provider to
18 induce that provider to provide care to an insured under the contract in a
19 manner that is inconsistent with this subsection.

20 5. Except as described in subsection O of this section, restrict
21 benefits for any portion of a period within the minimum length of stay in a
22 manner that is less favorable than the benefits provided for any preceding
23 portion of that stay.

24 O. Nothing in subsection N of this section:

25 1. Requires a mother to give birth in a hospital or to stay in the
26 hospital for a fixed period of time following the birth of the child.

27 2. Prevents a corporation from imposing deductibles, coinsurance or
28 other cost sharing in relation to benefits for hospital lengths of stay in
29 connection with childbirth for a mother or a newborn child under the
30 contract, except that any coinsurance or other cost sharing for any portion
31 of a period within a hospital length of stay required pursuant to subsection
32 N of this section shall not be greater than the coinsurance or cost sharing
33 for any preceding portion of that stay.

34 3. Prevents a corporation from negotiating the level and type of
35 reimbursement with a provider for care provided in accordance with subsection
36 N of this section.

37 P. Any contract that provides coverage for diabetes shall also provide
38 coverage for equipment and supplies that are medically necessary and that are
39 prescribed by a health care provider including:

40 1. Blood glucose monitors.

41 2. Blood glucose monitors for the legally blind.

42 3. Test strips for glucose monitors and visual reading and urine
43 testing strips.

44 4. Insulin preparations and glucagon.

- 1 5. Insulin cartridges.
- 2 6. Drawing up devices and monitors for the visually impaired.
- 3 7. Injection aids.
- 4 8. Insulin cartridges for the legally blind.
- 5 9. Syringes and lancets including automatic lancing devices.
- 6 10. Prescribed oral agents for controlling blood sugar that are
- 7 included on the plan formulary.

8 11. To the extent coverage is required under medicare, podiatric
9 appliances for prevention of complications associated with diabetes.

10 12. Any other device, medication, equipment or supply for which
11 coverage is required under medicare from and after January 1, 1999. The
12 coverage required in this paragraph is effective six months after the
13 coverage is required under medicare.

14 Q. Nothing in subsection P of this section prohibits a medical service
15 corporation, a hospital service corporation or a hospital, medical, dental
16 and optometric service corporation from imposing deductibles, coinsurance or
17 other cost sharing in relation to benefits for equipment or supplies for the
18 treatment of diabetes.

19 R. Any hospital or medical service contract that provides coverage for
20 prescription drugs shall not limit or exclude coverage for any prescription
21 drug prescribed for the treatment of cancer on the basis that the
22 prescription drug has not been approved by the United States food and drug
23 administration for the treatment of the specific type of cancer for which the
24 prescription drug has been prescribed, if the prescription drug has been
25 recognized as safe and effective for treatment of that specific type of
26 cancer in one or more of the standard medical reference compendia prescribed
27 in subsection S of this section or medical literature that meets the criteria
28 prescribed in subsection S of this section. The coverage required under this
29 subsection includes covered medically necessary services associated with the
30 administration of the prescription drug. This subsection does not:

31 1. Require coverage of any prescription drug used in the treatment of
32 a type of cancer if the United States food and drug administration has
33 determined that the prescription drug is contraindicated for that type of
34 cancer.

35 2. Require coverage for any experimental prescription drug that is not
36 approved for any indication by the United States food and drug
37 administration.

38 3. Alter any law with regard to provisions that limit the coverage of
39 prescription drugs that have not been approved by the United States food and
40 drug administration.

41 4. Notwithstanding section 20-841.05, require reimbursement or
42 coverage for any prescription drug that is not included in the drug formulary
43 or list of covered prescription drugs specified in the contract.

1 5. Notwithstanding section 20-841.05, prohibit a contract from
2 limiting or excluding coverage of a prescription drug, if the decision to
3 limit or exclude coverage of the prescription drug is not based primarily on
4 the coverage of prescription drugs required by this section.

5 6. Prohibit the use of deductibles, coinsurance, copayments or other
6 cost sharing in relation to drug benefits and related medical benefits
7 offered.

8 S. For the purposes of subsection R of this section:

9 1. The acceptable standard medical reference compendia are the
10 following:

11 (a) The American medical association drug evaluations, a publication
12 of the American medical association.

13 (b) The American hospital formulary service drug information, a
14 publication of the American society of health system pharmacists.

15 (c) Drug information for the health care provider, a publication of
16 the United States pharmacopoeia convention.

17 2. Medical literature may be accepted if all of the following apply:

18 (a) At least two articles from major peer reviewed professional
19 medical journals have recognized, based on scientific or medical criteria,
20 the drug's safety and effectiveness for treatment of the indication for which
21 the drug has been prescribed.

22 (b) No article from a major peer reviewed professional medical journal
23 has concluded, based on scientific or medical criteria, that the drug is
24 unsafe or ineffective or that the drug's safety and effectiveness cannot be
25 determined for the treatment of the indication for which the drug has been
26 prescribed.

27 (c) The literature meets the uniform requirements for manuscripts
28 submitted to biomedical journals established by the international committee
29 of medical journal editors or is published in a journal specified by the
30 United States department of health and human services as acceptable peer
31 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
32 security act (42 United States Code section 1395x(t)(2)(B)).

33 T. A corporation shall not issue or deliver any advertising matter or
34 sales material to any person in this state until the corporation files the
35 advertising matter or sales material with the director. This subsection does
36 not require a corporation to have the prior approval of the director to issue
37 or deliver the advertising matter or sales material. If the director finds
38 that the advertising matter or sales material, in whole or in part, is false,
39 deceptive or misleading, the director may issue an order disapproving the
40 advertising matter or sales material, directing the corporation to cease and
41 desist from issuing, circulating, displaying or using the advertising matter
42 or sales material within a period of time specified by the director but not
43 less than ten days and imposing any penalties prescribed in this title. At
44 least five days before issuing an order pursuant to this subsection, the

1 director shall provide the corporation with a written notice of the basis of
2 the order to provide the corporation with an opportunity to cure the alleged
3 deficiency in the advertising matter or sales material within a single five
4 day period for the particular advertising matter or sales material at issue.
5 The corporation may appeal the director's order pursuant to title 41, chapter
6 6, article 10. Except as otherwise provided in this subsection, a
7 corporation may obtain a stay of the effectiveness of the order as prescribed
8 in section 20-162. If the director certifies in the order and provides a
9 detailed explanation of the reasons in support of the certification that
10 continued use of the advertising matter or sales material poses a threat to
11 the health, safety or welfare of the public, the order may be entered
12 immediately without opportunity for cure and the effectiveness of the order
13 is not stayed pending the hearing on the notice of appeal but the hearing
14 shall be promptly instituted and determined.

15 U. Any contract THAT IS offered by a hospital service corporation or
16 medical service corporation AND that contains a prescription drug benefit
17 shall provide coverage of medical foods to treat inherited metabolic
18 disorders as provided by this section.

19 V. The metabolic disorders triggering medical foods coverage under
20 this section shall:

21 1. Be part of the newborn screening program prescribed in section
22 36-694.

23 2. Involve amino acid, carbohydrate or fat metabolism.

24 3. Have medically standard methods of diagnosis, treatment and
25 monitoring including quantification of metabolites in blood, urine or spinal
26 fluid or enzyme or DNA confirmation in tissues.

27 4. Require specially processed or treated medical foods that are
28 generally available only under the supervision and direction of a physician
29 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed
30 throughout life and without which the person may suffer serious mental or
31 physical impairment.

32 W. Medical foods eligible for coverage under this section shall be
33 prescribed or ordered under the supervision of a physician licensed pursuant
34 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
35 treatment of an inherited metabolic disease.

36 X. A hospital service corporation or medical service corporation shall
37 cover at least fifty per cent of the cost of medical foods prescribed to
38 treat inherited metabolic disorders and covered pursuant to this section. A
39 hospital service corporation or medical service corporation may limit the
40 maximum annual benefit for medical foods under this section to five thousand
41 dollars, which applies to the cost of all prescribed modified low protein
42 foods and metabolic formula.

43 Y. For the purposes of:

44 1. This section:

1 (a) "Inherited metabolic disorder" means a disease caused by an
2 inherited abnormality of body chemistry and includes a disease tested under
3 the newborn screening program prescribed in section 36-694.

4 (b) "Medical foods" means modified low protein foods and metabolic
5 formula.

6 (c) "Metabolic formula" means foods that are all of the following:

7 (i) Formulated to be consumed or administered enterally under the
8 supervision of a physician who is licensed pursuant to title 32, chapter 13
9 or 17.

10 (ii) Processed or formulated to be deficient in one or more of the
11 nutrients present in typical foodstuffs.

12 (iii) Administered for the medical and nutritional management of a
13 person who has limited capacity to metabolize foodstuffs or certain nutrients
14 contained in the foodstuffs or who has other specific nutrient requirements
15 as established by medical evaluation.

16 (iv) Essential to a person's optimal growth, health and metabolic
17 homeostasis.

18 (d) "Modified low protein foods" means foods that are all of the
19 following:

20 (i) Formulated to be consumed or administered enterally under the
21 supervision of a physician who is licensed pursuant to title 32, chapter 13
22 or 17.

23 (ii) Processed or formulated to contain less than one gram of protein
24 per unit of serving, but does not include a natural food that is naturally
25 low in protein.

26 (iii) Administered for the medical and nutritional management of a
27 person who has limited capacity to metabolize foodstuffs or certain nutrients
28 contained in the foodstuffs or who has other specific nutrient requirements
29 as established by medical evaluation.

30 (iv) Essential to a person's optimal growth, health and metabolic
31 homeostasis.

32 2. Subsection E of this section, the term "child", for purposes of
33 initial coverage of an adopted child or a child placed for adoption but not
34 for purposes of termination of coverage of such child, means a person under
35 the age of eighteen years.

36 Sec. 20. Section 20-934, Arizona Revised Statutes, is amended to read:

37 20-934. Limitation on insuring powers; definitions

38 A. A benefit insurer shall not:

39 1. Issue any life insurance policy or policies under which the
40 maximum possible benefits payable on the death of any one insured exceed
41 three thousand dollars.

42 2. Issue any disability policy or policies under which the maximum
43 possible benefits for or on account of any one insured exceed five thousand
44 dollars.

1 3. Issue any policies, in combination or otherwise, whereby the
2 maximum possible benefits payable to or on account of any one insured exceed
3 five thousand dollars.

4 4. Issue any policy with cash surrender values, loan values or
5 paid-up or extended insurance provisions.

6 5. Issue any policy containing a prorate clause, also known as a
7 provision by which the insurer may within any given period of time compute
8 the total unpaid policy claims and prorate the amount of monies in the
9 mortuary or morbidity fund at such time, or that may be collected for such
10 period, or that may be collected as to such claims, and pay the prorated sum
11 to the beneficiaries or members as full payment of their claims.

12 6. Issue any graded life insurance policy, also known as a policy
13 providing for a period of time in which only a portion of the maximum benefit
14 will be paid with periodic increases until the maximum amount is attained,
15 unless the policy provides that after it has attained its maximum amount,
16 such amount shall thereafter remain unchanged.

17 7. Authorize the deduction of any premium or assessment from any
18 benefit payable under the terms of a policy, except such premiums or
19 assessments as may be due or covered by a written order or note at the time
20 of payment of the benefit.

21 8. Limit the amount of the benefit to be paid to a sum less than that
22 stated in the policy and for which the premium has been paid.

23 9. Issue any endowment, limited payment whole life or annuity
24 contract.

25 10. Issue group or blanket insurance policies, except family group.

26 11. Restrict or prohibit, by means of a policy or contract, whether
27 written or otherwise, a licensed health care professional's good faith
28 communication with the health care professional's patient concerning the
29 patient's health care or medical needs, treatment options, health care risks
30 or benefits.

31 12. Terminate a contract with or refuse to renew a contract with a
32 health care professional solely because the professional in good faith does
33 any of the following:

34 (a) Advocates in private or in public on behalf of a patient.

35 (b) Assists a patient in seeking reconsideration of a decision made
36 by the benefit insurer to deny coverage for a health care service.

37 (c) Reports a violation of law to an appropriate authority.

38 B. The insurer shall keep reinsured all accidental death risks as to
39 any one individual in excess of one thousand dollars or ten per cent of the
40 insurer's assets exclusive of its statutory deposit, whichever is the larger
41 amount.

42 C. Any policy, except accidental death and dismemberment, applied for
43 that provides family coverage shall, as to such coverage of family members,
44 also provide that the benefits applicable for children shall be payable with

1 respect to a newly born child of the insured from the instant of such child's
2 birth, to a child adopted by the insured, regardless of the age at which the
3 child was adopted, and to a child who has been placed for adoption with the
4 insured and for whom the application and approval procedures for adoption
5 pursuant to section 8-105 or 8-108 have been completed to the same extent
6 that such coverage applies to other members of the family. The coverage for
7 newly born or adopted children or children placed for adoption shall include
8 coverage of injury or sickness including necessary care and treatment of
9 medically diagnosed congenital defects and birth abnormalities. If payment
10 of a specific premium is required to provide coverage for a child, the policy
11 may require that notification of birth, adoption or adoption placement of the
12 child and payment of the required premium must be furnished to the insurer
13 within thirty-one days after the date of birth, adoption or adoption
14 placement in order to have the coverage continue beyond the thirty-one day
15 period. Any such policy that provides family coverage shall be so written
16 that the benefit insurer shall pay benefits:

17 1. For performance of any surgical service which THAT is covered by
18 the terms of such policy, regardless of the place of service.

19 2. For any home health services which THAT are performed by a
20 licensed home health agency and which THAT a physician has prescribed in lieu
21 of hospital services, as defined by the director, providing the hospital
22 services would have been covered.

23 3. For any diagnostic service which THAT a physician has performed
24 outside a hospital in lieu of inpatient service, providing the inpatient
25 service would have been covered.

26 4. For any service performed in a hospital's outpatient department or
27 in a freestanding surgical facility, providing such service would have been
28 covered if performed as an inpatient service.

29 D. Any contract, except accidental death and dismemberment, that
30 provides coverage for psychiatric, drug abuse or alcoholism services shall
31 require the benefit insurer to provide reimbursement for such services in
32 accordance with the terms of the contract without regard to whether the
33 covered services are rendered in a psychiatric special hospital or general
34 hospital.

35 E. Any contract, except accidental death and dismemberment, that
36 provides coverage for childhood and adolescent psychiatric services shall
37 require the benefit insurer to provide reimbursement for such services in
38 accordance with the terms of the contract without regard to whether the
39 covered services are rendered in a psychiatric special hospital, a general
40 hospital or a nationally accredited and state licensed residential treatment
41 center which THAT meets or exceeds the standards for such facilities
42 established by the joint commission on the accreditation of hospitals.

43 F. A policy that provides coverage for surgical services for a
44 mastectomy shall also provide coverage incidental to the patient's covered

1 mastectomy for surgical services for reconstruction of the breast on which
2 the mastectomy was performed, surgery and reconstruction of the other breast
3 to produce a symmetrical appearance, prostheses, treatment of physical
4 complications for all stages of the mastectomy, including lymphedemas, and
5 at least two external postoperative prostheses subject to all of the terms
6 and conditions of the policy.

7 G. A contract that provides coverage for surgical services for a
8 mastectomy shall also provide coverage for mammography screening performed
9 on dedicated equipment for diagnostic purposes on referral by a patient's
10 physician, subject to all of the terms and conditions of the policy and
11 according to the following guidelines:

12 1. A baseline mammogram for a woman from age thirty-five to
13 thirty-nine.

14 2. A mammogram for a woman from age forty to forty-nine every two
15 years or more frequently based on the recommendation of the woman's
16 physician.

17 3. A mammogram every year for a woman fifty years of age and over.

18 H. Any contract that is issued to the insured and that provides
19 coverage for maternity benefits shall also provide that the maternity
20 benefits apply to the costs of the birth of any child legally adopted by the
21 insured if all of the following are true:

22 1. The child is adopted within one year of birth.

23 2. The insured is legally obligated to pay the cost of birth.

24 3. All preexisting conditions and other limitations have been met by
25 the insured.

26 4. The insured has notified the insurer of the insured's
27 acceptability to adopt children pursuant to section 8-105, within sixty days
28 after such approval or within sixty days after a change in insurance
29 policies, plans or companies.

30 I. The coverage prescribed by subsection H of this section is excess
31 to any other coverage the natural mother may have for maternity benefits
32 except coverage made available to persons pursuant to title 36, chapter 29
33 but not including coverage made available to persons defined as eligible
34 under section 36-2901, paragraph 4-6, subdivisions ~~(d)~~, ~~(e)~~, ~~(f)~~ and ~~(g)~~
35 (b), (c), (d) AND (e). If such other coverage exists the agency, attorney
36 or individual arranging the adoption shall make arrangements for the
37 insurance to pay those costs that may be covered under that policy and shall
38 advise the adopting parent in writing of the existence and extent of the
39 coverage without disclosing any confidential information such as the identity
40 of the natural parent. The insured adopting parents shall notify their
41 insurer of the existence and extent of the other coverage.

42 J. Any contract that provides maternity benefits shall not restrict
43 benefits for any hospital length of stay in connection with childbirth for
44 the mother or the newborn child to less than forty-eight hours following a

1 normal vaginal delivery or ninety-six hours following a cesarean
2 section. The contract shall not require the provider to obtain authorization
3 from the insurer for prescribing the minimum length of stay required by this
4 subsection. The contract may provide that an attending provider in
5 consultation with the mother may discharge the mother or the newborn child
6 before the expiration of the minimum length of stay required by this
7 subsection. The insurer shall not:

8 1. Deny the mother or the newborn child eligibility or continued
9 eligibility to enroll or to renew coverage under the terms of the contract
10 solely for the purpose of avoiding the requirements of this subsection.

11 2. Provide monetary payments or rebates to mothers to encourage those
12 mothers to accept less than the minimum protections available pursuant to
13 this subsection.

14 3. Penalize or otherwise reduce or limit the reimbursement of an
15 attending provider because that provider provided care to any insured under
16 the contract in accordance with this subsection.

17 4. Provide monetary or other incentives to an attending provider to
18 induce that provider to provide care to an insured under the contract in a
19 manner that is inconsistent with this subsection.

20 5. Except as described in subsection K of this section, restrict
21 benefits for any portion of a period within the minimum length of stay in a
22 manner that is less favorable than the benefits provided for any preceding
23 portion of that stay.

24 K. Nothing in subsection J of this section:

25 1. Requires a mother to give birth in a hospital or to stay in the
26 hospital for a fixed period of time following the birth of the child.

27 2. Prevents an insurer from imposing deductibles, coinsurance or
28 other cost sharing in relation to benefits for hospital lengths of stay in
29 connection with childbirth for a mother or a newborn child under the
30 contract, except that any coinsurance or other cost sharing for any portion
31 of a period within a hospital length of stay required pursuant to subsection
32 J of this section shall not be greater than the coinsurance or cost sharing
33 for any preceding portion of that stay.

34 3. Prevents an insurer from negotiating the level and type of
35 reimbursement with a provider for care provided in accordance with subsection
36 J of this section.

37 L. Any contract that provides coverage for diabetes shall also
38 provide coverage for equipment and supplies that are medically necessary and
39 that are prescribed by a health care provider including:

40 1. Blood glucose monitors.

41 2. Blood glucose monitors for the legally blind.

42 3. Test strips for glucose monitors and visual reading and urine
43 testing strips.

44 4. Insulin preparations and glucagon.

- 1 5. Insulin cartridges.
- 2 6. Drawing up devices and monitors for the visually impaired.
- 3 7. Injection aids.
- 4 8. Insulin cartridges for the legally blind.
- 5 9. Syringes and lancets including automatic lancing devices.
- 6 10. Prescribed oral agents for controlling blood sugar that are
- 7 included on the plan formulary.

8 11. To the extent coverage is required under medicare, podiatric

9 appliances for prevention of complications associated with diabetes.

10 12. Any other device, medication, equipment or supply for which

11 coverage is required under medicare from and after January 1, 1999. The

12 coverage required in this paragraph is effective six months after the

13 coverage is required under medicare.

14 M. ~~Nothing in~~ Subsection L of this section prohibits DOES NOT

15 PROHIBIT a benefit insurer from imposing deductibles, coinsurance or other

16 cost sharing in relation to benefits for equipment or supplies for the

17 treatment of diabetes.

18 N. Any contract that provides coverage for prescription drugs shall

19 not limit or exclude coverage for any prescription drug prescribed for the

20 treatment of cancer on the basis that the prescription drug has not been

21 approved by the United States food and drug administration for the treatment

22 of the specific type of cancer for which the prescription drug has been

23 prescribed, if the prescription drug has been recognized as safe and

24 effective for treatment of that specific type of cancer in one or more of the

25 standard medical reference compendia prescribed in subsection 0 of this

26 section or medical literature that meets the criteria prescribed in

27 subsection 0 of this section. The coverage required under this subsection

28 includes covered medically necessary services associated with the

29 administration of the prescription drug. This subsection does not:

30 1. Require coverage of any drug used in the treatment of a type of

31 cancer if the United States food and drug administration has determined that

32 the prescription drug is contraindicated for that type of cancer.

33 2. Require coverage for any experimental prescription drug that is

34 not approved for any indication by the United States food and drug

35 administration.

36 3. Alter any law with regard to provisions that limit the coverage of

37 prescription drugs that have not been approved by the United States food and

38 drug administration.

39 4. Notwithstanding section 20-936.02, require reimbursement or

40 coverage for any prescription drug that is not included in the drug formulary

41 or list of covered prescription drugs specified in the contract.

42 5. Notwithstanding section 20-936.02, prohibit a contract from

43 limiting or excluding coverage of a prescription drug, if the decision to

1 limit or exclude coverage of the prescription drug is not based primarily on
2 the coverage of prescription drugs required by this section.

3 6. Prohibit the use of deductibles, coinsurance, copayments or other
4 cost sharing in relation to drug benefits and related medical benefits
5 offered.

6 0. For the purposes of subsection N of this section:

7 1. The acceptable standard medical reference compendia are the
8 following:

9 (a) The American medical association drug evaluations, a publication
10 of the American medical association.

11 (b) The American hospital formulary service drug information, a
12 publication of the American society of health system pharmacists.

13 (c) Drug information for the health care provider, a publication of
14 the United States pharmacopoeia convention.

15 2. Medical literature may be accepted if all of the following apply:

16 (a) At least two articles from major peer reviewed professional
17 medical journals have recognized, based on scientific or medical criteria,
18 the drug's safety and effectiveness for treatment of the indication for which
19 the drug has been prescribed.

20 (b) No article from a major peer reviewed professional medical
21 journal has concluded, based on scientific or medical criteria, that the drug
22 is unsafe or ineffective or that the drug's safety and effectiveness cannot
23 be determined for the treatment of the indication for which the drug has been
24 prescribed.

25 (c) The literature meets the uniform requirements for manuscripts
26 submitted to biomedical journals established by the international committee
27 of medical journal editors or is published in a journal specified by the
28 United States department of health and human services as acceptable peer
29 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
30 security act (42 United States Code section 1395x(t)(2)(B)).

31 P. A contract between the benefit insurer and a health care
32 professional shall not contain a financial incentive plan that includes a
33 specific payment made to or withheld from the health care professional as an
34 inducement to deny, reduce, limit or delay medically necessary care that is
35 covered by the contract with an insured or group of insureds for a specific
36 disease or condition. This section does not prohibit per diem or per case
37 payments, diagnostic related grouping payments, or financial incentive plans,
38 including capitation payments or shared risk arrangements, that are not
39 connected to specific medical decisions relating to an insured or a group of
40 insureds for a specific disease or condition. Each benefit insurer shall
41 file with its annual report a written statement with the director that
42 certifies that the benefit insurer is in compliance with this subsection.

1 Q. Any contract THAT IS offered by a benefit insurer AND that
2 contains a prescription drug benefit shall provide coverage of medical foods
3 to treat inherited metabolic disorders as provided by this section.

4 R. The metabolic disorders triggering medical foods coverage under
5 this section shall:

6 1. Be part of the newborn screening program prescribed in section
7 36-694.

8 2. Involve amino acid, carbohydrate or fat metabolism.

9 3. Have medically standard methods of diagnosis, treatment and
10 monitoring including quantification of metabolites in blood, urine or spinal
11 fluid or enzyme or DNA confirmation in tissues.

12 4. Require specially processed or treated medical foods that are
13 generally available only under the supervision and direction of a physician
14 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed
15 throughout life and without which the person may suffer serious mental or
16 physical impairment.

17 S. Medical foods eligible for coverage under this section shall be
18 prescribed or ordered under the supervision of a physician licensed pursuant
19 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
20 treatment of an inherited metabolic disease.

21 T. An insurer shall cover at least fifty per cent of the cost of
22 medical foods prescribed to treat inherited metabolic disorders and covered
23 pursuant to this section. ~~A corporation~~ AN INSURER may limit the maximum
24 annual benefit for medical foods under this section to five thousand dollars,
25 which applies to the cost of all prescribed modified low protein foods and
26 metabolic formula.

27 U. For the purposes of:

28 1. This section:

29 (a) "Health care professional" means a practitioner of a health
30 profession as defined in section 32-3101.

31 (b) "Inherited metabolic disorder" means a disease caused by an
32 inherited abnormality of body chemistry and includes a disease tested under
33 the newborn screening program prescribed in section 36-694.

34 (c) "Medical foods" means modified low protein foods and metabolic
35 formula.

36 (d) "Metabolic formula" means foods that are all of the following:

37 (i) Formulated to be consumed or administered enterally under the
38 supervision of a physician who is licensed pursuant to title 32, chapter 13
39 or 17.

40 (ii) Processed or formulated to be deficient in one or more of the
41 nutrients present in typical foodstuffs.

42 (iii) Administered for the medical and nutritional management of a
43 person who has limited capacity to metabolize foodstuffs or certain nutrients

1 contained in the foodstuffs or who has other specific nutrient requirements
2 as established by medical evaluation.

3 (iv) Essential to a person's optimal growth, health and metabolic
4 homeostasis.

5 (e) "Modified low protein foods" means foods that are all of the
6 following:

7 (i) Formulated to be consumed or administered enterally under the
8 supervision of a physician who is licensed pursuant to title 32, chapter 13
9 or 17.

10 (ii) Processed or formulated to contain less than one gram of protein
11 per unit of serving, but does not include a natural food that is naturally
12 low in protein.

13 (iii) Administered for the medical and nutritional management of a
14 person who has limited capacity to metabolize foodstuffs or certain nutrients
15 contained in the foodstuffs or who has other specific nutrient requirements
16 as established by medical evaluation.

17 (iv) Essential to a person's optimal growth, health and metabolic
18 homeostasis.

19 2. Subsection C of this section, "child", for purposes of initial
20 coverage of an adopted child or a child placed for adoption but not for
21 purposes of termination of coverage of such child, means a person under the
22 age of eighteen years.

23 Sec. 21. Section 20-1057, Arizona Revised Statutes, as amended by Laws
24 2000, chapter 37, section 15 and chapter 282, section 3, is amended to read:
25 20-1057. Evidence of coverage by health care services

26 organizations; renewability; definitions

27 A. Every enrollee in a health care plan shall be issued an evidence
28 of coverage by the responsible health care services organization.

29 B. Any contract, except accidental death and dismemberment, applied
30 for that provides family coverage shall, as to such coverage of family
31 members, also provide that the benefits applicable for children shall be
32 payable with respect to a newly born child of the enrollee from the instant
33 of such child's birth, to a child adopted by the enrollee, regardless of the
34 age at which the child was adopted, and to a child who has been placed for
35 adoption with the enrollee and for whom the application and approval
36 procedures for adoption pursuant to section 8-105 or 8-108 have been
37 completed to the same extent that such coverage applies to other members of
38 the family. The coverage for newly born or adopted children or children
39 placed for adoption shall include coverage of injury or sickness including
40 necessary care and treatment of medically diagnosed congenital defects and
41 birth abnormalities. If payment of a specific premium is required to provide
42 coverage for a child, the contract may require that notification of birth,
43 adoption or adoption placement of the child and payment of the required
44 premium must be furnished to the insurer within thirty-one days after the

1 date of birth, adoption or adoption placement in order to have the coverage
2 continue beyond the thirty-one day period.

3 C. Any contract, except accidental death and dismemberment, that
4 provides coverage for psychiatric, drug abuse or alcoholism services shall
5 require the health care services organization to provide reimbursement for
6 such services in accordance with the terms of the contract without regard to
7 whether the covered services are rendered in a psychiatric special hospital
8 or general hospital.

9 D. No evidence of coverage or amendment to the coverage shall be
10 issued or delivered to any person in this state until a copy of the form of
11 the evidence of coverage or amendment to the coverage has been filed with and
12 approved by the director.

13 E. An evidence of coverage shall contain a clear and complete
14 statement if a contract, or a reasonably complete summary if a certificate
15 of contract, of:

16 1. The health care services and the insurance or other benefits, if
17 any, to which the enrollee is entitled under the health care plan.

18 2. Any limitations of the services, kind of services, benefits or kind
19 of benefits to be provided, including any deductible or copayment feature.

20 3. Where and in what manner information is available as to how
21 services may be obtained.

22 4. The enrollee's obligation, if any, respecting charges for the
23 health care plan.

24 F. An evidence of coverage shall NOT contain no provisions or
25 statements which THAT are unjust, unfair, inequitable, misleading or
26 deceptive, which THAT encourage misrepresentation or which THAT are untrue.

27 G. The director shall approve any form of evidence of coverage if the
28 requirements of subsections E and F of this section are met. It is unlawful
29 to issue such form until approved. If the director does not disapprove any
30 such form within forty-five days after the filing of the form, it is deemed
31 approved. If the director disapproves a form of evidence of coverage, the
32 director shall notify the health care services organization. In the notice,
33 the director shall specify the reasons for the director's disapproval. The
34 director shall grant a hearing on such disapproval within fifteen days after
35 a request for a hearing in writing is received from the health care services
36 organization.

37 H. A health care services organization shall not cancel or refuse to
38 renew an enrollee's evidence of coverage that was issued on a group basis
39 without giving notice of the cancellation or nonrenewal to the enrollee and,
40 on request of the director, to the department of insurance. A notice by the
41 organization to the enrollee of cancellation or nonrenewal of the enrollee's
42 evidence of coverage shall be mailed to the enrollee at least sixty days
43 prior to BEFORE the effective date of such cancellation or nonrenewal. The
44 notice shall include or be accompanied by a statement in writing of the

1 reasons as stated in the contract for such action by the organization.
2 Failure of the organization to comply with this subsection shall invalidate
3 any cancellation or nonrenewal except a cancellation or nonrenewal for
4 nonpayment of premium, for fraud or misrepresentation in the application or
5 other enrollment documents or for loss of eligibility as defined in the
6 evidence of coverage. A health care services organization shall not cancel
7 an enrollee's evidence of coverage issued on a group basis because of the
8 enrollee's or dependent's age, except for loss of eligibility as defined in
9 the evidence of coverage, sex, health status-related factor, national origin
10 or frequency of utilization of basic health care services of the enrollee.
11 An evidence of coverage issued on a group basis shall clearly delineate all
12 terms under which the health care services organization may cancel or refuse
13 to renew an evidence of coverage for an enrollee or dependent. Nothing in
14 this subsection prohibits the cancellation or nonrenewal of a health benefits
15 plan contract issued on a group basis for any of the reasons allowed in
16 section 20-2309. A health care services organization may cancel or nonrenew
17 an evidence of coverage issued to an individual on a nongroup basis only for
18 the reasons allowed by subsection N of this section.

19 I. A health care plan that provides coverage for surgical services for
20 a mastectomy shall also provide coverage incidental to the patient's covered
21 mastectomy for surgical services for reconstruction of the breast on which
22 the mastectomy was performed, surgery and reconstruction of the other breast
23 to produce a symmetrical appearance, prostheses, treatment of physical
24 complications for all stages of the mastectomy, including lymphedemas, and
25 at least two external postoperative prostheses subject to all of the terms
26 and conditions of the policy.

27 J. A contract that provides coverage for surgical services for a
28 mastectomy shall also provide coverage for mammography screening performed
29 on dedicated equipment for diagnostic purposes on referral by a patient's
30 physician, subject to all of the terms and conditions of the policy and
31 according to the following guidelines:

32 1. A baseline mammogram for a woman from age thirty-five to
33 thirty-nine.

34 2. A mammogram for a woman from age forty to forty-nine every two
35 years or more frequently based on the recommendation of the woman's
36 physician.

37 3. A mammogram every year for a woman fifty years of age and over.

38 K. Any contract that is issued to the enrollee and that provides
39 coverage for maternity benefits shall also provide that the maternity
40 benefits apply to the costs of the birth of any child legally adopted by the
41 enrollee if all the following are true:

42 1. The child is adopted within one year of birth.

43 2. The enrollee is legally obligated to pay the costs of birth.

1 3. All preexisting conditions and other limitations have been met and
2 all deductibles and copayments have been paid by the enrollee.

3 4. The enrollee has notified the insurer of the enrollee's
4 acceptability to adopt children pursuant to section 8-105 within sixty days
5 after such approval or within sixty days after a change in insurance
6 policies, plans or companies.

7 L. The coverage prescribed by subsection K of this section is excess
8 to any other coverage the natural mother may have for maternity benefits
9 except coverage made available to persons pursuant to title 36, chapter 29
10 but not including coverage made available to persons defined as eligible
11 under section 36-2901, paragraph 4- 6, subdivisions ~~(d), (e), (f) and (g)~~
12 (b), (c), (d) AND (e). If such other coverage exists the agency, attorney
13 or individual arranging the adoption shall make arrangements for the
14 insurance to pay those costs that may be covered under that policy and shall
15 advise the adopting parent in writing of the existence and extent of the
16 coverage without disclosing any confidential information such as the identity
17 of the natural parent. The enrollee adopting parents shall notify their
18 health care services organization of the existence and extent of the other
19 coverage. A health care services organization is not required to pay any
20 costs in excess of the amounts it would have been obligated to pay to its
21 hospitals and providers if the natural mother and child had received the
22 maternity and newborn care directly from or through that health care services
23 organization.

24 M. Each health care services organization shall offer membership to
25 the following in a conversion plan which THAT provides the basic health care
26 benefits required by the ~~department of health services~~ DIRECTOR:

27 1. Each enrollee including the enrollee's enrolled dependents leaving
28 a group.

29 2. Each enrollee and the enrollee's dependents who would otherwise
30 cease to be eligible for membership because of the age of the enrollee or the
31 enrollee's dependents or the death or the dissolution of marriage of an
32 enrollee.

33 N. A health care services organization shall not cancel or nonrenew
34 an evidence of coverage issued to an individual on a nongroup basis,
35 including a conversion plan, except for any of the following reasons and in
36 compliance with the notice and disclosure requirements contained in
37 subsection H of this section:

38 1. The individual has failed to pay premiums or contributions in
39 accordance with the terms of the evidence of coverage or the health care
40 services organization has not received premium payments in a timely manner.

41 2. The individual has performed an act or practice that constitutes
42 fraud or the individual made an intentional misrepresentation of material
43 fact under the terms of the evidence of coverage.

1 3. The health care services organization has ceased to offer coverage
2 to individuals that is consistent with the requirements of sections 20-1379
3 and 20-1380.

4 4. If the health care services organization offers a health care plan
5 in this state through a network plan, the individual no longer resides, lives
6 or works in the service area served by the network plan or in an area for
7 which the health care services organization is authorized to transact
8 business but only if the coverage is terminated uniformly without regard to
9 any health status-related factor of the covered individual.

10 5. If the health care services organization offers health coverage in
11 this state in the individual market only through one or more bona fide
12 associations, the membership of the individual in the association has ceased
13 but only if that coverage is terminated uniformly without regard to any
14 health status-related factor of any covered individual.

15 O. A conversion plan may be modified if the modification complies with
16 the notice and disclosure provisions for cancellation and nonrenewal under
17 subsection H of this section. A modification of a conversion plan which THAT
18 has already been issued shall not result in the effective elimination of any
19 benefit originally included in the conversion plan.

20 P. Any person who is a United States armed forces reservist, who is
21 ordered to active military duty on or after August 22, 1990 and who was
22 enrolled in a health care plan shall have the right to reinstate such
23 coverage upon release from active military duty subject to the following
24 conditions:

25 1. The reservist shall make written application to the health plan
26 within ninety days of discharge from active military duty or within one year
27 of hospitalization continuing after discharge. Coverage shall be effective
28 upon receipt of the application by the health plan.

29 2. The health plan may exclude from such coverage any health or
30 physical condition arising during and occurring as a direct result of active
31 military duty.

32 Q. The director shall adopt emergency rules applicable to persons who
33 are leaving active service in the armed forces of the United States and
34 returning to civilian status consistent with the provisions of subsection P
35 of this section including:

- 36 1. Conditions of eligibility.
- 37 2. Coverage of dependents.
- 38 3. Preexisting conditions.
- 39 4. Termination of insurance.
- 40 5. Probationary periods.
- 41 6. Limitations.
- 42 7. Exceptions.
- 43 8. Reductions.
- 44 9. Elimination periods.

1 10. Requirements for replacement.

2 11. Any other conditions of evidences of coverage.

3 R. Any contract that provides maternity benefits shall not restrict
4 benefits for any hospital length of stay in connection with childbirth for
5 the mother or the newborn child to less than forty-eight hours following a
6 normal vaginal delivery or ninety-six hours following a cesarean
7 section. The contract shall not require the provider to obtain authorization
8 from the health care services organization for prescribing the minimum length
9 of stay required by this subsection. The contract may provide that an
10 attending provider in consultation with the mother may discharge the mother
11 or the newborn child before the expiration of the minimum length of stay
12 required by this subsection. The health care services organization shall
13 not:

14 1. Deny the mother or the newborn child eligibility or continued
15 eligibility to enroll or to renew coverage under the terms of the contract
16 solely for the purpose of avoiding the requirements of this subsection.

17 2. Provide monetary payments or rebates to mothers to encourage those
18 mothers to accept less than the minimum protections available pursuant to
19 this subsection.

20 3. Penalize or otherwise reduce or limit the reimbursement of an
21 attending provider because that provider provided care to any insured under
22 the contract in accordance with this subsection.

23 4. Provide monetary or other incentives to an attending provider to
24 induce that provider to provide care to an insured under the contract in a
25 manner that is inconsistent with this subsection.

26 5. Except as described in subsection S of this section, restrict
27 benefits for any portion of a period within the minimum length of stay in a
28 manner that is less favorable than the benefits provided for any preceding
29 portion of that stay.

30 S. Nothing in subsection R of this section:

31 1. Requires a mother to give birth in a hospital or to stay in the
32 hospital for a fixed period of time following the birth of the child.

33 2. Prevents a health care services organization from imposing
34 deductibles, coinsurance or other cost sharing in relation to benefits for
35 hospital lengths of stay in connection with childbirth for a mother or a
36 newborn child under the contract, except that any coinsurance or other cost
37 sharing for any portion of a period within a hospital length of stay required
38 pursuant to subsection R of this section shall not be greater than the
39 coinsurance or cost sharing for any preceding portion of that stay.

40 3. Prevents a health care services organization from negotiating the
41 level and type of reimbursement with a provider for care provided in
42 accordance with subsection R of this section.

43 T. Any contract or evidence of coverage that provides coverage for
44 diabetes shall also provide coverage for equipment and supplies that are

1 medically necessary and that are prescribed by a health care provider
2 including:

- 3 1. Blood glucose monitors.
- 4 2. Blood glucose monitors for the legally blind.
- 5 3. Test strips for glucose monitors and visual reading and urine
6 testing strips.
- 7 4. Insulin preparations and glucagon.
- 8 5. Insulin cartridges.
- 9 6. Drawing up devices and monitors for the visually impaired.
- 10 7. Injection aids.
- 11 8. Insulin cartridges for the legally blind.
- 12 9. Syringes and lancets including automatic lancing devices.
- 13 10. Prescribed oral agents for controlling blood sugar that are
14 included on the plan formulary.
- 15 11. To the extent coverage is required under medicare, podiatric
16 appliances for prevention of complications associated with diabetes.
- 17 12. Any other device, medication, equipment or supply for which
18 coverage is required under medicare from and after January 1, 1999. The
19 coverage required in this paragraph is effective six months after the
20 coverage is required under medicare.

21 U. Nothing in subsection T of this section:

- 22 1. Entitles a member or enrollee of a health care services
23 organization to equipment or supplies for the treatment of diabetes that are
24 not medically necessary as determined by the health care services
25 organization medical director or the medical director's designee.
- 26 2. Provides coverage for diabetic supplies obtained by a member or
27 enrollee of a health care services organization without a prescription unless
28 otherwise permitted pursuant to the terms of the health care plan.
- 29 3. Prohibits a health care services organization from imposing
30 deductibles, coinsurance or other cost sharing in relation to benefits for
31 equipment or supplies for the treatment of diabetes.

32 V. Any contract or evidence of coverage that provides coverage for
33 prescription drugs shall not limit or exclude coverage for any prescription
34 drug prescribed for the treatment of cancer on the basis that the
35 prescription drug has not been approved by the United States food and drug
36 administration for the treatment of the specific type of cancer for which the
37 prescription drug has been prescribed, if the prescription drug has been
38 recognized as safe and effective for treatment of that specific type of
39 cancer in one or more of the standard medical reference compendia prescribed
40 in subsection W of this section or medical literature that meets the criteria
41 prescribed in subsection W of this section. The coverage required under this
42 subsection includes covered medically necessary services associated with the
43 administration of the prescription drug. This subsection does not:

1 1. Require coverage of any prescription drug used in the treatment of
2 a type of cancer if the United States food and drug administration has
3 determined that the prescription drug is contraindicated for that type of
4 cancer.

5 2. Require coverage for any experimental prescription drug that is not
6 approved for any indication by the United States food and drug
7 administration.

8 3. Alter any law with regard to provisions that limit the coverage of
9 prescription drugs that have not been approved by the United States food and
10 drug administration.

11 4. Notwithstanding section 20-1057.02, require reimbursement or
12 coverage for any prescription drug that is not included in the drug formulary
13 or list of covered prescription drugs specified in the contract or evidence
14 of coverage.

15 5. Notwithstanding section 20-1057.02, prohibit a contract OR EVIDENCE
16 OF COVERAGE from limiting or excluding coverage of a prescription drug, if
17 the decision to limit or exclude coverage of the prescription drug is not
18 based primarily on the coverage of prescription drugs required by this
19 section.

20 6. Prohibit the use of deductibles, coinsurance, copayments or other
21 cost sharing in relation to drug benefits and related medical benefits
22 offered.

23 W. For the purposes of subsection V of this section:

24 1. The acceptable standard medical reference compendia are the
25 following:

26 (a) The American medical association drug evaluations, a publication
27 of the American medical association.

28 (b) The American hospital formulary service drug information, a
29 publication of the American society of health system pharmacists.

30 (c) Drug information for the health care provider, a publication of
31 the United States pharmacopoeia convention.

32 2. Medical literature may be accepted if all of the following apply:

33 (a) At least two articles from major peer reviewed professional
34 medical journals have recognized, based on scientific or medical criteria,
35 the drug's safety and effectiveness for treatment of the indication for which
36 the drug has been prescribed.

37 (b) No article from a major peer reviewed professional medical journal
38 has concluded, based on scientific or medical criteria, that the drug is
39 unsafe or ineffective or that the drug's safety and effectiveness cannot be
40 determined for the treatment of the indication for which the drug has been
41 prescribed.

42 (c) The literature meets the uniform requirements for manuscripts
43 submitted to biomedical journals established by the international committee
44 of medical journal editors or is published in a journal specified by the

1 United States department of health and human services as acceptable peer
2 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
3 security act (42 United States Code section 1395x(t)(2)(B)).

4 X. A health care services organization shall not issue or deliver any
5 advertising matter or sales material to any person in this state until the
6 health care services organization files the advertising matter or sales
7 material with the director. This subsection does not require a health care
8 services organization to have the prior approval of the director to issue or
9 deliver the advertising matter or sales material. If the director finds that
10 the advertising matter or sales material, in whole or in part, is false,
11 deceptive or misleading, the director may issue an order disapproving the
12 advertising matter or sales material, directing the health care services
13 organization to cease and desist from issuing, circulating, displaying or
14 using the advertising matter or sales material within a period of time
15 specified by the director but not less than ten days and imposing any
16 penalties prescribed in this title. At least five days before issuing an
17 order pursuant to this subsection, the director shall provide the health care
18 services organization with a written notice of the basis of the order to
19 provide the health care services organization with an opportunity to cure the
20 alleged deficiency in the advertising matter or sales material within a
21 single five day period for the particular advertising matter or sales
22 material at issue. The health care services organization may appeal the
23 director's order pursuant to title 41, chapter 6, article 10. Except as
24 otherwise provided in this subsection, a health care services organization
25 may obtain a stay of the effectiveness of the order as prescribed in section
26 20-162. If the director certifies in the order and provides a detailed
27 explanation of the reasons in support of the certification that continued use
28 of the advertising matter or sales material poses a threat to the health,
29 safety or welfare of the public, the order may be entered immediately without
30 opportunity for cure and the effectiveness of the order is not stayed pending
31 the hearing on the notice of appeal but the hearing shall be promptly
32 instituted and determined.

33 Y. Any contract or evidence of coverage THAT IS offered by a health
34 care services organization AND that contains a prescription drug benefit
35 shall provide coverage of medical foods to treat inherited metabolic
36 disorders as provided by this section.

37 Z. The metabolic disorders triggering medical foods coverage under
38 this section shall:

39 1. Be part of the newborn screening program prescribed in section
40 36-694.

41 2. Involve amino acid, carbohydrate or fat metabolism.

42 3. Have medically standard methods of diagnosis, treatment and
43 monitoring including quantification of metabolites in blood, urine or spinal
44 fluid or enzyme or DNA confirmation in tissues.

1 4. Require specially processed or treated medical foods that are
2 generally available only under the supervision and direction of a physician
3 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed
4 throughout life and without which the person may suffer serious mental or
5 physical impairment.

6 AA. Medical foods eligible for coverage under this section shall be
7 prescribed or ordered under the supervision of a physician licensed pursuant
8 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
9 treatment of an inherited metabolic disease.

10 BB. A health care services organization shall cover at least fifty per
11 cent of the cost of medical foods prescribed to treat inherited metabolic
12 disorders and covered pursuant to this section. ~~A corporation~~ AN
13 ORGANIZATION may limit the maximum annual benefit for medical foods under
14 this section to five thousand dollars, which applies to the cost of all
15 prescribed modified low protein foods and metabolic formula.

16 CC. Unless preempted under federal law or unless federal law imposes
17 greater requirements than this section, this section applies to a provider
18 sponsored health care services organization.

19 DD. For the purposes of:

20 1. This section:

21 (a) "Inherited metabolic disorder" means a disease caused by an
22 inherited abnormality of body chemistry and includes a disease tested under
23 the newborn screening program prescribed in section 36-694.

24 (b) "Medical foods" means modified low protein foods and metabolic
25 formula.

26 (c) "Metabolic formula" means foods that are all of the following:

27 (i) Formulated to be consumed or administered enterally under the
28 supervision of a physician who is licensed pursuant to title 32, chapter 13
29 or 17.

30 (ii) Processed or formulated to be deficient in one or more of the
31 nutrients present in typical foodstuffs.

32 (iii) Administered for the medical and nutritional management of a
33 person who has limited capacity to metabolize foodstuffs or certain nutrients
34 contained in the foodstuffs or who has other specific nutrient requirements
35 as established by medical evaluation.

36 (iv) Essential to a person's optimal growth, health and metabolic
37 homeostasis.

38 (d) "Modified low protein foods" means foods that are all of the
39 following:

40 (i) Formulated to be consumed or administered enterally under the
41 supervision of a physician who is licensed pursuant to title 32, chapter 13
42 or 17.

1 (ii) Processed or formulated to contain less than one gram of protein
2 per unit of serving, but does not include a natural food that is naturally
3 low in protein.

4 (iii) Administered for the medical and nutritional management of a
5 person who has limited capacity to metabolize foodstuffs or certain nutrients
6 contained in the foodstuffs or who has other specific nutrient requirements
7 as established by medical evaluation.

8 (iv) Essential to a person's optimal growth, health and metabolic
9 homeostasis.

10 2. Subsection B of this section, "child", for purposes of initial
11 coverage of an adopted child or a child placed for adoption but not for
12 purposes of termination of coverage of such child, means a person under the
13 age of eighteen years.

14 Sec. 22. Repeal

15 Section 20-1057, Arizona Revised Statutes, as amended by Laws 2000,
16 chapter 355, section 5, is repealed.

17 Sec. 23. Section 20-1342, Arizona Revised Statutes, is amended to
18 read:

19 20-1342. Scope and format of policy; definitions

20 A. A policy of disability insurance shall not be delivered or issued
21 for delivery to any person in this state unless it otherwise complies with
22 this title and complies with the following:

23 1. The entire money and other considerations shall be expressed in
24 the policy.

25 2. The time when the insurance takes effect and terminates shall be
26 expressed in the policy.

27 3. It shall purport to insure only one person, except that a policy
28 may insure, originally or by subsequent amendment, upon ON the application
29 of the policyholder or the policyholder's spouse, any two or more eligible
30 members of that family, including husband, wife, dependent children or any
31 children under a specified age which ~~shall~~ THAT DOES not exceed nineteen
32 years and any other person dependent upon the policyholder. Any policy,
33 except accidental death and dismemberment, applied for that provides family
34 coverage shall, as to such coverage of family members, also provide that the
35 benefits applicable for children shall be payable with respect to a newly
36 born child of the insured from the instant of such child's birth, to a child
37 adopted by the insured, regardless of the age at which the child was adopted,
38 and to a child who has been placed for adoption with the insured and for whom
39 the application and approval procedures for adoption pursuant to section
40 8-105 or 8-108 have been completed to the same extent that such coverage
41 applies to other members of the family. The coverage for newly born or
42 adopted children or children placed for adoption shall include coverage of
43 injury or sickness including necessary care and treatment of medically
44 diagnosed congenital defects and birth abnormalities. If payment of a

1 specific premium is required to provide coverage for a child, the policy may
2 require that notification of birth, adoption or adoption placement of the
3 child and payment of the required premium must be furnished to the insurer
4 within thirty-one days after the date of birth, adoption or adoption
5 placement in order to have the coverage continue beyond the thirty-one day
6 period.

7 4. The style, arrangement and overall appearance of the policy shall
8 give no undue prominence to any portion of the text, and every printed
9 portion of the text of the policy and of any endorsements or attached papers
10 shall be plainly printed in light-faced type of a style in general use, the
11 size of which shall be uniform and not less than ten point with a lower case
12 unspaced alphabet length of not less than one hundred and twenty point.
13 "Text" shall include all printed matter except the name and address of the
14 insurer, name or title of the policy, the brief description, if any, and
15 captions and subcaptions.

16 5. The exceptions and reductions of indemnity shall be set forth in
17 the policy and, other than those contained in sections 20-1345 through
18 20-1368, shall be printed and, at the insurer's option, either included with
19 the benefit provision to which they apply or under an appropriate caption
20 such as "exceptions", or "exceptions and reductions", except that if an
21 exception or reduction specifically applies only to a particular benefit of
22 the policy, a statement of such exception or reduction shall be included with
23 the benefit provision to which it applies.

24 6. Each such form, including riders and endorsements, shall be
25 identified by a form number in the lower left-hand corner of the first page.

26 7. The policy shall contain no provision purporting to make any
27 portion of the charter, rules, constitution or bylaws of the insurer a part
28 of the policy unless such portion is set forth in full in the policy, except
29 in the case of the incorporation of, or reference to, a statement of rates
30 or classification of risks, or short-rate table filed with the director.

31 8. Each contract shall be so written that the corporation shall pay
32 benefits:

33 (a) For performance of any surgical service which THAT is covered by
34 the terms of such contract, regardless of the place of service.

35 (b) For any home health services which THAT are performed by a
36 licensed home health agency and which THAT a physician has prescribed in lieu
37 of hospital services, as defined by the director, providing the hospital
38 services would have been covered.

39 (c) For any diagnostic service which THAT a physician has performed
40 outside a hospital in lieu of inpatient service, providing the inpatient
41 service would have been covered.

42 (d) For any service performed in a hospital's outpatient department
43 or in a freestanding surgical facility, providing such service would have
44 been covered if performed as an inpatient service.

1 9. A disability insurance policy that provides coverage for the
2 surgical expense of a mastectomy shall also provide coverage incidental to
3 the patient's covered mastectomy for the expense of reconstructive surgery
4 of the breast on which the mastectomy was performed, surgery and
5 reconstruction of the other breast to produce a symmetrical appearance,
6 prostheses, treatment of physical complications for all stages of the
7 mastectomy, including lymphedemas, and at least two external postoperative
8 prostheses subject to all of the terms and conditions of the policy.

9 10. A contract, except a supplemental contract covering a specified
10 disease or other limited benefits, that provides coverage for surgical
11 services for a mastectomy shall also provide coverage for mammography
12 screening performed on dedicated equipment for diagnostic purposes on
13 referral by a patient's physician, subject to all of the terms and conditions
14 of the policy and according to the following guidelines:

15 (a) A baseline mammogram for a woman from age thirty-five to
16 thirty-nine.

17 (b) A mammogram for a woman from age forty to forty-nine every two
18 years or more frequently based on the recommendation of the woman's
19 physician.

20 (c) A mammogram every year for a woman fifty years of age and over.

21 11. Any contract that is issued to the insured and that provides
22 coverage for maternity benefits shall also provide that the maternity
23 benefits apply to the costs of the birth of any child legally adopted by the
24 insured if all the following are true:

25 (a) The child is adopted within one year of birth.

26 (b) The insured is legally obligated to pay the costs of birth.

27 (c) All preexisting conditions and other limitations have been met by
28 the insured.

29 (d) The insured has notified the insurer of the insured's
30 acceptability to adopt children pursuant to section 8-105, within sixty days
31 after such approval or within sixty days after a change in insurance
32 policies, plans or companies.

33 12. The coverage prescribed by paragraph 11 of this subsection is
34 excess to any other coverage the natural mother may have for maternity
35 benefits except coverage made available to persons pursuant to title 36,
36 chapter 29, but not including coverage made available to persons defined as
37 eligible under section 36-2901, paragraph 4-6, subdivisions ~~(d)~~, ~~(e)~~, ~~(f)~~
38 ~~and (g)~~ (b), (c), (d) AND (e). If such other coverage exists the agency,
39 attorney or individual arranging the adoption shall make arrangements for the
40 insurance to pay those costs that may be covered under that policy and shall
41 advise the adopting parent in writing of the existence and extent of the
42 coverage without disclosing any confidential information such as the identity
43 of the natural parent. The insured adopting parents shall notify their
44 insurer of the existence and extent of the other coverage.

1 B. Any contract that provides maternity benefits shall not restrict
2 benefits for any hospital length of stay in connection with childbirth for
3 the mother or the newborn child to less than forty-eight hours following a
4 normal vaginal delivery or ninety-six hours following a cesarean
5 section. The contract shall not require the provider to obtain authorization
6 from the insurer for prescribing the minimum length of stay required by this
7 subsection. The contract may provide that an attending provider in
8 consultation with the mother may discharge the mother or the newborn child
9 before the expiration of the minimum length of stay required by this
10 subsection. The insurer shall not:

11 1. Deny the mother or the newborn child eligibility or continued
12 eligibility to enroll or to renew coverage under the terms of the contract
13 solely for the purpose of avoiding the requirements of this subsection.

14 2. Provide monetary payments or rebates to mothers to encourage those
15 mothers to accept less than the minimum protections available pursuant to
16 this subsection.

17 3. Penalize or otherwise reduce or limit the reimbursement of an
18 attending provider because that provider provided care to any insured under
19 the contract in accordance with this subsection.

20 4. Provide monetary or other incentives to an attending provider to
21 induce that provider to provide care to an insured under the contract in a
22 manner that is inconsistent with this subsection.

23 5. Except as described in subsection C of this section, restrict
24 benefits for any portion of a period within the minimum length of stay in a
25 manner that is less favorable than the benefits provided for any preceding
26 portion of that stay.

27 C. Nothing in subsection B of this section:

28 1. Requires a mother to give birth in a hospital or to stay in the
29 hospital for a fixed period of time following the birth of the child.

30 2. Prevents an insurer from imposing deductibles, coinsurance or
31 other cost sharing in relation to benefits for hospital lengths of stay in
32 connection with childbirth for a mother or a newborn child under the
33 contract, except that any coinsurance or other cost sharing for any portion
34 of a period within a hospital length of stay required pursuant to subsection
35 B of this section shall not be greater than the coinsurance or cost sharing
36 for any preceding portion of that stay.

37 3. Prevents an insurer from negotiating the level and type of
38 reimbursement with a provider for care provided in accordance with subsection
39 B of this section.

40 D. Any contract that provides coverage for diabetes shall also
41 provide coverage for equipment and supplies that are medically necessary and
42 that are prescribed by a health care provider including:

43 1. Blood glucose monitors.

44 2. Blood glucose monitors for the legally blind.

1 3. Test strips for glucose monitors and visual reading and urine
2 testing strips.

3 4. Insulin preparations and glucagon.

4 5. Insulin cartridges.

5 6. Drawing up devices and monitors for the visually impaired.

6 7. Injection aids.

7 8. Insulin cartridges for the legally blind.

8 9. Syringes and lancets including automatic lancing devices.

9 10. Prescribed oral agents for controlling blood sugar that are
10 included on the plan formulary.

11 11. To the extent coverage is required under medicare, podiatric
12 appliances for prevention of complications associated with diabetes.

13 12. Any other device, medication, equipment or supply for which
14 coverage is required under medicare from and after January 1, 1999. The
15 coverage required in this paragraph is effective six months after the
16 coverage is required under medicare.

17 E. Nothing in subsection D of this section:

18 1. Prohibits a disability insurer from imposing deductibles,
19 coinsurance or other cost sharing in relation to benefits for equipment or
20 supplies for the treatment of diabetes.

21 2. Requires a policy to provide an insured with outpatient benefits
22 if the policy does not cover outpatient benefits.

23 F. Any contract that provides coverage for prescription drugs shall
24 not limit or exclude coverage for any prescription drug prescribed for the
25 treatment of cancer on the basis that the prescription drug has not been
26 approved by the United States food and drug administration for the treatment
27 of the specific type of cancer for which the prescription drug has been
28 prescribed, if the prescription drug has been recognized as safe and
29 effective for treatment of that specific type of cancer in one or more of the
30 standard medical reference compendia prescribed in subsection G of this
31 section or medical literature that meets the criteria prescribed in
32 subsection G of this section. The coverage required under this subsection
33 includes covered medically necessary services associated with the
34 administration of the prescription drug. This subsection does not:

35 1. Require coverage of any prescription drug used in the treatment of
36 a type of cancer if the United States food and drug administration has
37 determined that the prescription drug is contraindicated for that type of
38 cancer.

39 2. Require coverage for any experimental prescription drug that is
40 not approved for any indication by the United States food and drug
41 administration.

42 3. Alter any law with regard to provisions that limit the coverage of
43 prescription drugs that have not been approved by the United States food and
44 drug administration.

1 4. Require reimbursement or coverage for any prescription drug that
2 is not included in the drug formulary or list of covered prescription drugs
3 specified in the contract.

4 5. Prohibit a contract from limiting or excluding coverage of a
5 prescription drug, if the decision to limit or exclude coverage of the
6 prescription drug is not based primarily on the coverage of prescription
7 drugs required by this section.

8 6. Prohibit the use of deductibles, coinsurance, copayments or other
9 cost sharing in relation to drug benefits and related medical benefits
10 offered.

11 G. For the purposes of subsection F of this section:

12 1. The acceptable standard medical reference compendia are the
13 following:

14 (a) The American medical association drug evaluations, a publication
15 of the American medical association.

16 (b) The American hospital formulary service drug information, a
17 publication of the American society of health system pharmacists.

18 (c) Drug information for the health care provider, a publication of
19 the United States pharmacopoeia convention.

20 2. Medical literature may be accepted if all of the following apply:

21 (a) At least two articles from major peer reviewed professional
22 medical journals have recognized, based on scientific or medical criteria,
23 the drug's safety and effectiveness for treatment of the indication for which
24 the drug has been prescribed.

25 (b) No article from a major peer reviewed professional medical
26 journal has concluded, based on scientific or medical criteria, that the drug
27 is unsafe or ineffective or that the drug's safety and effectiveness cannot
28 be determined for the treatment of the indication for which the drug has been
29 prescribed.

30 (c) The literature meets the uniform requirements for manuscripts
31 submitted to biomedical journals established by the international committee
32 of medical journal editors or is published in a journal specified by the
33 United States department of health and human services as acceptable peer
34 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
35 security act (42 United States Code section 1395x(t)(2)(B)).

36 H. Any contract THAT IS offered by a disability insurer AND that
37 contains a routine outpatient prescription drug benefit shall provide
38 coverage of medical foods to treat inherited metabolic disorders as provided
39 by this section.

40 I. The metabolic disorders triggering medical foods coverage under
41 this section shall:

42 1. Be part of the newborn screening program prescribed in section
43 36-694.

44 2. Involve amino acid, carbohydrate or fat metabolism.

1 3. Have medically standard methods of diagnosis, treatment and
2 monitoring including quantification of metabolites in blood, urine or spinal
3 fluid or enzyme or DNA confirmation in tissues.

4 4. Require specially processed or treated medical foods that are
5 generally available only under the supervision and direction of a physician
6 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed
7 throughout life and without which the person may suffer serious mental or
8 physical impairment.

9 J. Medical foods eligible for coverage under this section shall be
10 prescribed or ordered under the supervision of a physician licensed pursuant
11 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
12 treatment of an inherited metabolic disease.

13 K. An insurer shall cover at least fifty per cent of the cost of
14 medical foods prescribed to treat inherited metabolic disorders and covered
15 pursuant to this section. ~~A corporation~~ AN INSURER may limit the maximum
16 annual benefit for medical foods under this section to five thousand dollars,
17 which applies to the cost of all prescribed modified low protein foods and
18 metabolic formula.

19 L. For the purposes of:

20 1. This section:

21 (a) "Inherited metabolic disorder" means a disease caused by an
22 inherited abnormality of body chemistry and includes a disease tested under
23 the newborn screening program prescribed in section 36-694.

24 (b) "Medical foods" means modified low protein foods and metabolic
25 formula.

26 (c) "Metabolic formula" means foods that are all of the following:

27 (i) Formulated to be consumed or administered enterally under the
28 supervision of a physician who is licensed pursuant to title 32, chapter 13
29 or 17.

30 (ii) Processed or formulated to be deficient in one or more of the
31 nutrients present in typical foodstuffs.

32 (iii) Administered for the medical and nutritional management of a
33 person who has limited capacity to metabolize foodstuffs or certain nutrients
34 contained in the foodstuffs or who has other specific nutrient requirements
35 as established by medical evaluation.

36 (iv) Essential to a person's optimal growth, health and metabolic
37 homeostasis.

38 (d) "Modified low protein foods" means foods that are all of the
39 following:

40 (i) Formulated to be consumed or administered enterally under the
41 supervision of a physician who is licensed pursuant to title 32, chapter 13
42 or 17.

1 (ii) Processed or formulated to contain less than one gram of protein
2 per unit of serving, but does not include a natural food that is naturally
3 low in protein.

4 (iii) Administered for the medical and nutritional management of a
5 person who has limited capacity to metabolize foodstuffs or certain nutrients
6 contained in the foodstuffs or who has other specific nutrient requirements
7 as established by medical evaluation.

8 (iv) Essential to a person's optimal growth, health and metabolic
9 homeostasis.

10 2. Subsection A of this section, the term "child", for purposes of
11 initial coverage of an adopted child or a child placed for adoption but not
12 for purposes of termination of coverage of such child, means a person under
13 the age of eighteen years.

14 Sec. 24. Section 20-1379, Arizona Revised Statutes, as amended by Laws
15 2000, chapter 355, section 10, is amended to read:

16 20-1379. Guaranteed availability of individual health insurance
17 coverage; prior group coverage; definitions

18 A. Every health care insurer that offers individual health insurance
19 coverage in the individual market in this state shall provide guaranteed
20 availability of coverage to an eligible individual who desires to enroll in
21 individual health insurance coverage and shall not:

22 1. Decline to offer that coverage to, or deny enrollment of, that
23 individual.

24 2. Impose any preexisting condition exclusion for that coverage.

25 B. Every health care insurer that offers individual health insurance
26 coverage in the individual market in this state shall offer all policy forms
27 of health insurance coverage that are designed for, are made generally
28 available and actively marketed to and enroll both eligible or other
29 individuals. A health care insurer that offers only one policy form in the
30 individual market complies with this section by offering that form to
31 eligible individuals. A health care insurer also may comply with the
32 requirements of this section by electing to offer at least two different
33 policy forms to eligible individuals as provided by subsection C of this
34 section.

35 C. A health care insurer shall meet the requirements prescribed in
36 subsection B of this section if:

37 1. The health care insurer offers at least two different policy forms,
38 both of which are designed for, made generally available and actively
39 marketed to and enroll both eligible and other individuals.

40 2. The offer includes at least either:

41 (a) The policy forms with the largest and next to the largest earned
42 premium volume of all policy forms offered by the health care insurer in this
43 state in the individual market during a period not to exceed the preceding
44 two calendar years.

1 (b) A choice of two policy forms with representative coverage,
2 consisting of a lower level of coverage policy form and a higher level of
3 coverage policy form, each of which includes benefits that are substantially
4 similar to other individual health insurance coverage offered by the health
5 care insurer in this state and each of which is covered by a method that
6 provides for risk adjustment, risk spreading or a risk spreading mechanism
7 among the health care insurer's policies.

8 D. The health care insurer's election pursuant to subsection C of this
9 section is effective for policies offered during a period of at least two
10 years.

11 E. If a health care insurer offers individual health insurance
12 coverage in the individual market through a network plan, the health care
13 insurer may do both of the following:

14 1. Limit the individuals who may be enrolled under health insurance
15 coverage to those who live, reside or work within the service area for a
16 network plan.

17 2. Within the service area of a network plan, deny health insurance
18 coverage to individuals if the health care insurer has demonstrated, if
19 required, to the director that both:

20 (a) The health care insurer will not have the capacity to deliver
21 services adequately to additional individual enrollees because of the health
22 care insurer's obligations to existing group contract holders and enrollees
23 and individual enrollees.

24 (b) The health care insurer is applying this paragraph uniformly to
25 individuals without regard to any health status-related factor of the
26 individuals and without regard to whether the individuals are eligible
27 individuals.

28 F. A health care insurer may deny individual health insurance coverage
29 in the individual market to an eligible individual if the health care insurer
30 demonstrates to the director that the health care insurer:

31 1. Does not have the financial reserves necessary to underwrite
32 additional coverage.

33 2. Is denying coverage uniformly to all individuals in the individual
34 market in this state pursuant to state law and without regard to any health
35 status-related factor of the individuals and without regard to whether the
36 individuals are eligible individuals.

37 G. If a health care insurer denies health insurance coverage in this
38 state pursuant to subsection F of this section, the health care insurer shall
39 not offer that coverage in the individual market in this state for one
40 hundred eighty days after the date the coverage is denied or until the health
41 care insurer demonstrates to the director that the health care insurer has
42 sufficient financial reserves to underwrite additional coverage, whichever
43 is later.

1 H. An accountable health plan as defined in section 20-2301 that
2 offers conversion policies on an individual or group basis in connection with
3 a health benefits plan pursuant to this title is not a health care insurer
4 that offers individual health insurance coverage solely because of the offer
5 of a conversion policy.

6 I. Nothing in this section:

7 1. Creates additional restrictions on the amount of the premium rates
8 that a health care insurer may charge an individual for health insurance
9 coverage provided in the individual market.

10 2. Prevents a health care insurer that offers health insurance
11 coverage in the individual market from establishing premium rates or
12 modifying otherwise applicable copayments or deductibles in return for
13 adherence to programs of health promotion and disease prevention.

14 3. Requires a health care insurer that offers only short-term limited
15 duration insurance limited benefit coverage or to individuals and no other
16 coverage to individuals in the individual market to offer individual health
17 insurance coverage in the individual market.

18 4. Requires a health care insurer offering health care coverage only
19 on a group basis or through one or more bona fide associations, or both, to
20 offer health insurance coverage in the individual market.

21 J. A health care insurer shall provide, without charge, a written
22 certificate of creditable coverage as described in this section for
23 creditable coverage occurring after June 30, 1996 if the individual:

24 1. Ceases to be covered under a policy offered by a health care
25 insurer. An individual who is covered by a policy that is issued on a group
26 basis by a health care insurer, that is terminated or not renewed at the
27 choice of the sponsor of the group and where the replacement of the coverage
28 is without a break in coverage is not entitled to receive the certification
29 prescribed in this paragraph but is instead entitled to receive the
30 certification prescribed in paragraph 2 of this subsection.

31 2. Requests certification from the health care insurer within
32 twenty-four months after the coverage under a health insurance coverage
33 policy offered by a health care insurer ceases.

34 K. The certificate of creditable coverage provided by a health care
35 insurer is a written certification of the period of creditable coverage of
36 the individual under the health insurance coverage offered by the health care
37 insurer. The department may enforce and monitor the issuance and delivery
38 of the notices and certificates by health care insurers as required by this
39 section, section 20-1380, the health insurance portability and accountability
40 act of 1996 (P.L. 104-191; 110 Stat. 1936) and any federal regulations
41 adopted to implement the health insurance portability and accountability act
42 of 1996.

43 L. Any health care insurer, accountable health plan or other entity
44 that issues health care coverage in this state, as applicable, shall issue

1 and accept a certificate of creditable coverage of the individual that
2 contains at least the following information:

3 1. The date that the certificate is issued.

4 2. The name of the individual or dependent for whom the certificate
5 applies and any other information that is necessary to allow the issuer
6 providing the coverage specified in the certificate to identify the
7 individual, including the individual's identification number under the policy
8 and the name of the policyholder if the certificate is for or includes a
9 dependent.

10 3. The name, address and telephone number of the issuer providing the
11 certificate.

12 4. The telephone number to call for further information regarding the
13 certificate.

14 5. One of the following:

15 (a) A statement that the individual has at least eighteen months of
16 creditable coverage. For purposes of this subdivision, eighteen months means
17 five hundred forty-six days.

18 (b) Both the date that the individual first sought coverage, as
19 evidenced by a substantially complete application, and the date that
20 creditable coverage began.

21 6. The date creditable coverage ended, unless the certificate
22 indicates that creditable coverage is continuing from the date of the
23 certificate.

24 7. The consumer assistance telephone number for the department.

25 8. The following statement in at least fourteen point type:

26 **Important Notice!**

27 Keep this certificate with your important personal records to
28 protect your rights under the health insurance portability and
29 accountability act of 1996 ("HIPAA"). This certificate is proof
30 of your prior health insurance coverage. You may need to show
31 this certificate to have a guaranteed right to buy new health
32 insurance ("Guaranteed issue"). This certificate may also help
33 you avoid waiting periods or exclusions for preexisting
34 conditions. Under HIPAA, these rights are guaranteed only for
35 a very short time period. After your group coverage ends, you
36 must apply for new coverage within 63 days to be protected by
37 HIPAA. If you have questions, call the Arizona department of
38 insurance.

39 M. A health care insurer has satisfied the certification requirement
40 under this section if the insurer offering the health benefits plan provides
41 the certificate of creditable coverage in accordance with this section within
42 thirty days after the event that triggered the issuance of the certificate.

43 N. Periods of creditable coverage for an individual are established
44 by the presentation of the certificate described in this section and section

1 20-2310. In addition to the written certificate of creditable coverage as
2 described in this section, individuals may establish creditable coverage
3 through the presentation of documents or other means. In order to make a
4 determination that is based on the relevant facts and circumstances of the
5 amount of creditable coverage that an individual has, a health care insurer
6 shall take into account all information that the insurer obtains or that is
7 presented to the insurer on behalf of the individual.

8 0. A health care insurer shall calculate creditable coverage according
9 to the following rules:

10 1. The health care insurer shall allow an individual credit for each
11 day the individual was covered by creditable coverage.

12 2. The health care insurer shall not count a period of creditable
13 coverage for an individual enrolled under any form of health insurance
14 coverage if after the period of coverage and before the enrollment date there
15 were sixty-three consecutive days during which the individual was not covered
16 by any creditable coverage.

17 3. The health care insurer shall not include any period that an
18 individual is in a waiting period or an affiliation period for any health
19 coverage or is awaiting action by a health care insurer on an application for
20 the issuance of health insurance coverage when the health care insurer
21 determines the continuous period pursuant to paragraph 1 of this subsection.

22 4. The health care insurer shall not include any period that an
23 individual is waiting for approval of an application for health care
24 coverage, provided the individual submitted an application to the health care
25 insurer for health care coverage within sixty-three consecutive days after
26 the individual's most recent creditable coverage.

27 5. The health care insurer shall not count a period of creditable
28 coverage with respect to enrollment of an individual, if, after the most
29 recent period of creditable coverage and before the enrollment date,
30 sixty-three consecutive days lapse during all of which the individual was not
31 covered under any creditable coverage. The health care insurer shall not
32 include in the determination of the period of continuous coverage described
33 in this section any period that an individual is in a waiting period for
34 health insurance coverage offered by a health care insurer, is in a waiting
35 period for benefits under a health benefits plan offered by an accountable
36 health plan or is in an affiliation period.

37 6. In determining the extent to which an individual has satisfied any
38 portion of any applicable preexisting condition period the health care
39 insurer shall count a period of creditable coverage without regard to the
40 specific benefits covered during that period.

41 P. An individual is an eligible individual if, on the date the
42 individual seeks coverage pursuant to this section, the individual has an
43 aggregate period of creditable coverage as defined and calculated pursuant
44 to this section of at least eighteen months and all of the following apply:

1 1. The most recent creditable coverage for the individual was under
2 a plan offered by:

3 (a) An employee welfare benefit plan that provides medical care to
4 employees or the employees' dependents directly or through insurance,
5 reimbursement or otherwise pursuant to the employee retirement income
6 security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code
7 sections 1001 through 1461).

8 (b) A church plan as defined in the employee retirement income
9 security act of 1974.

10 (c) A governmental plan as defined in the employee retirement income
11 security act of 1974, including a plan established or maintained for its
12 employees by the government of the United States or by any agency or
13 instrumentality of the United States.

14 (d) An accountable health plan as defined in section 20-2301.

15 (e) A plan made available to a person defined as eligible pursuant to
16 section 36-2901, paragraph 4- 6, subdivision (f) (d) or a dependent pursuant
17 to section 36-2901, paragraph 4- 6, subdivision (g) (e) of a person eligible
18 under section 36-2901, paragraph 4- 6, subdivision (f) (d), provided the
19 person was most recently employed by a business in this state with at least
20 two but not more than fifty full-time employees.

21 2. The individual is not eligible for coverage under:

22 (a) An employee welfare benefit plan that provides medical care to
23 employees or the employees' dependents directly or through insurance,
24 reimbursement or otherwise pursuant to the employee retirement income
25 security act of 1974.

26 (b) A health benefits plan issued by an accountable health plan as
27 defined in section 20-2301.

28 (c) Part A or part B of title XVIII of the social security act.

29 (d) Title 36, chapter 29, except coverage to persons defined as
30 eligible under section 36-2901, paragraph 4- 6, subdivisions (d), (e), (f)
31 and (g) (b), (c), (d) AND (e), or any other plan established under title XIX
32 of the social security act, and the individual does not have other health
33 insurance coverage.

34 3. The most recent coverage within the coverage period was not
35 terminated based on any factor described in section 20-2309, subsection B,
36 paragraph 1 or 2 relating to nonpayment of premiums or fraud.

37 4. The individual was offered and elected the option of continuation
38 coverage under a COBRA continuation provision pursuant to the consolidated
39 omnibus budget reconciliation act of 1985 (P.L. 99-272; 100 Stat. 82) or a
40 similar state program.

41 5. The individual exhausted the continuation coverage pursuant to the
42 consolidated omnibus budget reconciliation act of 1985.

43 Q. Notwithstanding subsection P of this section, a newborn child,
44 adopted child or child placed for adoption is an eligible individual if the

1 child was timely enrolled and otherwise would have met the definition of an
2 eligible individual as prescribed in this section other than the required
3 period of creditable coverage and the child is not subject to any preexisting
4 condition exclusion or limitation if the child has been continuously covered
5 under health insurance coverage or a health benefits plan offered by an
6 accountable health plan since birth, adoption or placement for adoption.

7 R. If a health care insurer imposes a waiting period for coverage of
8 preexisting conditions, within a reasonable period of time after receiving
9 an individual's proof of creditable coverage and not later than the date by
10 which the individual must select an insurance plan, the health care insurer
11 shall give the individual written disclosure of the insurer's determination
12 regarding any preexisting condition exclusion period that applies to that
13 individual. The disclosure shall include all of the following information:

14 1. The period of creditable coverage allowed toward the waiting period
15 for coverage of preexisting conditions.

16 2. The basis for the insurer's determination and the source and
17 substance of any information on which the insurer has relied.

18 3. A statement of any right the individual may have to present
19 additional evidence of creditable coverage and to appeal the insurer's
20 determination, including an explanation of any procedures for submission and
21 appeal.

22 S. This section and section 20-1380 apply to all health insurance
23 coverage that is offered, sold, issued, renewed, in effect or operated in the
24 individual market after June 30, 1997, regardless of when a period of
25 creditable coverage occurs.

26 T. For the purposes of this section and section 20-1380 as applicable:

27 1. "Affiliation period" has the same meaning prescribed in section
28 20-2301.

29 2. "Bona fide association" means, for health care coverage issued by
30 a health care insurer, an association that meets the requirements of section
31 20-2324.

32 3. "Creditable coverage" means coverage solely for an individual,
33 other than limited benefits coverage, under any of the following:

34 (a) An employee welfare benefit plan that provides medical care to
35 employees or the employees' dependents directly or through insurance,
36 reimbursement or otherwise pursuant to the employee retirement income
37 security act of 1974.

38 (b) A church plan as defined in the employee retirement income
39 security act of 1974.

40 (c) A health benefits plan issued by an accountable health plan as
41 defined in section 20-2301.

42 (d) Part A or part B of title XVIII of the social security act.

43 (e) Title XIX of the social security act, other than coverage
44 consisting solely of benefits under section 1928.

1 (f) Title 10, chapter 55 of the United States Code.

2 (g) A medical care program of the Indian health service or of a tribal
3 organization.

4 (h) A health benefits risk pool operated by any state of the United
5 States.

6 (i) A health plan offered pursuant to title 5, chapter 89 of the
7 United States Code.

8 (j) A public health plan as defined by federal law.

9 (k) A health benefit plan pursuant to section 5(e) of the peace corps
10 act (P.L. 87-293; 75 Stat. 612; 22 United States Code sections 2501 through
11 2523).

12 (l) A policy or contract, including short-term limited duration
13 insurance, issued on an individual basis by an insurer, a health care
14 services organization, a hospital service corporation, a medical service
15 corporation or a hospital, medical, dental and optometric service corporation
16 or made available to persons defined as eligible under section 36-2901,
17 paragraph 4-6, subdivision ~~(d)~~, ~~(e)~~, ~~(f)~~ or ~~(g)~~ (b), (c), (d) OR (e).

18 (m) A policy or contract issued by a health care insurer or an
19 accountable health plan to a member of a bona fide association.

20 4. "Different policy forms" means variations between policy forms
21 offered by a health care insurer, including policy forms which THAT have
22 different cost sharing arrangements or different riders.

23 5. "Genetic information" means information about genes, gene products
24 and inherited characteristics that may derive from the individual or a family
25 member, including information regarding carrier status and information
26 derived from laboratory tests that identify mutations in specific genes or
27 chromosomes, physical medical examinations, family histories and direct
28 analysis of genes or chromosomes.

29 6. "Health care insurer" means a disability insurer, group disability
30 insurer, blanket disability insurer, benefit insurer, health care services
31 organization, hospital service corporation, medical service corporation or
32 a hospital, medical, dental and optometric service corporation.

33 7. "Health status-related factor" means any factor in relation to the
34 health of the individual or a dependent of the individual enrolled or to be
35 enrolled in a health care services organization including:

36 (a) Health status.

37 (b) Medical condition, including physical and mental illness.

38 (c) Claims experience.

39 (d) Receipt of health care.

40 (e) Medical history.

41 (f) Genetic information.

42 (g) Evidence of insurability, including conditions arising out of acts
43 of domestic violence as defined in section 20-448.

44 (h) The existence of a physical or mental disability.

1 8. "Higher level of coverage" means a policy form for which the
2 actuarial value of the benefits under the health insurance coverage offered
3 by a health care insurer is at least fifteen per cent more than the actuarial
4 value of the health insurance coverage offered by the health care insurer as
5 a lower level of coverage in this state but not more than one hundred twenty
6 per cent of a policy form weighted average.

7 9. "Individual health insurance coverage" means health insurance
8 coverage offered by a health care insurer to individuals in the individual
9 market but does not include limited benefit coverage or short-term limited
10 duration insurance. A health care insurer that offers limited benefit
11 coverage or short-term limited duration insurance to individuals and no other
12 coverage to individuals in the individual market is not a health care insurer
13 that offers health insurance coverage in the individual market.

14 10. "Limited benefit coverage" has the same meaning prescribed in
15 section 20-1137.

16 11. "Lower level of coverage" means a policy form offered by a health
17 care insurer for which the actuarial value of the benefits under the health
18 insurance coverage is at least eighty-five per cent but not more than one
19 hundred per cent of the policy form weighted average.

20 12. "Network plan" means a health care plan provided by a health care
21 insurer under which the financing and delivery of health care services are
22 provided, in whole or in part, through a defined set of providers under
23 contract with the health care insurer in accordance with the determination
24 made by the director pursuant to section 20-1053 regarding the geographic or
25 service area in which a health care insurer may operate.

26 13. "Policy form weighted average" means the average actuarial value
27 of the benefits provided by a health care insurer that issues health coverage
28 in this state that is provided by either the health care insurer or, if the
29 data are available, by all health care insurers that issue health coverage
30 in this state in the individual health coverage market during the previous
31 calendar year, except coverage pursuant to this section, weighted by the
32 enrollment for all coverage forms.

33 14. "Preexisting condition" means a condition, regardless of the cause
34 of the condition, for which medical advice, diagnosis, care, or treatment was
35 recommended or received within not more than six months before the date of
36 the enrollment of the individual under the health insurance policy or other
37 contract that provides health coverage benefits. A genetic condition is not
38 a preexisting condition in the absence of a diagnosis of the condition
39 related to the genetic information and shall not result in a preexisting
40 condition limitation or preexisting condition exclusion.

41 15. "Preexisting condition limitation" or "preexisting condition
42 exclusion" means a limitation or exclusion of benefits for a preexisting
43 condition under a health insurance policy or other contract that provides
44 health coverage benefits.

1 16. "Short-term limited duration insurance" means health insurance
2 coverage that is offered by a health care insurer, that remains in effect for
3 no more than one hundred eighty-five days, that cannot be renewed or
4 otherwise continued for more than one hundred eighty days and that is not
5 intended or marketed as health insurance coverage subject to guaranteed
6 issuance or guaranteed renewal provisions of the laws of this state but that
7 is creditable coverage within the meaning of this section and section
8 20-2301.

9 Sec. 25. Section 20-1402, Arizona Revised Statutes, is amended to
10 read:

11 20-1402. Provisions of group disability policies; definitions

12 A. Each group disability policy shall contain in substance the
13 following provisions:

14 1. A provision that, in the absence of fraud, all statements made by
15 the policyholder or by any insured person shall be deemed representations and
16 not warranties, and that no statement made for the purpose of effecting
17 insurance shall avoid such insurance or reduce benefits unless contained in
18 a written instrument signed by the policyholder or the insured person, a copy
19 of which has been furnished to the policyholder or to the person or
20 beneficiary.

21 2. A provision that the insurer will furnish to the policyholder, for
22 delivery to each employee or member of the insured group, an individual
23 certificate setting forth in summary form a statement of the essential
24 features of the insurance coverage of the employee or member and to whom
25 benefits are payable. If dependents or family members are included in the
26 coverage additional certificates need not be issued for delivery to the
27 dependents or family members. Any policy, except accidental death and
28 dismemberment, applied for that provides family coverage shall, as to such
29 coverage of family members, also provide that the benefits applicable for
30 children shall be payable with respect to a newly born child of the insured
31 from the instant of such child's birth, to a child adopted by the insured,
32 regardless of the age at which the child was adopted, and to a child who has
33 been placed for adoption with the insured and for whom the application and
34 approval procedures for adoption pursuant to section 8-105 or 8-108 have been
35 completed to the same extent that such coverage applies to other members of
36 the family. The coverage for newly born or adopted children or children
37 placed for adoption shall include coverage of injury or sickness including
38 the necessary care and treatment of medically diagnosed congenital defects
39 and birth abnormalities. If payment of a specific premium is required to
40 provide coverage for a child, the policy may require that notification of
41 birth, adoption or adoption placement of the child and payment of the
42 required premium must be furnished to the insurer within thirty-one days
43 after the date of birth, adoption or adoption placement in order to have the
44 coverage continue beyond such thirty-one day period.

1 3. A provision that to the group originally insured may be added from
2 time to time eligible new employees or members or dependents, as the case may
3 be, in accordance with the terms of the policy.

4 4. Each contract shall be so written that the corporation shall pay
5 benefits:

6 (a) For performance of any surgical service which THAT is covered by
7 the terms of such contract, regardless of the place of service.

8 (b) For any home health services which THAT are performed by a
9 licensed home health agency and which THAT a physician has prescribed in lieu
10 of hospital services, as defined by the director, providing the hospital
11 services would have been covered.

12 (c) For any diagnostic service which THAT a physician has performed
13 outside a hospital in lieu of inpatient service, providing the inpatient
14 service would have been covered.

15 (d) For any service performed in a hospital's outpatient department
16 or in a freestanding surgical facility, providing such service would have
17 been covered if performed as an inpatient service.

18 5. A group disability insurance policy that provides coverage for the
19 surgical expense of a mastectomy shall also provide coverage incidental to
20 the patient's covered mastectomy for the expense of reconstructive surgery
21 of the breast on which the mastectomy was performed, surgery and
22 reconstruction of the other breast to produce a symmetrical appearance,
23 prostheses, treatment of physical complications for all stages of the
24 mastectomy, including lymphedemas, and at least two external postoperative
25 prostheses subject to all of the terms and conditions of the policy.

26 6. A contract, except a supplemental contract covering a specified
27 disease or other limited benefits, that provides coverage for surgical
28 services for a mastectomy shall also provide coverage for mammography
29 screening performed on dedicated equipment for diagnostic purposes on
30 referral by a patient's physician, subject to all of the terms and conditions
31 of the policy and according to the following guidelines:

32 (a) A baseline mammogram for a woman from age thirty-five to
33 thirty-nine.

34 (b) A mammogram for a woman from age forty to forty-nine every two
35 years or more frequently based on the recommendation of the woman's
36 physician.

37 (c) A mammogram every year for a woman fifty years of age and over.

38 7. Any contract that is issued to the insured and that provides
39 coverage for maternity benefits shall also provide that the maternity
40 benefits apply to the costs of the birth of any child legally adopted by the
41 insured if all the following are true:

42 (a) The child is adopted within one year of birth.

43 (b) The insured is legally obligated to pay the costs of birth.

1 (c) All preexisting conditions and other limitations have been met by
2 the insured.

3 (d) The insured has notified the insurer of the insured's
4 acceptability to adopt children pursuant to section 8-105, within sixty days
5 after such approval or within sixty days after a change in insurance
6 policies, plans or companies.

7 8. The coverage prescribed by paragraph 7 of this subsection is
8 excess to any other coverage the natural mother may have for maternity
9 benefits except coverage made available to persons pursuant to title 36,
10 chapter 29, but not including coverage made available to persons defined as
11 eligible under section 36-2901, paragraph 4- 6, subdivisions ~~(d), (e), (f)~~
12 ~~and (g)~~ (b), (c), (d) AND (e). If such other coverage exists the agency,
13 attorney or individual arranging the adoption shall make arrangements for the
14 insurance to pay those costs that may be covered under that policy and shall
15 advise the adopting parent in writing of the existence and extent of the
16 coverage without disclosing any confidential information such as the identity
17 of the natural parent. The insured adopting parents shall notify their
18 insurer of the existence and extent of the other coverage.

19 B. Any policy that provides maternity benefits shall not restrict
20 benefits for any hospital length of stay in connection with childbirth for
21 the mother or the newborn child to less than forty-eight hours following a
22 normal vaginal delivery or ninety-six hours following a cesarean
23 section. The policy shall not require the provider to obtain authorization
24 from the insurer for prescribing the minimum length of stay required by this
25 subsection. The policy may provide that an attending provider in
26 consultation with the mother may discharge the mother or the newborn child
27 before the expiration of the minimum length of stay required by this
28 subsection. The insurer shall not:

29 1. Deny the mother or the newborn child eligibility or continued
30 eligibility to enroll or to renew coverage under the terms of the policy
31 solely for the purpose of avoiding the requirements of this subsection.

32 2. Provide monetary payments or rebates to mothers to encourage those
33 mothers to accept less than the minimum protections available pursuant to
34 this subsection.

35 3. Penalize or otherwise reduce or limit the reimbursement of an
36 attending provider because that provider provided care to any insured under
37 the policy in accordance with this subsection.

38 4. Provide monetary or other incentives to an attending provider to
39 induce that provider to provide care to an insured under the policy in a
40 manner that is inconsistent with this subsection.

41 5. Except as described in subsection C of this section, restrict
42 benefits for any portion of a period within the minimum length of stay in a
43 manner that is less favorable than the benefits provided for any preceding
44 portion of that stay.

- 1 C. Nothing in subsection B of this section:
2 1. Requires a mother to give birth in a hospital or to stay in the
3 hospital for a fixed period of time following the birth of the child.
4 2. Prevents an insurer from imposing deductibles, coinsurance or
5 other cost sharing in relation to benefits for hospital lengths of stay in
6 connection with childbirth for a mother or a newborn child under the policy,
7 except that any coinsurance or other cost sharing for any portion of a period
8 within a hospital length of stay required pursuant to subsection B of this
9 section shall not be greater than the coinsurance or cost sharing for any
10 preceding portion of that stay.
11 3. Prevents an insurer from negotiating the level and type of
12 reimbursement with a provider for care provided in accordance with subsection
13 B of this section.
14 D. Any contract that provides coverage for diabetes shall also
15 provide coverage for equipment and supplies that are medically necessary and
16 that are prescribed by a health care provider including:
17 1. Blood glucose monitors.
18 2. Blood glucose monitors for the legally blind.
19 3. Test strips for glucose monitors and visual reading and urine
20 testing strips.
21 4. Insulin preparations and glucagon.
22 5. Insulin cartridges.
23 6. Drawing up devices and monitors for the visually impaired.
24 7. Injection aids.
25 8. Insulin cartridges for the legally blind.
26 9. Syringes and lancets including automatic lancing devices.
27 10. Prescribed oral agents for controlling blood sugar that are
28 included on the plan formulary.
29 11. To the extent coverage is required under medicare, podiatric
30 appliances for prevention of complications associated with diabetes.
31 12. Any other device, medication, equipment or supply for which
32 coverage is required under medicare from and after January 1, 1999. The
33 coverage required in this paragraph is effective six months after the
34 coverage is required under medicare.
35 E. Nothing in subsection D of this section prohibits a group
36 disability insurer from imposing deductibles, coinsurance or other cost
37 sharing in relation to benefits for equipment or supplies for the treatment
38 of diabetes.
39 F. Any contract that provides coverage for prescription drugs shall
40 not limit or exclude coverage for any prescription drug prescribed for the
41 treatment of cancer on the basis that the prescription drug has not been
42 approved by the United States food and drug administration for the treatment
43 of the specific type of cancer for which the prescription drug has been
44 prescribed, if the prescription drug has been recognized as safe and

1 effective for treatment of that specific type of cancer in one or more of the
2 standard medical reference compendia prescribed in subsection G of this
3 section or medical literature that meets the criteria prescribed in
4 subsection G of this section. The coverage required under this subsection
5 includes covered medically necessary services associated with the
6 administration of the prescription drug. This subsection does not:

7 1. Require coverage of any prescription drug used in the treatment of
8 a type of cancer if the United States food and drug administration has
9 determined that the prescription drug is contraindicated for that type of
10 cancer.

11 2. Require coverage for any experimental prescription drug that is
12 not approved for any indication by the United States food and drug
13 administration.

14 3. Alter any law with regard to provisions that limit the coverage of
15 prescription drugs that have not been approved by the United States food and
16 drug administration.

17 4. Require reimbursement or coverage for any prescription drug that
18 is not included in the drug formulary or list of covered prescription drugs
19 specified in the contract.

20 5. Prohibit a contract from limiting or excluding coverage of a
21 prescription drug, if the decision to limit or exclude coverage of the
22 prescription drug is not based primarily on the coverage of prescription
23 drugs required by this section.

24 6. Prohibit the use of deductibles, coinsurance, copayments or other
25 cost sharing in relation to drug benefits and related medical benefits
26 offered.

27 G. For the purposes of subsection F of this section:

28 1. The acceptable standard medical reference compendia are the
29 following:

30 (a) The American medical association drug evaluations, a publication
31 of the American medical association.

32 (b) The American hospital formulary service drug information, a
33 publication of the American society of health system pharmacists.

34 (c) Drug information for the health care provider, a publication of
35 the United States pharmacopoeia convention.

36 2. Medical literature may be accepted if all of the following apply:

37 (a) At least two articles from major peer reviewed professional
38 medical journals have recognized, based on scientific or medical criteria,
39 the drug's safety and effectiveness for treatment of the indication for which
40 the drug has been prescribed.

41 (b) No article from a major peer reviewed professional medical
42 journal has concluded, based on scientific or medical criteria, that the drug
43 is unsafe or ineffective or that the drug's safety and effectiveness cannot

1 be determined for the treatment of the indication for which the drug has been
2 prescribed.

3 (c) The literature meets the uniform requirements for manuscripts
4 submitted to biomedical journals established by the international committee
5 of medical journal editors or is published in a journal specified by the
6 United States department of health and human services as acceptable peer
7 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
8 security act (42 United States Code section 1395x(t)(2)(B)).

9 H. Any contract THAT IS offered by a group disability insurer AND
10 that contains a prescription drug benefit shall provide coverage of medical
11 foods to treat inherited metabolic disorders as provided by this section.

12 I. The metabolic disorders triggering medical foods coverage under
13 this section shall:

14 1. Be part of the newborn screening program prescribed in section
15 36-694.

16 2. Involve amino acid, carbohydrate or fat metabolism.

17 3. Have medically standard methods of diagnosis, treatment and
18 monitoring including quantification of metabolites in blood, urine or spinal
19 fluid or enzyme or DNA confirmation in tissues.

20 4. Require specially processed or treated medical foods that are
21 generally available only under the supervision and direction of a physician
22 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed
23 throughout life and without which the person may suffer serious mental or
24 physical impairment.

25 J. Medical foods eligible for coverage under this section shall be
26 prescribed or ordered under the supervision of a physician licensed pursuant
27 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
28 treatment of an inherited metabolic disease.

29 K. An insurer shall cover at least fifty per cent of the cost of
30 medical foods prescribed to treat inherited metabolic disorders and covered
31 pursuant to this section. ~~A corporation~~ AN INSURER may limit the maximum
32 annual benefit for medical foods under this section to five thousand dollars,
33 which applies to the cost of all prescribed modified low protein foods and
34 metabolic formula.

35 L. For the purposes of:

36 1. This section:

37 (a) "Inherited metabolic disorder" means a disease caused by an
38 inherited abnormality of body chemistry and includes a disease tested under
39 the newborn screening program prescribed in section 36-694.

40 (b) "Medical foods" means modified low protein foods and metabolic
41 formula.

42 (c) "Metabolic formula" means foods that are all of the following:

1 (i) Formulated to be consumed or administered enterally under the
2 supervision of a physician who is licensed pursuant to title 32, chapter 13
3 or 17.

4 (ii) Processed or formulated to be deficient in one or more of the
5 nutrients present in typical foodstuffs.

6 (iii) Administered for the medical and nutritional management of a
7 person who has limited capacity to metabolize foodstuffs or certain nutrients
8 contained in the foodstuffs or who has other specific nutrient requirements
9 as established by medical evaluation.

10 (iv) Essential to a person's optimal growth, health and metabolic
11 homeostasis.

12 (d) "Modified low protein foods" means foods that are all of the
13 following:

14 (i) Formulated to be consumed or administered enterally under the
15 supervision of a physician who is licensed pursuant to title 32, chapter 13
16 or 17.

17 (ii) Processed or formulated to contain less than one gram of protein
18 per unit of serving, but does not include a natural food that is naturally
19 low in protein.

20 (iii) Administered for the medical and nutritional management of a
21 person who has limited capacity to metabolize foodstuffs or certain nutrients
22 contained in the foodstuffs or who has other specific nutrient requirements
23 as established by medical evaluation.

24 (iv) Essential to a person's optimal growth, health and metabolic
25 homeostasis.

26 2. Subsection A of this section, the term "child", for purposes of
27 initial coverage of an adopted child or a child placed for adoption but not
28 for purposes of termination of coverage of such child, means a person under
29 the age of eighteen years.

30 Sec. 26. Section 20-1404, Arizona Revised Statutes, is amended to
31 read:

32 20-1404. Blanket disability insurance; definitions

33 A. Blanket disability insurance is that form of disability insurance
34 covering special groups of persons as enumerated in one of the following
35 paragraphs:

36 1. Under a policy or contract issued to any common carrier, which
37 shall be deemed the policyholder, covering a group defined as all persons who
38 may become passengers on such common carrier.

39 2. Under a policy or contract issued to an employer, who shall be
40 deemed the policyholder, covering all employees or any group of employees
41 defined by reference to exceptional hazards incident to such employment.
42 Dependents of the employees and guests of the employer may also be included
43 where exposed to the same hazards.

1 3. Under a policy or contract issued to a college, school or other
2 institution of learning or to the head or principal thereof, who or which
3 shall be deemed the policyholder, covering students or teachers.

4 4. Under a policy or contract issued in the name of any volunteer fire
5 department or first aid or other such volunteer group, or agency having
6 jurisdiction thereof, which shall be deemed the policyholder, covering all
7 of the members of such fire department or group.

8 5. Under a policy or contract issued to a creditor, who shall be
9 deemed the policyholder, to insure debtors of the creditor.

10 6. Under a policy or contract issued to a sports team or to a camp or
11 sponsor thereof, which team or camp or sponsor thereof shall be deemed the
12 policyholder, covering members or campers.

13 7. Under a policy or contract which THAT is issued to any other
14 substantially similar group and which THAT, in the discretion of the
15 director, may be subject to the issuance of a blanket disability policy or
16 contract.

17 B. An individual application need not be required from a person
18 covered under a blanket disability policy or contract, nor shall it be
19 necessary for the insurer to furnish each person with a certificate.

20 C. All benefits under any blanket disability policy shall be payable
21 to the person insured, or to the insured's designated beneficiary or
22 beneficiaries, or to the insured's estate, except that if the person insured
23 is a minor, such benefits may be made payable to the insured's parent or
24 guardian or any other person actually supporting the insured, and except that
25 the policy may provide that all or any portion of any indemnities provided
26 by any such policy on account of hospital, nursing, medical or surgical
27 services may, at the insurer's option, be paid directly to the hospital or
28 person rendering such services, but the policy may not require that the
29 service be rendered by a particular hospital or person. Payment so made
30 shall discharge the insurer's obligation with respect to the amount of
31 insurance so paid.

32 D. Nothing contained in this section shall be deemed to affect the
33 legal liability of policyholders for the death of or injury to any member of
34 the group.

35 E. Any policy or contract, except accidental death and dismemberment,
36 applied for that provides family coverage shall, as to such coverage of
37 family members, also provide that the benefits applicable for children shall
38 be payable with respect to a newly born child of the insured from the instant
39 of such child's birth, to a child adopted by the insured, regardless of the
40 age at which the child was adopted, and to a child who has been placed for
41 adoption with the insured and for whom the application and approval
42 procedures for adoption pursuant to section 8-105 or 8-108 have been
43 completed to the same extent that such coverage applies to other members of
44 the family. The coverage for newly born or adopted children or children

1 placed for adoption shall include coverage of injury or sickness including
2 necessary care and treatment of medically diagnosed congenital defects and
3 birth abnormalities. If payment of a specific premium is required to provide
4 coverage for a child, the policy or contract may require that notification
5 of birth, adoption or adoption placement of the child and payment of the
6 required premium must be furnished to the insurer within thirty-one days
7 after the date of birth, adoption or adoption placement in order to have the
8 coverage continue beyond the thirty-one day period.

9 F. Each policy or contract shall be so written that the insurer shall
10 pay benefits:

11 1. For performance of any surgical service which THAT is covered by
12 the terms of such contract, regardless of the place of service.

13 2. For any home health services which THAT are performed by a licensed
14 home health agency and which THAT a physician has prescribed in lieu of
15 hospital services, as defined by the director, providing the hospital
16 services would have been covered.

17 3. For any diagnostic service which THAT a physician has performed
18 outside a hospital in lieu of inpatient service, providing the inpatient
19 service would have been covered.

20 4. For any service performed in a hospital's outpatient department or
21 in a freestanding surgical facility, providing such service would have been
22 covered if performed as an inpatient service.

23 G. A blanket disability insurance policy that provides coverage for
24 the surgical expense of a mastectomy shall also provide coverage incidental
25 to the patient's covered mastectomy for the expense of reconstructive surgery
26 of the breast on which the mastectomy was performed, surgery and
27 reconstruction of the other breast to produce a symmetrical appearance,
28 prostheses, treatment of physical complications for all stages of the
29 mastectomy, including lymphedemas, and at least two external postoperative
30 prostheses subject to all of the terms and conditions of the policy.

31 H. A contract that provides coverage for surgical services for a
32 mastectomy shall also provide coverage for mammography screening performed
33 on dedicated equipment for diagnostic purposes on referral by a patient's
34 physician, subject to all of the terms and conditions of the policy and
35 according to the following guidelines:

36 1. A baseline mammogram for a woman from age thirty-five to
37 thirty-nine.

38 2. A mammogram for a woman from age forty to forty-nine every two
39 years or more frequently based on the recommendation of the woman's
40 physician.

41 3. A mammogram every year for a woman fifty years of age and over.

42 I. Any contract that is issued to the insured and that provides
43 coverage for maternity benefits shall also provide that the maternity

1 benefits apply to the costs of the birth of any child legally adopted by the
2 insured if all the following are true:

3 1. The child is adopted within one year of birth.
4 2. The insured is legally obligated to pay the costs of birth.
5 3. All preexisting conditions and other limitations have been met by
6 the insured.

7 4. The insured has notified the insurer of his acceptability to adopt
8 children pursuant to section 8-105, within sixty days after such approval or
9 within sixty days after a change in insurance policies, plans or companies.

10 J. The coverage prescribed by subsection I of this section is excess
11 to any other coverage the natural mother may have for maternity benefits
12 except coverage made available to persons pursuant to title 36, chapter 29,
13 but not including coverage made available to persons defined as eligible
14 under section 36-2901, paragraph 4-6, subdivisions ~~(d), (e), (f) and (g)~~
15 (b), (c), (d) AND (e). If such other coverage exists the agency, attorney
16 or individual arranging the adoption shall make arrangements for the
17 insurance to pay those costs that may be covered under that policy and shall
18 advise the adopting parent in writing of the existence and extent of the
19 coverage without disclosing any confidential information such as the identity
20 of the natural parent. The insured adopting parents shall notify their
21 insurer of the existence and extent of the other coverage.

22 K. Any contract that provides maternity benefits shall not restrict
23 benefits for any hospital length of stay in connection with childbirth for
24 the mother or the newborn child to less than forty-eight hours following a
25 normal vaginal delivery or ninety-six hours following a cesarean section. The
26 contract shall not require the provider to obtain authorization from the
27 insurer for prescribing the minimum length of stay required by this
28 subsection. The contract may provide that an attending provider in
29 consultation with the mother may discharge the mother or the newborn child
30 before the expiration of the minimum length of stay required by this
31 subsection. The insurer shall not:

32 1. Deny the mother or the newborn child eligibility or continued
33 eligibility to enroll or to renew coverage under the terms of the contract
34 solely for the purpose of avoiding the requirements of this subsection.

35 2. Provide monetary payments or rebates to mothers to encourage those
36 mothers to accept less than the minimum protections available pursuant to
37 this subsection.

38 3. Penalize or otherwise reduce or limit the reimbursement of an
39 attending provider because that provider provided care to any insured under
40 the contract in accordance with this subsection.

41 4. Provide monetary or other incentives to an attending provider to
42 induce that provider to provide care to an insured under the contract in a
43 manner that is inconsistent with this subsection.

1 5. Except as described in subsection L of this section, restrict
2 benefits for any portion of a period within the minimum length of stay in a
3 manner that is less favorable than the benefits provided for any preceding
4 portion of that stay.

5 L. Nothing in subsection K of this section:

6 1. Requires a mother to give birth in a hospital or to stay in the
7 hospital for a fixed period of time following the birth of the child.

8 2. Prevents an insurer from imposing deductibles, coinsurance or other
9 cost sharing in relation to benefits for hospital lengths of stay in
10 connection with childbirth for a mother or a newborn child under the
11 contract, except that any coinsurance or other cost sharing for any portion
12 of a period within a hospital length of stay required pursuant to subsection
13 K of this section shall not be greater than the coinsurance or cost sharing
14 for any preceding portion of that stay.

15 3. Prevents an insurer from negotiating the level and type of
16 reimbursement with a provider for care provided in accordance with subsection
17 K of this section.

18 M. Any contract that provides coverage for diabetes shall also provide
19 coverage for equipment and supplies that are medically necessary and that are
20 prescribed by a health care provider including:

21 1. Blood glucose monitors.

22 2. Blood glucose monitors for the legally blind.

23 3. Test strips for glucose monitors and visual reading and urine
24 testing strips.

25 4. Insulin preparations and glucagon.

26 5. Insulin cartridges.

27 6. Drawing up devices and monitors for the visually impaired.

28 7. Injection aids.

29 8. Insulin cartridges for the legally blind.

30 9. Syringes and lancets including automatic lancing devices.

31 10. Prescribed oral agents for controlling blood sugar that are
32 included on the plan formulary.

33 11. To the extent coverage is required under medicare, podiatric
34 appliances for prevention of complications associated with diabetes.

35 12. Any other device, medication, equipment or supply for which
36 coverage is required under medicare from and after January 1, 1999. The
37 coverage required in this paragraph is effective six months after the
38 coverage is required under medicare.

39 N. Nothing in subsection M of this section prohibits a blanket
40 disability insurer from imposing deductibles, coinsurance or other cost
41 sharing in relation to benefits for equipment or supplies for the treatment
42 of diabetes.

43 O. Any contract that provides coverage for prescription drugs shall
44 not limit or exclude coverage for any prescription drug prescribed for the

1 treatment of cancer on the basis that the prescription drug has not been
2 approved by the United States food and drug administration for the treatment
3 of the specific type of cancer for which the prescription drug has been
4 prescribed, if the prescription drug has been recognized as safe and
5 effective for treatment of that specific type of cancer in one or more of the
6 standard medical reference compendia prescribed in subsection P of this
7 section or medical literature that meets the criteria prescribed in
8 subsection P of this section. The coverage required under this subsection
9 includes covered medically necessary services associated with the
10 administration of the prescription drug. This subsection does not:

11 1. Require coverage of any prescription drug used in the treatment of
12 a type of cancer if the United States food and drug administration has
13 determined that the prescription drug is contraindicated for that type of
14 cancer.

15 2. Require coverage for any experimental prescription drug that is not
16 approved for any indication by the United States food and drug
17 administration.

18 3. Alter any law with regard to provisions that limit the coverage of
19 prescription drugs that have not been approved by the United States food and
20 drug administration.

21 4. Require reimbursement or coverage for any prescription drug that
22 is not included in the drug formulary or list of covered prescription drugs
23 specified in the contract.

24 5. Prohibit a contract from limiting or excluding coverage of a
25 prescription drug, if the decision to limit or exclude coverage of the
26 prescription drug is not based primarily on the coverage of prescription
27 drugs required by this section.

28 6. Prohibit the use of deductibles, coinsurance, copayments or other
29 cost sharing in relation to drug benefits and related medical benefits
30 offered.

31 P. For the purposes of subsection O of this section:

32 1. The acceptable standard medical reference compendia are the
33 following:

34 (a) The American medical association drug evaluations, a publication
35 of the American medical association.

36 (b) The American hospital formulary service drug information, a
37 publication of the American society of health system pharmacists.

38 (c) Drug information for the health care provider, a publication of
39 the United States pharmacopoeia convention.

40 2. Medical literature may be accepted if all of the following apply:

41 (a) At least two articles from major peer reviewed professional
42 medical journals have recognized, based on scientific or medical criteria,
43 the drug's safety and effectiveness for treatment of the indication for which
44 the drug has been prescribed.

1 (b) No article from a major peer reviewed professional medical journal
2 has concluded, based on scientific or medical criteria, that the drug is
3 unsafe or ineffective or that the drug's safety and effectiveness cannot be
4 determined for the treatment of the indication for which the drug has been
5 prescribed.

6 (c) The literature meets the uniform requirements for manuscripts
7 submitted to biomedical journals established by the international committee
8 of medical journal editors or is published in a journal specified by the
9 United States department of health and human services as acceptable peer
10 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
11 security act (42 United States Code section 1395x(t)(2)(B)).

12 Q. Any contract THAT IS offered by a blanket disability insurer AND
13 that contains a prescription drug benefit shall provide coverage of medical
14 foods to treat inherited metabolic disorders as provided by this section.

15 R. The metabolic disorders triggering medical foods coverage under
16 this section shall:

17 1. Be part of the newborn screening program prescribed in section
18 36-694.

19 2. Involve amino acid, carbohydrate or fat metabolism.

20 3. Have medically standard methods of diagnosis, treatment and
21 monitoring including quantification of metabolites in blood, urine or spinal
22 fluid or enzyme or DNA confirmation in tissues.

23 4. Require specially processed or treated medical foods that are
24 generally available only under the supervision and direction of a physician
25 who is licensed pursuant to title 32, chapter 13 or 17, that must be consumed
26 throughout life and without which the person may suffer serious mental or
27 physical impairment.

28 S. Medical foods eligible for coverage under this section shall be
29 prescribed or ordered under the supervision of a physician licensed pursuant
30 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
31 treatment of an inherited metabolic disease.

32 T. An insurer shall cover at least fifty per cent of the cost of
33 medical foods prescribed to treat inherited metabolic disorders and covered
34 pursuant to this section. ~~A corporation~~ AN INSURER may limit the maximum
35 annual benefit for medical foods under this section to five thousand dollars
36 which applies to the cost of all prescribed modified low protein foods and
37 metabolic formula.

38 U. For the purposes of:

39 1. This section:

40 (a) "Inherited metabolic disorder" means a disease caused by an
41 inherited abnormality of body chemistry and includes a disease tested under
42 the newborn screening program prescribed in section 36-694.

43 (b) "Medical foods" means modified low protein foods and metabolic
44 formula.

1 (c) "Metabolic formula" means foods that are all of the following:

2 (i) Formulated to be consumed or administered enterally under the
3 supervision of a physician who is licensed pursuant to title 32, chapter 13
4 or 17.

5 (ii) Processed or formulated to be deficient in one or more of the
6 nutrients present in typical foodstuffs.

7 (iii) Administered for the medical and nutritional management of a
8 person who has limited capacity to metabolize foodstuffs or certain nutrients
9 contained in the foodstuffs or who has other specific nutrient requirements
10 as established by medical evaluation.

11 (iv) Essential to a person's optimal growth, health and metabolic
12 homeostasis.

13 (d) "Modified low protein foods" means foods that are all of the
14 following:

15 (i) Formulated to be consumed or administered enterally under the
16 supervision of a physician who is licensed pursuant to title 32, chapter 13
17 or 17.

18 (ii) Processed or formulated to contain less than one gram of protein
19 per unit of serving, but does not include a natural food that is naturally
20 low in protein.

21 (iii) Administered for the medical and nutritional management of a
22 person who has limited capacity to metabolize foodstuffs or certain nutrients
23 contained in the foodstuffs or who has other specific nutrient requirements
24 as established by medical evaluation.

25 (iv) Essential to a person's optimal growth, health and metabolic
26 homeostasis.

27 2. Subsection E of this section, the term "child", for purposes of
28 initial coverage of an adopted child or a child placed for adoption but not
29 for purposes of termination of coverage of such child, means a person under
30 the age of eighteen years.

31 Sec. 27. Section 20-2301, Arizona Revised Statutes, as amended by Laws
32 2000, chapter 355, section 11, is amended to read:

33 20-2301. Definitions; late enrollee coverage

34 A. In this chapter, unless the context otherwise requires:

35 1. "Accountable health plan" means an entity that offers, issues or
36 otherwise provides a health benefits plan and is approved by the director as
37 an accountable health plan pursuant to section 20-2303.

38 2. "Affiliation period" means a period of two months, or three months
39 for late enrollees, that under the terms of the health benefits plan offered
40 by a health care services organization must expire before the health benefits
41 plan becomes effective and in which the health care services organization is
42 not required to provide health care services or benefits and cannot charge
43 the participant or beneficiary a premium for any coverage during the period.

1 3. "Base premium rate" means, for each rating period, the lowest
2 premium rate that could have been charged under a rating system by the
3 accountable health plan to small employers for health benefits plans
4 involving the same or similar coverage, family size and composition, and
5 geographic area.

6 4. "Basic health benefit plan" means a plan that is developed by a
7 committee established by the legislature and that is adopted by the director.

8 5. "Bona fide association" means, for a health benefits plan issued
9 by an accountable health plan, an association that meets the requirements of
10 section 20-2324.

11 6. "COBRA continuation provision" means:

12 (a) Section 4980B, except subsection (f)(1) as it relates to pediatric
13 vaccines, of the internal revenue code of 1986.

14 (b) Title I, subtitle B, part 6, except section 609, of the employee
15 retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United
16 States Code sections 1001 through 1461).

17 (c) Title XXII of the public health service act.

18 (d) Any similar provision of the law of this state or any other state.

19 7. "Creditable coverage" means coverage solely for an individual,
20 other than limited benefits coverage, under any of the following:

21 (a) An employee welfare benefit plan that provides medical care to
22 employees or the employees' dependents directly or through insurance,
23 reimbursement or otherwise pursuant to the employee retirement income
24 security act of 1974.

25 (b) A church plan as defined in the employee retirement income
26 security act of 1974.

27 (c) A health benefits plan issued by an accountable health plan as
28 defined in section 20-2301.

29 (d) Part A or part B of title XVIII of the social security act.

30 (e) Title XIX of the social security act, other than coverage
31 consisting solely of benefits under section 1928.

32 (f) Title 10, chapter 55 of the United States Code.

33 (g) A medical care program of the Indian health service or of a tribal
34 organization.

35 (h) A health benefits risk pool operated by any state of the United
36 States.

37 (i) A health plan offered pursuant to title 5, chapter 89 of the
38 United States Code.

39 (j) A public health plan as defined by federal law.

40 (k) A health benefit plan pursuant to section 5(e) of the peace corps
41 act (P.L. 87-293; 75 Stat. 612; 22 United States Code sections 2501 through
42 2523).

43 (l) A policy or contract, including short-term limited duration
44 insurance, issued on an individual basis by an insurer, a health care

1 services organization, a hospital service corporation, a medical service
2 corporation or a hospital, medical, dental and optometric service corporation
3 or made available to persons defined as eligible under section 36-2901,
4 paragraph 4-6, subdivisions (d), (e), (f) and (g) (b), (c), (d) AND (e).

5 (m) A policy or contract issued by a health care insurer or an
6 accountable health plan to a member of a bona fide association.

7 8. "Demographic characteristics" means objective factors an insurer
8 considers in determining premium rates. Demographic characteristics do not
9 include health status-related factors, industry or duration of coverage since
10 issue.

11 9. "Different policy forms" means variations between policy forms
12 offered by a health care insurer, including policy forms which THAT have
13 different cost sharing arrangements or different riders.

14 10. "Genetic information" means information about genes, gene products
15 and inherited characteristics that may derive from the individual or a family
16 member, including information regarding carrier status and information
17 derived from laboratory tests that identify mutations in specific genes or
18 chromosomes, physical medical examinations, family histories and direct
19 analysis of genes or chromosomes.

20 11. "Health benefits plan" means a hospital and medical service
21 corporation policy or certificate, a health care services organization
22 contract, a multiple employer welfare arrangement or any other arrangement
23 under which health services or health benefits are provided to two or more
24 individuals. Health benefits plan does not include the following:

25 (a) Accident only, dental only, vision only, disability income only
26 or long-term care only insurance, fixed or hospital indemnity coverage,
27 limited benefit coverage, specified disease coverage, credit coverage or
28 Taft-Hartley trusts.

29 (b) Coverage that is issued as a supplement to liability insurance.

30 (c) Medicare supplemental insurance.

31 (d) Workers' compensation insurance.

32 (e) Automobile medical payment insurance.

33 12. "Health status-related factor" means any factor in relation to the
34 health of the individual or a dependent of the individual enrolled or to be
35 enrolled in an accountable health plan including:

36 (a) Health status.

37 (b) Medical condition, including physical and mental illness.

38 (c) Claims experience.

39 (d) Receipt of health care.

40 (e) Medical history.

41 (f) Genetic information.

42 (g) Evidence of insurability, including conditions arising out of acts
43 of domestic violence as defined in section 20-448.

44 (h) The existence of a physical or mental disability.

1 13. "Higher level of coverage" means a health benefits plan offered by
2 an accountable health plan for which the actuarial value of the benefits
3 under the coverage is at least fifteen per cent more than the actuarial value
4 of the health benefits plan offered by the accountable health plan as a lower
5 level of coverage in this state but not more than one hundred twenty per cent
6 of a policy form weighted average.

7 14. "Index rate" means, as to a rating period, the arithmetic average
8 of the applicable base premium rate and the highest premium rate that could
9 have been charged under a rating system by the accountable health plan to
10 small employers for a health benefits plan involving the same or similar
11 coverage, family size and composition, and geographic area.

12 15. "Late enrollee" means an employee or dependent who requests
13 enrollment in a health benefits plan after the initial enrollment period that
14 is provided under the terms of the health benefits plan if the initial
15 enrollment period is at least thirty-one days. An employee or dependent
16 shall not be considered a late enrollee if:

17 (a) The person:

18 (i) At the time of the initial enrollment period was covered under a
19 public or private health insurance policy or any other health benefits plan.

20 (ii) Lost coverage under a public or private health insurance policy
21 or any other health benefits plan due to the employee's termination of
22 employment or eligibility, the reduction in the number of hours of
23 employment, the termination of the other plan's coverage, the death of the
24 spouse, legal separation or divorce or the termination of employer
25 contributions toward the coverage.

26 (iii) Requests enrollment within thirty-one days after the termination
27 of creditable coverage that is provided under a public or private health
28 insurance or other health benefits plan.

29 (iv) Requests enrollment within thirty-one days after the date of
30 marriage.

31 (b) The person is employed by an employer that offers multiple health
32 benefits plans and the person elects a different plan during an open
33 enrollment period.

34 (c) A court orders that coverage be provided for a spouse or minor
35 child under a covered employee's health benefits plan and the person requests
36 enrollment within thirty-one days after the court order is issued.

37 (d) The person becomes a dependent of a covered person through
38 marriage, birth, adoption or placement for adoption and requests enrollment
39 no later than thirty-one days after becoming a dependent.

40 16. "Lower level of coverage" means a health benefits plan offered by
41 an accountable health plan for which the actuarial value of the benefits
42 under the health benefits plan is at least eighty-five per cent but not more
43 than one hundred per cent of the policy form weighted average.

1 17. "Network plan" means a health benefits plan provided by an
2 accountable health plan under which the financing and delivery of health
3 benefits are provided, in whole or in part, through a defined set of
4 providers under contract with the accountable health plan in accordance with
5 the determination made by the director pursuant to section 20-1053 regarding
6 the geographic or service area in which an accountable health plan may
7 operate.

8 18. "Participating provider" means a professional or institutional
9 health care provider that is employed by or has a written contract with an
10 accountable health plan.

11 19. "Policy form weighted average" means the average actuarial value
12 of the benefits provided by all health benefits plans issued by either the
13 accountable health plan or, if the data are available, by all accountable
14 health plans in the group market in this state during the previous calendar
15 year, weighted by the enrollment for all coverage forms.

16 20. "Preexisting condition" means a condition, regardless of the cause
17 of the condition, for which medical advice, diagnosis, care or treatment was
18 recommended or received within not more than six months before the date of
19 the enrollment of the individual under a health benefits plan issued by an
20 accountable health plan. A genetic condition is not a preexisting condition
21 in the absence of a diagnosis of the condition related to the genetic
22 information and shall not result in a preexisting condition limitation or
23 preexisting condition exclusion.

24 21. "Preexisting condition limitation" or "preexisting condition
25 exclusion" means a limitation or exclusion of benefits for a preexisting
26 condition under a health benefits plan offered by an accountable health plan.

27 22. "Small employer" means an employer who employs at least two but not
28 more than fifty eligible employees on a typical business day during any one
29 calendar year.

30 23. "Taft-Hartley trust" means a jointly-managed trust, as allowed by
31 29 United States Code sections 141 through 187, that contains a plan of
32 benefits for employees and that is negotiated in a collective bargaining
33 agreement governing the wages, hours and working conditions of the employees,
34 as allowed by 29 United States Code section 157.

35 24. "Waiting period" means the period that must pass before a potential
36 participant or beneficiary in a health benefits plan offered by an
37 accountable health plan is eligible to be covered for benefits as determined
38 by the individual's employer.

39 B. Coverage for a late enrollee begins on the date the person becomes
40 a dependent if a request for enrollment is received within thirty-one days
41 after the person becomes a dependent.

1 Sec. 28. Section 20-2321, Arizona Revised Statutes, is amended to
2 read:

3 20-2321. Maternity benefits; adoption; coverage

4 A. A contract that is issued to an enrollee pursuant to this article
5 and that provides coverage for maternity benefits shall also provide that the
6 maternity benefits apply to the costs of the birth of a child who is legally
7 adopted by the enrollee if all of the following are true:

8 1. The child is adopted within one year of birth.

9 2. The enrollee is legally obligated to pay the costs of birth.

10 3. All preexisting conditions and other limitations have been met and
11 all deductibles and copayments have been paid by the enrollee.

12 4. The enrollee has notified the insurer of the enrollee's
13 acceptability to adopt children pursuant to section 8-105 within sixty days
14 after this approval or within sixty days after a change in insurance
15 policies, plans or companies.

16 B. The coverage prescribed by subsection A of this section is excess
17 to any other coverage the natural mother may have for maternity benefits
18 except coverage made available to persons pursuant to title 36, chapter 29
19 but not including coverage made available to persons defined as eligible
20 under section 36-2901, paragraph 4- 6, subdivisions ~~(d), (e), (f) and (g)~~
21 (b), (c), (d) AND (e).

22 C. If other coverage exists the agency, attorney or individual
23 arranging the adoption shall make arrangements for the insurance to pay those
24 costs that may be covered under that policy and shall advise the adopting
25 parent in writing of the existence and extent of the coverage without
26 disclosing any confidential information such as the identity of the natural
27 parent.

28 D. The enrollee adopting parents shall notify their accountable health
29 plan of the existence and extent of the other coverage.

30 E. An accountable health plan is not required to pay any costs in
31 excess of the amounts it would have been obligated to pay to its hospitals
32 and providers if the natural mother and child had received the maternity and
33 newborn care directly from or through that accountable health plan.

34 F. Beginning January 1, 1998, any contract that provides maternity
35 benefits shall not restrict benefits for any hospital length of stay in
36 connection with childbirth for the mother or the newborn child to less than
37 forty-eight hours following a normal vaginal delivery or ninety-six hours
38 following a cesarean section. The contract shall not require the provider
39 to obtain authorization from the accountable health plan for prescribing the
40 minimum length of stay required by this section SUBSECTION. The contract may
41 provide that an attending provider in consultation with the mother may
42 discharge the mother or the newborn child before the expiration of the
43 minimum length of stay required by this subsection. The accountable health
44 plan shall not:

1 1. Deny the mother or the newborn child eligibility or continued
2 eligibility to enroll or to renew coverage under the terms of the contract
3 solely for the purpose of avoiding the requirements of this section
4 SUBSECTION.

5 2. Provide monetary payments or rebates to mothers to encourage those
6 mothers to accept less than the minimum protections available pursuant to
7 this subsection.

8 3. Penalize or otherwise reduce or limit the reimbursement of an
9 attending provider because that provider provided care to any insured under
10 the contract in accordance with this subsection.

11 4. Provide monetary or other incentives to an attending provider to
12 induce that provider to provide care to an insured under the contract in a
13 manner that is inconsistent with this subsection.

14 5. Except as described in subsection G of this section, restrict
15 benefits for any portion of a period within the minimum length of stay in a
16 manner that is less favorable than the benefits provided for any preceding
17 portion of that stay.

18 G. Nothing in subsection F of this section:

19 1. Requires a mother to give birth in a hospital or to stay in the
20 hospital for a fixed period of time following the birth of the child.

21 2. Prevents an accountable health plan from imposing deductibles,
22 coinsurance or other cost sharing in relation to benefits for hospital
23 lengths of stay in connection with childbirth for a mother or a newborn child
24 under the contract, except that any coinsurance or other cost sharing for any
25 portion of a period within a hospital length of stay required pursuant to
26 subsection F of this section shall not be greater than the coinsurance or
27 cost sharing for any preceding portion of that stay.

28 3. Prevents an accountable health plan from negotiating the level and
29 type of reimbursement with a provider for care provided in accordance with
30 subsection F of this section.

31 H. An accountable health plan shall not impose any preexisting
32 condition exclusions or limitations relating to pregnancy as a preexisting
33 condition.

34 Sec. 29. Section 28-907, Arizona Revised Statutes, is amended to read:

35 28-907. Child passenger restraint system; civil penalty;
36 exemptions; notice; child passenger restraint fund;
37 definitions

38 A. Except as provided in subsection G of this section, a person shall
39 not operate a motor vehicle on the highways in this state when transporting
40 a child who is under five years of age unless that child is properly secured
41 in a child passenger restraint system.

42 B. The department shall adopt standards in accordance with 49 Code of
43 Federal Regulations section 571.213 for the performance, design and

1 installation of child passenger restraint systems for use in motor vehicles
2 as prescribed in this section.

3 C. A person who violates this section is subject to a civil penalty
4 of fifty dollars, except that a civil penalty shall not be imposed if the
5 person makes a sufficient showing that the motor vehicle has been
6 subsequently equipped with a child passenger restraint system that meets the
7 standards adopted pursuant to subsection B of this section. A sufficient
8 showing may include a receipt mailed to the appropriate court officer that
9 evidences purchase or acquisition of a child passenger restraint system. The
10 court imposing and collecting the civil penalty shall deposit, pursuant to
11 sections 35-146 and 35-147, the monies, exclusive of any assessments imposed
12 pursuant to sections 12-116.01 and 12-116.02, in the child passenger
13 restraint fund.

14 D. If a law enforcement officer stops a vehicle for an apparent
15 violation of this section, the officer shall determine from the driver
16 whether the unrestrained child or children in the vehicle are under five
17 years of age.

18 E. If the information given to the officer indicates that a violation
19 of this section has not been committed, the officer shall not detain the
20 vehicle any further unless some additional violation is involved. The
21 stopping of a vehicle for an apparent or actual violation of this section is
22 not probable cause for the search or seizure of the vehicle unless there is
23 probable cause for another violation of law.

24 F. The requirements of this section or evidence of a violation of this
25 section are not admissible as evidence in a judicial proceeding except in a
26 judicial proceeding for a violation of this section.

27 G. This section does not apply to any of the following:

28 1. A person who operates a motor vehicle that was originally
29 manufactured without passenger restraint devices.

30 2. A person who operates a motor vehicle that is also a recreational
31 vehicle as defined in section 41-2142.

32 3. A person who operates a commercial motor vehicle and who holds a
33 current commercial driver license issued pursuant to chapter 8 of this title.

34 4. A person who must transport a child in an emergency to obtain
35 necessary medical care.

36 5. A person who transports more than one child under five years of age
37 in a motor vehicle that because of the restricted size of the passenger area
38 does not provide sufficient area for the required number of child passenger
39 restraint devices, if both of the following conditions are met:

40 (a) At least one child is restrained as required by this section.

41 (b) The person has secured as many of the other children in child
42 passenger restraint devices pursuant to this section as is reasonable given
43 the restricted size of the passenger area and the number of passengers being
44 transported in the motor vehicle.

1 H. Before the release of any newly born child from a hospital, the
2 hospital in conjunction with the attending physician shall provide the
3 parents of the child with a copy of this section and information with regard
4 to the availability of loaner or rental programs for child passenger
5 restraint devices that may be available in the community where the child is
6 born.

7 I. A child passenger restraint fund is established. The fund consists
8 of all civil penalties deposited pursuant to this section and any monies
9 donated by the public. The department of economic security shall administer
10 the fund.

11 J. The department of economic security shall purchase child passenger
12 restraint systems that meet the requirements of this section from monies
13 deposited in the fund. If a responsible agency requests child passenger
14 restraint systems and if they are available, the department of economic
15 security shall distribute child passenger restraint systems to the requesting
16 responsible agency.

17 K. On the application of a person to a responsible agency on a finding
18 by the responsible agency to which the application was made that the
19 applicant is unable to acquire a child passenger restraint system because the
20 person is indigent and subject to availability, the responsible agency shall
21 loan the applicant a child passenger restraint system at no charge for as
22 long as the applicant has a need to transport a child who is subject to this
23 section.

24 L. Monies in the child passenger restraint fund shall not exceed
25 twenty thousand dollars. All monies collected over the twenty thousand
26 dollar limit shall be deposited in the Arizona highway user revenue fund
27 established by section 28-6533.

28 M. For the purposes of this section:

29 1. ~~"Indigent" has the same meaning prescribed in section 11-297;~~
30 ~~subsection 8 MEANS A PERSON WHO IS DEFINED AS AN ELIGIBLE PERSON PURSUANT TO~~
31 ~~SECTION 36-2901.01.~~

32 2. "Responsible agency" means a licensed hospital, a public or private
33 agency providing shelter services to victims of domestic violence, a public
34 or private agency providing shelter services to homeless families or a health
35 clinic.

36 Sec. 30. Section 36-183.01, Arizona Revised Statutes, is amended to
37 read:

38 36-183.01. County hospital under board of health; powers and
39 duties

40 A. In any county that maintains a hospital ~~for the indigent sick of~~
41 ~~the county~~, the board of supervisors may delegate to a county board of health
42 the responsibility to manage and operate the hospital or if the county has
43 a population of more than one million persons according to the most recent
44 United States decennial census, by majority vote, appoint a hospital board

1 to perform that function. If the board of supervisors decides to appoint a
2 hospital board, the board shall be composed of the following members:

3 1. A member of the board of supervisors who is chosen by the board of
4 supervisors. This member shall act as board chairman.

5 2. The director of the county hospital, who is a nonvoting member.

6 3. A physician licensed pursuant to title 32, chapter 13 or 17. This
7 member shall not be a county employee.

8 4. A professional nurse licensed pursuant to title 32, chapter
9 15. This member shall not be a county employee.

10 5. Each current president or chairman of the hospital's medical staff,
11 who is a nonvoting member.

12 6. Five public members selected by the board of supervisors for their
13 interest in health care. The public members shall be residents of different
14 supervisorial districts.

15 7. Two additional public members selected by the board of supervisors,
16 one who has financial expertise and one who has legal expertise.

17 B. The member of the hospital board from the board of supervisors
18 shall serve at the pleasure of the board of supervisors but no longer than
19 four years. Other members of the hospital board shall serve staggered
20 four-year terms, but no member may serve more than two full terms. A vacancy
21 occurring on the hospital board shall be filled by the board of supervisors
22 appointing another qualified person to serve the remainder of the term.

23 C. The county board of health or the appointed hospital board may:

24 1. With the consent of the board of supervisors and at salaries fixed
25 by the supervisors, appoint a hospital director, physicians and employees to
26 perform the work of the hospital.

27 2. Advise the director of the hospital and request from him THAT
28 PERSON the information it deems necessary.

29 3. Prescribe standards of medical care to be furnished by the hospital
30 and make reasonable rules for the operation and maintenance of the hospital.

31 4. With the consent of the board of supervisors, prescribe the charges
32 to be made by the hospital to persons able to pay in whole or in part for
33 services furnished by the hospital.

34 5. Prepare and submit to the board of supervisors an annual statement
35 of the financial affairs of the hospital and an estimate of the amounts
36 required to meet the expenses of the hospital for the next fiscal year. The
37 estimate shall include an estimate of the amount of money required for each
38 item of expenditure by the hospital.

39 6. Make long-range plans for the hospital and the care of the indigent
40 sick of the county.

41 7. Advise the board of supervisors on all matters relating to the
42 county hospital and medical services furnished by the county.

1 Sec. 31. Section 36-210, Arizona Revised Statutes, is amended to read:

2 36-210. Expenditures

3 A. This article does not give the director or any employee authority
4 to create a debt or obligation in excess of the amount appropriated by the
5 legislature to carry out its provisions. If monies are not appropriated to
6 carry out the purpose of this article, the director shall submit
7 recommendations to the legislature, with a statement of the cost when an
8 improvement is requested.

9 B. Except as provided by subsection D of this section, the director
10 of the department of administration shall not issue a warrant for
11 expenditures by the state hospital in excess of the estimate contained in the
12 monthly financial statement unless the superintendent submits a written
13 request that is approved in writing by the deputy director and that states
14 the reasons for the request. The director of the department of administration
15 shall not issue warrants in excess of the amount available for the current
16 quarter.

17 C. If a patient in the state hospital requires a health care service
18 that the state hospital or a facility or provider contracted by the state
19 hospital cannot provide, the department of health services shall pay approved
20 claims from a facility or provider that provides these required services as
21 follows:

22 1. For inpatient and outpatient hospital services, the state shall
23 reimburse at a level that does not exceed the reimbursement methodology
24 established in section 36-2903.01, subsection ~~J~~ H.

25 2. For health and medical services, the state shall reimburse
26 providers at a level that does not exceed the capped fee-for-service schedule
27 that is adopted by the Arizona health care cost containment system
28 administration pursuant to chapter 29, article 1 of this title and that is
29 in effect at the time the service is delivered.

30 D. Monies appropriated for capital investment may be expended at any
31 time during the fiscal period for which the monies are appropriated as
32 directed by the director.

33 Sec. 32. Section 36-263, Arizona Revised Statutes, is amended to read:

34 36-263. Eligibility for children's rehabilitative services

35 A. Any chronically ill or physically disabled person or the person's
36 parent or legal guardian who applies for children's rehabilitative services
37 is subject to a preliminary financial screening process developed by the
38 department in coordination with the Arizona health care cost containment
39 system administration to be administered at the initial intake level. If the
40 results of a screening indicate that a child may be title XIX eligible, in
41 order to continue to receive services pursuant to this article the applicant
42 must then submit a complete application within ten working days to the
43 department of economic security, or the Arizona health care cost containment
44 system administration, which shall determine the applicant's eligibility

1 pursuant to section 36-2901, paragraph 4- 6, subdivision (b) (a) or section
2 36-2931, paragraph 5 for health and medical or long-term care services. If
3 the person is in need of emergency services provided pursuant to this
4 article, the person may begin to receive these services immediately, provided
5 that within five days from the date of service a financial screen is
6 initiated.

7 B. Applicants who refuse to cooperate in the financial screen and
8 eligibility process are not eligible for services pursuant to this
9 article. A form explaining loss of benefits due to refusal to cooperate
10 shall be signed by the applicant. Refusal to cooperate shall not be
11 construed to mean the applicant's inability to obtain documentation required
12 for eligibility determination.

13 C. The department of economic security shall, in coordination with the
14 department of health services, provide on-site eligibility determination at
15 appropriate program locations subject to legislative appropriation.

16 D. ~~The provisions of This section shall only apply~~ APPLIES to persons
17 who receive services that are provided pursuant to this section and that are
18 paid for in whole or in part with state funds.

19 E. Notwithstanding any other law, beginning on July 1, 2000, the
20 department of health services shall not provide services in the children's
21 rehabilitative services non-title XIX program to persons who are not citizens
22 of the United States or who do not meet the alienage requirements that are
23 established pursuant to title XIX of the social security act. This
24 subsection does not apply to persons who are receiving services before the
25 ~~effective date of this amendment to this section~~ AUGUST 6, 1999.

26 Sec. 33. Section 36-551, Arizona Revised Statutes, is amended to read:

27 36-551. Definitions

28 In this chapter, unless the context otherwise requires:

29 1. "Adaptive behavior" means the effectiveness or degree to which the
30 individual meets the standards of personal independence and social
31 responsibility expected of the person's age and cultural group.

32 2. "Adult developmental home" means a residential setting in a family
33 home in which the care, physical custody and supervision of the adult client
34 are the responsibility, under a twenty-four hour care model, of the licensee
35 who, in that capacity, is not an employee of the division or of a service
36 provider and the home provides the following services for a group of siblings
37 or up to three adults with developmental disabilities:

38 (a) Room and board.

39 (b) Habilitation.

40 (c) Appropriate personal care.

41 (d) Appropriate supervision.

42 3. "Adult household member" means a person who is at least eighteen
43 years of age and who resides in an adult developmental home, child
44 developmental foster home, secure setting or home and community based service

1 setting for at least thirty days or who resides in the household throughout
2 the year for more than a cumulative total of thirty days.

3 4. "Advisory council" means the developmental disabilities advisory
4 council.

5 5. "Arizona training program facility" means a state operated
6 institution for developmentally disabled clients of the department.

7 6. "Attributable to mental retardation, epilepsy, cerebral palsy or
8 autism" means that there is a causal relationship between the presence of an
9 impairing condition and the developmental disability.

10 7. "Autism" means a condition characterized by severe disorders in
11 communication and behavior resulting in limited ability to communicate,
12 understand, learn and participate in social relationships.

13 8. "Case manager" means a person who coordinates the implementation
14 of the individual program plan of goals, objectives and appropriate services
15 for persons with developmental disabilities.

16 9. "Case management" means coordinating the assistance needed by
17 persons with developmental disabilities and their families in order to ensure
18 that persons with developmental disabilities attain their maximum potential
19 for independence, productivity and integration into the community.

20 10. "Cerebral palsy" means a permanently disabling condition resulting
21 from damage to the developing brain which may occur before, after or during
22 birth and results in loss or impairment of control over voluntary muscles.

23 11. "Child developmental foster home" means a residential setting in
24 a family home in which the care, physical custody and supervision of the
25 child are the responsibility, under a twenty-four hour care model, of the
26 licensee who serves as the foster parent of the child in the home setting and
27 who, in that capacity, is not an employee of the division or of a service
28 provider and the home provides the following services for a group of siblings
29 or up to three children with developmental disabilities:

30 (a) Room and board.

31 (b) Habilitation.

32 (c) Appropriate personal care.

33 (d) Appropriate supervision.

34 12. "Client" means a person receiving developmental disabilities
35 services from the department.

36 13. "Community residential setting" means a child developmental foster
37 home, an adult developmental home or a secure setting operated or contracted
38 by the department in which persons with developmental disabilities live and
39 are provided with appropriate supervision by the service provider responsible
40 for the operation of the residential setting.

41 14. "Consent" means voluntary informed consent. Consent is voluntary
42 if not given as the result of coercion or undue influence. Consent is
43 informed if the person giving the consent has been informed of and
44 comprehends the nature, purpose, consequences, risks and benefits of the

1 alternatives to the procedure, and has been informed and comprehends that
2 withholding or withdrawal of consent will not prejudice the future provision
3 of care and services to the client. In cases of unusual or hazardous
4 treatment procedures performed pursuant to section 36-561, subsection A,
5 experimental research, organ transplantation and non-therapeutic surgery,
6 consent is informed if, in addition to the foregoing, the person giving the
7 consent has been informed of and comprehends the method to be used in the
8 proposed procedure.

9 15. "Daily habilitation" means habilitation as defined in this section
10 except that the method of payment is for one unit per residential day.

11 16. "Department" means the department of economic security.

12 17. "Developmental disability" means either a strongly demonstrated
13 potential that a child under the age of six years is developmentally disabled
14 or will become developmentally disabled, as determined by a test performed
15 pursuant to section 36-694 or by other appropriate tests, or a severe,
16 chronic disability which:

17 (a) Is attributable to mental retardation, cerebral palsy, epilepsy
18 or autism.

19 (b) Is manifest before age eighteen.

20 (c) Is likely to continue indefinitely.

21 (d) Results in substantial functional limitations in three or more of
22 the following areas of major life activity:

23 (i) Self-care.

24 (ii) Receptive and expressive language.

25 (iii) Learning.

26 (iv) Mobility.

27 (v) Self-direction.

28 (vi) Capacity for independent living.

29 (vii) Economic self-sufficiency.

30 (e) Reflects the need for a combination and sequence of individually
31 planned or coordinated special, interdisciplinary or generic care, treatment
32 or other services which are of lifelong or extended duration.

33 18. "Director" means the director of the department of economic
34 security.

35 19. "Division" means the division of developmental disabilities in the
36 department of economic security.

37 20. "Epilepsy" means a neurological condition characterized by abnormal
38 electrical-chemical discharge in the brain. This discharge is manifested in
39 various forms of physical activities called seizures.

40 21. "Group home" means a residential setting for not more than six
41 persons with developmental disabilities that is operated by a service
42 provider under contract with the division and that provides, in a shared
43 living environment, room and board and daily habilitation. Group home does

1 not include an adult developmental home, a child developmental foster home,
2 A secure setting or an intermediate care facility for the mentally retarded.

3 22. "Guardian" means the person who, under court order, is appointed
4 to fulfill the powers and duties prescribed in section 14-5312. Guardian
5 does not include a guardian pursuant to section 14-5312.01.

6 23. "Habilitation" means the process by which ~~an individual~~ A PERSON
7 is assisted to acquire and maintain those life skills ~~which~~ THAT enable the
8 person to cope more effectively with the PERSONAL AND ENVIRONMENTAL demands
9 of ~~his person and environment~~ and to raise the level of his THE PERSON'S
10 physical, mental and social efficiency.

11 24. "Indigent" means a developmentally disabled person whose estate or
12 parent is unable to bear the full cost of maintaining or providing services
13 for ~~such~~ THAT person in a developmental disabilities program.

14 25. "Individual program plan" means a written statement of services to
15 be provided to a person with developmental disabilities, including
16 habilitation goals and objectives, which is developed following initial
17 placement evaluation and revised after periodic evaluations.

18 26. "Intermediate care facility for the mentally retarded" means a
19 facility that primarily provides health and rehabilitative services to
20 persons with developmental disabilities that are above the service level of
21 room and board, ~~OR~~ supervisory care services or personal care services as
22 defined in section 36-401 but that are less intensive than skilled nursing
23 services.

24 27. "Large group setting" means a setting which in addition to
25 residential care provides support services such as therapy, recreation and
26 transportation to seven or more developmentally disabled persons who require
27 intensive supervision.

28 28. "Least restrictive alternative" means an available program or
29 facility that fosters independent living, ~~which~~ THAT is the least confining
30 for the client's condition and where service and treatment are provided in
31 the least intrusive manner reasonably and humanely appropriate to the
32 individual's needs.

33 29. "Likely to continue indefinitely" means that the developmental
34 disability has a reasonable likelihood of continuing for a protracted period
35 of time or for life.

36 30. "Manifested before age eighteen" means that the disability must be
37 apparent and have a substantially limiting effect on a person's
38 functioning before age eighteen.

39 ~~31. "Medically needy resident" has the same meaning prescribed in~~
40 ~~section 36-2905.~~

41 ~~32.~~ 31. "Mental retardation" means a condition involving subaverage
42 general intellectual functioning and existing concurrently with deficits in
43 adaptive behavior manifested before age eighteen.

1 ~~33.~~ 32. "Physician" means a person licensed to practice pursuant to
2 title 32, chapter 13 or 17.

3 ~~34.~~ 33. "Placement evaluation" means an interview and evaluation of
4 a developmentally disabled person and a review of the person's prior medical
5 and program histories to determine the appropriate developmental disability
6 programs and services for the person and recommendations for specific program
7 placements for the person.

8 ~~35.~~ 34. "Psychologist" means a person licensed pursuant to title 32,
9 chapter 19.1.

10 ~~36.~~ 35. "Respite services" means services that provide a short-term
11 or long-term interval of rest or relief to the care provider of a
12 developmentally disabled person.

13 ~~37.~~ 36. "Responsible person" means the parent or guardian of a
14 developmentally disabled minor, the guardian of a developmentally disabled
15 adult or a developmentally disabled adult who is a client or an applicant for
16 whom no guardian has been appointed.

17 ~~38.~~ 37. "Secure facility" means a facility that is licensed and
18 monitored by the division, that is designed to provide both residential and
19 program services within the facility and that is operated to prevent clients
20 from leaving because of the danger they may present to themselves and the
21 community.

22 ~~39.~~ 38. "Service provider" means a person or agency that provides
23 services to clients pursuant to a contract or service agreement with the
24 division.

25 ~~40.~~ 39. "State operated service center" means a state owned or leased
26 facility that is operated by the department and that provides temporary
27 residential care and space for child and adult services which include respite
28 care, crisis intervention and diagnostic evaluation.

29 ~~41.~~ 40. "Subaverage general intellectual functioning" means measured
30 intelligence on standardized psychometric instruments of two or more standard
31 deviations below the mean for the tests used.

32 ~~42.~~ 41. "Substantial functional limitation" means a limitation so
33 severe that extraordinary assistance from other people, programs, services
34 or mechanical devices is required to assist the person in performing
35 appropriate major life activities.

36 ~~43.~~ 42. "Supervision" means the process by which the activities of an
37 individual with developmental disabilities are directed, influenced or
38 monitored.

39 Sec. 34. Section 36-774, Arizona Revised Statutes, is amended to read:

40 36-774. Medically needy account; definition

41 A. Seventy cents of each dollar in the tobacco tax and health care
42 fund shall be deposited in the medically needy account to provide HEALTH CARE
43 SERVICES TO persons who are determined to be medically indigent pursuant to
44 section ~~11-297~~, medically needy pursuant to section ~~36-2905~~ or low income

1 ~~children pursuant to section 36-2905.03 with health care services~~ ELIGIBLE
2 FOR SERVICES PURSUANT TO SECTION 36-2901.01 OR 36-2901.04 AS provided by the
3 Arizona health care cost containment system pursuant to chapter 29, article
4 1 of this title or any expansion of that program or any substantially
5 equivalent or expanded successor program established by the legislature
6 providing health care services to persons who cannot afford those services
7 and for whom there would otherwise be no coverage. These services shall
8 include preventive care and the treatment of catastrophic illness or injury,
9 as provided by the Arizona health care cost containment system.

10 B. The Arizona health care cost containment system administration or
11 any successor shall administer the account.

12 C. Monies that are deposited in the medically needy account:

13 1. Shall only be used to supplement monies that are appropriated by
14 the legislature for the purpose of providing levels of service that are
15 established pursuant to chapter 29, article 1 of this title to eligible
16 persons as defined in section 36-2901 or any expansion of those levels of
17 service, or for any successor program established by the legislature
18 providing levels of service that are substantially equivalent to, or
19 expanding, those provided pursuant to chapter 29, article 1 of this title to
20 eligible persons.

21 2. Shall not be used to supplant monies that are appropriated by the
22 legislature for the purpose of providing levels of service established
23 pursuant to chapter 29, article 1 of this title.

24 D. For purposes of this section, "levels of service" means the
25 provider payment methodology, eligibility criteria and covered services
26 established pursuant to chapter 29, article 1 of this title in effect on July
27 1, 1993.

28 Sec. 35. Section 36-2901, Arizona Revised Statutes, is amended to
29 read:

30 36-2901. Definitions

31 In this article, unless the context otherwise requires:

32 1. "Administration" means the Arizona health care cost containment
33 system administration.

34 2. "Administrator" means the administrator of the Arizona health care
35 cost containment system.

36 3. "CONTRACTOR" MEANS A PERSON OR ENTITY THAT HAS A PREPAID CAPITATED
37 CONTRACT WITH THE ADMINISTRATION PURSUANT TO SECTION 36-2904 TO PROVIDE
38 HEALTH CARE TO MEMBERS UNDER THIS ARTICLE EITHER DIRECTLY OR THROUGH
39 SUBCONTRACTS WITH PROVIDERS.

40 4. "DEPARTMENT" MEANS THE DEPARTMENT OF ECONOMIC SECURITY.

41 ~~3-~~ 5. "Director" means the director of the Arizona health care cost
42 containment system administration.

43 ~~4-~~ 6. "Eligible person" means any person who is:

44 ~~(a) Classified as an indigent pursuant to section 11-297.~~

1 ~~(b)~~ (a) ~~Under federal law~~ Any of the following:

2 (i) Defined as mandatorily or optionally eligible pursuant to title
3 XIX of the social security act as authorized by the state plan.

4 (ii) Defined as an eligible pregnant woman, and an infant under the
5 age of one year, pursuant to section 1902(1)(1)(A) and (B) of title XIX of
6 the social security act, as amended by section 4603 of the omnibus budget
7 reconciliation act of 1990, and whose family income does not exceed one
8 hundred forty per cent of the federal poverty guidelines as updated annually
9 in the federal register by the United States department of health and human
10 services and children defined as eligible children who have not attained
11 nineteen years of age pursuant to section 1902(1)(1)(D) of title XIX of the
12 social security act, as amended by section 4601 of the omnibus budget
13 reconciliation act of 1990, and whose family income does not exceed one
14 hundred per cent of the federal poverty guidelines as updated annually in the
15 federal register by the United States department of health and human
16 services, and children defined as eligible pursuant to section 1902 (1)(1)(C)
17 of title XIX of the social security act, as amended by section 6401 of the
18 omnibus budget reconciliation act of 1989, and whose family income does not
19 exceed one hundred thirty-three per cent of the federal poverty guidelines
20 as updated annually in the federal register by the United States department
21 of health and human services.

22 (iii) Under twenty-one years of age, who was in the custody of the
23 department of economic security pursuant to title 8, chapter 5 or 10 when the
24 person became eighteen years of age and who has an income that does not
25 exceed two hundred per cent of the federal poverty guidelines as updated
26 annually in the federal register by the United States department of health
27 and human services.

28 (iv) DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901.01.

29 (v) DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901.04.

30 ~~(c)~~ Classified as a medically needy person pursuant to section
31 36-2905.

32 ~~(d)~~ (b) A full-time officer or employee of this state or of a city,
33 town or school district of this state or other person who is eligible for
34 hospitalization and medical care under title 38, chapter 4, article 4.

35 ~~(e)~~ (c) A full-time officer or employee of any county in this state
36 or other persons authorized by the county to participate in county medical
37 care and hospitalization programs if the county in which such officer or
38 employee is employed has authorized participation in the system by resolution
39 of the county board of supervisors.

40 ~~(f)~~ (d) An employee of a business within this state.

41 ~~(g)~~ (e) A dependent of an officer or employee who is participating
42 in the system.

43 ~~(h)~~ Classified as an eligible child pursuant to section 36-2905.03.

1 (i) (f) Not enrolled in the Arizona long-term care system pursuant
2 to article 2 of this chapter.

3 ~~(j) Classified as an eligible person pursuant to section 36-2905.05.~~

4 ~~5.~~ 7. "Malice" means evil intent and outrageous, oppressive or
5 intolerable conduct that creates a substantial risk of tremendous harm to
6 others.

7 ~~6.~~ 8. "Member" means an eligible person who enrolls in the system.

8 ~~7. "Nonprovider" means a person who provides hospital or medical care
9 but does not have a contract or subcontract within the system.~~

✓ 10 9. "NONCONTRACTING PROVIDER" MEANS A PERSON WHO PROVIDES HEALTH CARE
11 TO MEMBERS PURSUANT TO THIS ARTICLE BUT NOT PURSUANT TO A SUBCONTRACT WITH
12 A CONTRACTOR.

13 ~~8.~~ 10. "Physician" means a person licensed pursuant to title 32,
14 chapter 13 or 17.

15 ~~9.~~ 11. "Prepaid capitated" means a mode of payment by which a health
16 care provider CONTRACTOR directly delivers health care services for the
17 duration of a contract to a maximum specified number of members based on a
18 fixed rate per member notwithstanding:

19 (a) The actual number of members who receive care from the provider
20 CONTRACTOR.

21 (b) The amount of health care services provided to any member.

22 ~~10.~~ 12. "Primary care physician" means a physician who is a family
23 practitioner, general practitioner, pediatrician, general internist, or
24 obstetrician or gynecologist.

25 ~~11.~~ 13. "Primary care practitioner" means a nurse practitioner
26 certified pursuant to title 32, chapter 15 or a physician assistant certified
27 pursuant to title 32, chapter 25. This paragraph does not expand the scope
28 of practice for nurse practitioners as defined pursuant to title 32, chapter
29 15, or for physician assistants as defined pursuant to title 32, chapter 25.

30 ~~12. "Provider" means any person who contracts with the administration
31 for the provision of hospitalization and medical care to members according
32 to the provisions of this chapter or any subcontractor of such provider
33 delivering services pursuant to this article.~~

34 14. "SECTION 1115 WAIVER" MEANS THE RESEARCH AND DEMONSTRATION WAIVER
35 GRANTED BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

36 ~~13.~~ 15. "State plan" has the same meaning prescribed in section
37 36-2931.

38 ~~14.~~ 16. "System" means the Arizona health care cost containment system
39 established by this article.

40 Sec. 36. Title 36, chapter 29, article 1, Arizona Revised Statutes,
41 is amended by adding sections 36-2901.03 and 36-2901.04, to read:

42 36-2901.03. Federal poverty program; eligibility; services

43 A. THE ADMINISTRATION SHALL ADOPT RULES FOR A STREAMLINED ELIGIBILITY
44 DETERMINATION PROCESS FOR ANY PERSON WHO APPLIES TO BE AN ELIGIBLE PERSON AS

1 DEFINED IN SECTION 36-2901, PARAGRAPH 6, SUBDIVISION (a), ITEM (iv). THE
2 ADMINISTRATION SHALL ADOPT THESE RULES IN ACCORDANCE WITH STATE AND FEDERAL
3 REQUIREMENTS AND THE SECTION 1115 WAIVER.

4 B. THE ADMINISTRATION MUST BASE ELIGIBILITY ON AN ADJUSTED GROSS INCOME
5 THAT DOES NOT EXCEED ONE HUNDRED PER CENT OF THE FEDERAL POVERTY GUIDELINES.

6 C. FOR PERSONS WHO THE ADMINISTRATION DETERMINES ARE ELIGIBLE PURSUANT
7 TO THIS SECTION, THE DATE OF ELIGIBILITY IS THE FIRST DAY OF THE MONTH OF
8 APPLICATION.

9 D. THE ADMINISTRATION SHALL DETERMINE AN ELIGIBLE PERSON'S CONTINUED
10 ELIGIBILITY ON AN ANNUAL BASIS.

11 36-2901.04. Medical expense deduction eligibility process;
12 services

13 A. THE ADMINISTRATION SHALL ADOPT RULES FOR A STREAMLINED MEDICAL
14 EXPENSE DEDUCTION ELIGIBILITY PROCESS TO DETERMINE ELIGIBILITY FOR ANY PERSON
15 WHO APPLIES TO BE AN ELIGIBLE PERSON AS DEFINED IN SECTION 36-2901, PARAGRAPH
16 6, SUBDIVISION (a), ITEM (v). THE ADMINISTRATION SHALL ADOPT THESE RULES IN
17 ACCORDANCE WITH STATE AND FEDERAL REQUIREMENTS AND THE SECTION 1115 WAIVER.

18 B. TO BE ELIGIBLE FOR THE MEDICAL EXPENSE DEDUCTION PROGRAM
19 ESTABLISHED PURSUANT TO THIS SECTION A PERSON MUST MEET THE FOLLOWING
20 REQUIREMENTS:

21 1. HAVE A FAMILY INCOME THAT DOES NOT EXCEED FORTY PER CENT OF THE
22 FEDERAL POVERTY GUIDELINES AFTER DEDUCTING ALLOWABLE MEDICAL EXPENSES.

23 2. HAVE FAMILY RESOURCES THAT DO NOT EXCEED ONE HUNDRED THOUSAND
24 DOLLARS IN NET WORTH, INCLUDING FIVE THOUSAND DOLLARS IN LIQUID ASSETS. THE
25 ADMINISTRATION SHALL EXCLUDE ONE VEHICLE.

26 C. AN APPLICANT MAY USE THE ALLOWABLE MEDICAL EXPENSES OF A MEMBER OF
27 THE APPLICANT'S FAMILY UNIT TO REDUCE INCOME TO THE REQUIRED INCOME LEVEL
28 PRESCRIBED IN SUBSECTION A OF THIS SECTION. THE ADMINISTRATION SHALL
29 CALCULATE INCOME BY USING MEDICAL EXPENSES THAT ARE NOT REIMBURSABLE BY FIRST
30 OR THIRD PARTY LIABILITY AND THAT ARE INCURRED IN A THREE MONTH PERIOD
31 BEGINNING WITH THE MONTH BEFORE THE MONTH OF APPLICATION, THE MONTH OF
32 APPLICATION AND THE FOLLOWING MONTH.

33 D. TO DETERMINE WHEN SPEND DOWN IS MET, THE ADMINISTRATION SHALL
34 DEDUCT FROM THE APPLICANT'S FAMILY INCOME INCURRED MEDICAL EXPENSES
35 SEQUENTIALLY BEGINNING WITH THE MONTH BEFORE THE MONTH OF APPLICATION.

36 E. ELIGIBILITY IS THE DATE THAT SPEND DOWN IS MET AS DETERMINED BY THE
37 DEPARTMENT OR THE FIRST DAY OF THE MONTH OF APPLICATION, WHICHEVER IS LATER.

38 F. THE ADMINISTRATION SHALL GRANT ELIGIBILITY FOR FIVE CONTINUOUS
39 MONTHS PLUS ANY REMAINING DAYS STARTING WITH THE FIRST DAY OF ELIGIBILITY BUT
40 NOT TO EXCEED A MAXIMUM PERIOD OF SIX MONTHS.

41 Sec. 37. Section 36-2902.02, Arizona Revised Statutes, is amended to
42 read:

43 36-2902.02. Advisory council on Indian health care; duties

44 A. The advisory council on Indian health care shall:

1 1. Hire and employ a director who shall hire and employ staff, subject
2 to legislative appropriation, for purposes relating to the functions of the
3 advisory council. The staff shall provide technical assistance to tribal
4 governments on tribal health care initiatives. The director, on behalf of
5 the council, shall annually notify the director of the Arizona health care
6 cost containment system administration of the amount of appropriation
7 required by the council for the following fiscal year.

8 2. Develop a comprehensive health care delivery and financing system
9 for American Indians, specific to each Arizona Indian tribe, with a focus on
10 creating Indian health care demonstration projects pursuant to title XIX of
11 the social security act. In performing this duty the advisory council shall:

12 (a) Develop a comprehensive health care delivery and financing system,
13 specific to each Arizona Indian tribe, that uses title XIX funds and builds
14 on currently available private, state and federal funds.

15 (b) Develop new title XIX demonstration projects, specific to each
16 Arizona Indian tribe, both on and off reservations in cooperation with this
17 state and the federal government.

18 (c) Facilitate communications, planning and discussion among tribes,
19 this state and federal agencies regarding operations, financing, policy and
20 legislation relating to Indian health care.

21 (d) Recommend and advocate tribal, state and federal policy and
22 legislation that supports the design and implementation of health care
23 delivery and financing systems specific to each Arizona Indian tribe.

24 (e) Notwithstanding section 36-2903.01, subsection B, in conjunction
25 with the administration, request a federal waiver from the United States
26 department of health and human services that allows tribal governments that
27 perform eligibility determinations for temporary assistance for needy
28 families programs to perform the medicaid eligibility determinations for
29 persons who apply for services pursuant to section 36-2901, paragraph 4-6,
30 subdivision (b) (a). If the waiver is approved, the state shall provide the
31 state matching monies for the administrative costs associated with the
32 medicaid eligibility based on federal guidelines. As part of the waiver, the
33 administration shall recoup from a tribal government all federal fiscal
34 sanctions that result from inaccurate eligibility determinations.

35 (f) Perform other duties as requested by the legislature.

36 B. The advisory council shall submit a report of its findings and
37 recommendations to the governor, the president of the senate and the speaker
38 of the house of representatives on or before November 1 of each year.

39 C. The director, on notification by the advisory council, shall
40 include the amount of the appropriation request in the administration's
41 annual appropriations request.

1 Sec. 38. Section 36-2903, Arizona Revised Statutes, is amended to
2 read:

3 36-2903. Arizona health care cost containment system;
4 administrator; powers and duties of director and
5 administrator; exemption from attorney general
6 representation; definition

7 A. The Arizona health care cost containment system is established
8 consisting of contracts with providers CONTRACTORS for the provision of
9 hospitalization and medical care coverage to members. Except as specifically
10 required by federal law and by section 36-2909, the system is only
11 responsible for providing care on or after the date that the person has been
12 determined eligible for the system, and is only responsible for reimbursing
13 the cost of care rendered on or after the date that the person was determined
14 eligible for the system.

15 ~~B. The director shall take all steps necessary to implement the system~~
16 ~~on October 1, 1982. No hospitalization and medical care services may be~~
17 ~~provided pursuant to this article prior to October 1, 1982.~~

18 C. B. An agreement may be entered into with an independent
19 contractor, subject to title 41, chapter 23, to serve as the statewide
20 administrator of the system. The administrator has full operational
21 responsibility, subject to supervision by the director, for the system, which
22 may include any or all of the following:

23 1. Development of county-by-county implementation and operation plans
24 for the system which THAT include reasonable access to hospitalization and
25 medical care services for members.

26 2. Contract administration, certification and oversight of providers
27 CONTRACTORS.

28 3. Provision of technical assistance services to providers CONTRACTORS
29 and potential providers CONTRACTORS.

30 4. Development of a complete system of accounts and controls for the
31 system including provisions designed to ensure that covered health and
32 medical services provided through the system are not used unnecessarily or
33 unreasonably including but not limited to inpatient mental BEHAVIORAL health
34 services provided in a hospital. ~~Prior to the development of a system of~~
35 ~~accounts and controls and Periodically thereafter, the administrator shall~~
36 compare the scope, utilization rates, utilization control methods and unit
37 prices of major health and medical services provided in this state in
38 comparison with other states' health care services to identify any
39 unnecessary or unreasonable utilization within the system. The administrator
40 shall periodically assess the cost effectiveness and health implications of
41 alternate approaches to the provision of covered health and medical services
42 through the system in order to reduce unnecessary or unreasonable
43 utilization.

1 5. Establishment of peer review and utilization review functions for
2 all providers CONTRACTORS.

3 6. Assistance in the formation of medical care consortiums to provide
4 covered health and medical services under the system for a county.

5 7. Development and management of a provider CONTRACTOR payment system.

6 8. Establishment and management of a comprehensive system for assuring
7 the quality of care delivered by the system.

8 9. Establishment and management of a system to prevent fraud by
9 members, ~~eligible persons and providers of the system~~ SUBCONTRACTED PROVIDERS
10 OF CARE, CONTRACTORS AND NONCONTRACTING PROVIDERS.

11 10. Coordination of benefits provided under this article to any member.
12 The administrator may require that providers CONTRACTORS and nonproviders
13 NONCONTRACTING PROVIDERS are responsible for the coordination of benefits for
14 services provided under this article. Requirements for coordination of
15 benefits by nonproviders NONCONTRACTING PROVIDERS under this section shall
16 be ARE limited to coordination with standard health insurance and disability
17 insurance policies and similar programs for health coverage.

18 11. Development of a health education and information program.

19 12. Development and management of a participant AN enrollment system.

20 13. Establishment and maintenance of a claims resolution procedure to
21 ensure that ninety per cent of the clean claims shall be paid within thirty
22 days of receipt and ninety-nine per cent of the remaining clean claims shall
23 be paid within ninety days of receipt. For the purpose of this paragraph,
24 "clean claims" has the same meaning as prescribed in section 36-2904,
25 subsection H .

26 14. Establishment of standards for the coordination of medical care and
27 patient transfers pursuant to section 36-2909, subsection D- B.

28 15. Establishment of a system to implement medical child support
29 requirements, as required by federal law. The administration may enter into
30 an intergovernmental agreement with the department of economic security to
31 implement the provisions of this paragraph.

32 16. Establishment of an employee recognition fund.

33 D. C. If an agreement is not entered into with an independent
34 contractor to serve as statewide administrator of the system pursuant to
35 subsection C- B of this section, the director shall ensure that the
36 operational responsibilities set forth in subsection C- B of this section are
37 fulfilled by the administration and other contractors as necessary.

38 E. D. If the director determines that the administrator will fulfill
39 some but not all of the responsibilities set forth in subsection C- B of this
40 section, the director shall ensure that the remaining responsibilities are
41 fulfilled by the administration and other contractors as necessary.

42 F. E. The administrator or any direct or indirect subsidiary of the
43 administrator is not eligible to serve as a provider CONTRACTOR.

1 ~~G.~~ F. Except for reinsurance obtained by providers CONTRACTORS, the
 2 administrator shall coordinate benefits provided under this article to any
 3 eligible person who is covered by workers' compensation, disability
 4 insurance, a hospital and medical service corporation, a health care services
 5 organization, an accountable health plan or any other health or medical or
 6 disability insurance plan including coverage made available to persons
 7 defined as eligible by section 36-2901, paragraph ~~4~~ 6, subdivisions ~~(d)~~,
 8 ~~(e)~~, ~~(f)~~ and ~~(g)~~ (b), (c), (d) AND (e), or who receives payments for
 9 accident-related injuries, so that any costs for hospitalization and medical
 10 care paid by the system are recovered from any other available third party
 11 payors. The administrator may require that providers CONTRACTORS and
 12 nonproviders NONCONTRACTING PROVIDERS are responsible for the coordination
 13 of benefits for services provided under this article. Requirements for
 14 coordination of benefits by nonproviders NONCONTRACTING PROVIDERS under this
 15 section shall ~~be~~ ARE limited to coordination with standard health insurance
 16 and disability insurance policies and similar programs for health coverage.
 17 ~~The system shall act as a payor of last resort for persons defined as~~
 18 ~~eligible pursuant to section 36-2901, paragraph 4, subdivision (a), (c) or~~
 19 ~~(h) and section 36-2981, paragraph 6. The system shall also act as payor of~~
 20 ~~last resort for persons defined as eligible pursuant to section 36-2901,~~
 21 ~~paragraph 4~~ 6, subdivision (b) (a), or section 36-2974 OR SECTION 36-2981,
 22 PARAGRAPH 6 unless specifically prohibited by federal law. ~~The director may~~
 23 ~~require~~ BY OPERATION OF LAW, eligible persons to assign to the system and a
 24 county rights to all types of medical benefits to which the person is
 25 entitled, including ~~but not limited to~~ first party medical benefits under
 26 automobile insurance policies based on the order of priorities established
 27 pursuant to section 36-2915. The state has a right to subrogation against
 28 any other person or firm to enforce the assignment of medical benefits. The
 29 provisions of this subsection are controlling over the provisions of any
 30 insurance policy which THAT provides benefits to an eligible person if the
 31 policy is inconsistent with the provisions of this subsection.

32 ~~H.~~ G. Notwithstanding subsection ~~F~~ E of this section, the
 33 administrator may subcontract distinct administrative functions to one or
 34 more persons who may be providers CONTRACTORS within the system.

35 ~~I.~~ H. The director shall require as a condition of a contract with
 36 any provider CONTRACTOR that all records relating to contract compliance are
 37 available for inspection by the administrator and the director subject to
 38 subsection ~~J~~ I of this section and that such records be maintained by the
 39 provider CONTRACTOR for five years. The director shall also require that
 40 such THESE records be made available by a provider CONTRACTOR on request of
 41 the secretary of the United States department of health and human services,
 42 or its successor agency.

43 ~~J.~~ I. Subject to existing law relating to privilege and protection,
 44 the director shall prescribe by rule the types of information that are

1 confidential and circumstances under which such information may be used or
2 released, including requirements for physician-patient confidentiality.
3 Notwithstanding any other provision of law, such rules shall be designed to
4 provide for the exchange of necessary information among the counties, the
5 administration and the department of economic security for the purposes of
6 eligibility determination under this article. Notwithstanding any law to the
7 contrary, a member's medical record shall be released without the member's
8 consent in situations or suspected cases of fraud or abuse relating to the
9 system to an officer of the state's certified Arizona health care cost
10 containment system fraud control unit who has submitted a written request for
11 the medical record.

12 ~~K.~~ J. The director shall prescribe rules ~~which~~ THAT specify methods
13 for:

14 1. The transition of patients MEMBERS between system providers
15 CONTRACTORS and nonproviders NONCONTRACTING PROVIDERS.

16 2. The transfer of members and persons who have been determined
17 eligible from hospitals ~~which~~ THAT do not have contracts to care for such
18 persons.

19 ~~L.~~ K. The director shall adopt rules that set forth procedures and
20 standards for use by the system in requesting county long-term care for
21 members or persons determined eligible.

22 ~~M.~~ L. To the extent that services are furnished pursuant to this
23 article, and unless otherwise required pursuant to this chapter, a provider
24 CONTRACTOR is not subject to the provisions of title 20.

25 ~~N.~~ M. As a condition of the contract with any provider CONTRACTOR,
26 the director shall require such contract terms as ~~are~~ necessary in the
27 judgment of the director to ensure adequate performance and compliance with
28 all applicable federal laws by the provider CONTRACTOR of the provisions of
29 each contract executed pursuant to this article CHAPTER. Contract provisions
30 required by the director shall include, ~~but are not limited to,~~ AT A MINIMUM
31 the maintenance of deposits, performance bonds, financial reserves or other
32 financial security. The director may waive requirements for the posting of
33 bonds or security for providers ~~which~~ CONTRACTORS THAT have posted other
34 security, equal to or greater than that required by the system, with a state
35 agency for the performance of health service contracts if funds would be
36 available from such security for the system upon ON default by the provider
37 CONTRACTOR. The director may also adopt rules ~~which~~ provide for the
38 withholding or forfeiture of payments to be made to a provider CONTRACTOR by
39 the system for the failure of the provider CONTRACTOR to comply with a
40 provision of the provider's CONTRACTOR'S contract with the system or with the
41 provisions of adopted rules. The director may also require contract terms
42 allowing the administration to operate a provider CONTRACTOR directly under
43 circumstances specified in the contract. The administration shall operate
44 the provider CONTRACTOR only as long as it is necessary to assure delivery

1 of uninterrupted care to members enrolled with the provider CONTRACTOR and
2 accomplish the orderly transition of those members to other system providers
3 CONTRACTORS, or until the provider CONTRACTOR reorganizes or otherwise
4 corrects the contract performance failure. The administration shall not
5 operate a provider CONTRACTOR unless, prior to BEFORE that action, the
6 administration delivers notice to the provider CONTRACTOR and provides an
7 opportunity for a hearing in accordance with procedures established by the
8 director. Notwithstanding the provisions of a contract, if the
9 administration finds that the public health, safety or welfare requires
10 emergency action, it may operate as the provider CONTRACTOR on notice to the
11 provider CONTRACTOR and pending an administrative hearing, which it shall
12 promptly institute.

13 ~~O.~~ N. The administration for the sole purpose of matters concerning
14 and directly related to the Arizona health care cost containment system and
15 the Arizona long-term care system is exempt from section 41-192.

16 ~~P.~~ O. Notwithstanding subsection ~~G~~ F of this section, beginning on
17 July 1, 1991 and in accordance with section 4402 of the omnibus budget
18 reconciliation act of 1990, if the administration determines that according
19 to federal guidelines it is more cost-effective for a person defined as
20 eligible under section 36-2901, paragraph 4-6, subdivision (b) (a) to be
21 enrolled in a group health insurance plan in which the person is entitled to
22 be enrolled, the administration may pay all of that person's premiums,
23 deductibles, coinsurance and other cost sharing obligations for services
24 covered under section 36-2907. The person shall apply for enrollment in the
25 group health insurance plan as a condition of eligibility under section
26 36-2901, paragraph 4-6, subdivision (b) (a).

27 ~~Q.~~ P. The total amount of state monies that may be spent in any
28 fiscal year by the administration for health care shall not exceed the amount
29 appropriated or authorized by section 35-173 for all health care purposes.
30 This article does not impose a duty on an officer, agent or employee of this
31 state to discharge a responsibility or to create any right in a person or
32 group if the discharge or right would require an expenditure of state monies
33 in excess of the expenditure authorized by legislative appropriation for that
34 specific purpose.

35 ~~R.~~ Q. Notwithstanding section 36-470, a health plan CONTRACTOR or
36 program contractor may receive laboratory tests from a laboratory or
37 hospital-based laboratory for a system member enrolled with the health plan
38 CONTRACTOR or program contractor subject to all of the following
39 requirements:

40 1. The health plan CONTRACTOR or program contractor shall provide a
41 written request to the laboratory in a format mutually agreed to by the
42 laboratory and the requesting health plan or program contractor. The request
43 shall include the member's name, the member's plan identification number, the

1 specific test results that are being requested and the time periods and the
2 quality improvement activity that prompted the request.

3 2. The laboratory data may be provided in written or electronic format
4 based on the agreement between the laboratory and the health-plan CONTRACTOR
5 or program contractor. If there is no contract between the laboratory and
6 the health-plan CONTRACTOR or program contractor, the laboratory shall
7 provide the requested data in a format agreed to by the noncontracted
8 laboratory.

9 3. The laboratory test results provided to the member's health-plan
10 CONTRACTOR or program contractor shall only be used for quality improvement
11 activities authorized by the administration and health care outcome studies
12 required by the administration. The health-plans CONTRACTORS and program
13 contractors shall maintain strict confidentiality about the test results and
14 identity of the member as specified in contractual arrangements with the
15 administration and pursuant to state and federal law.

16 4. The administration, after collaboration with the department of
17 health services regarding quality improvement activities, may prohibit the
18 health-plans CONTRACTORS and program contractors from receiving certain test
19 results if the administration determines that a serious potential exists that
20 the results may be used for purposes other than those intended for the
21 quality improvement activities. The department of health services shall
22 consult with the clinical laboratory licensure advisory committee established
23 by section 36-465 before providing recommendations to the administration on
24 certain test results and quality improvement activities.

25 5. The administration shall provide contracted laboratories and the
26 department of health services with an annual report listing the quality
27 improvement activities that will require laboratory data. The report shall
28 be updated and distributed to the contracting laboratories and the department
29 of health services when laboratory data is needed for new quality improvement
30 activities.

31 6. A laboratory that complies with a request from the health-plan
32 CONTRACTOR or program contractor for laboratory results pursuant to this
33 section is not subject to civil liability for providing the data to the
34 health-plan CONTRACTOR or program contractor. The administration, the health
35 plan CONTRACTOR or a program contractor that uses data for reasons other than
36 quality improvement activities is subject to civil liability for this
37 improper use.

38 5. R. For the purpose of this section, "quality improvement
39 activities" means those requirements, including health care outcome studies
40 specified in federal law or required by the health care financing
41 administration or the administration, to improve health care outcomes.

1 (d) ESTABLISH ELIGIBILITY QUALITY CONTROL REVIEWS BY THE
2 ADMINISTRATION.

3 (e) REQUIRE THE DEPARTMENT TO ADOPT RULES, CONSISTENT WITH THE RULES
4 ADOPTED BY THE ADMINISTRATION FOR A HEARING PROCESS, THAT APPLICANTS OR
5 MEMBERS MAY USE FOR APPEALS OF ELIGIBILITY DETERMINATIONS OR
6 REDETERMINATIONS.

7 (f) ESTABLISH THE DEPARTMENT'S RESPONSIBILITY TO PLACE SUFFICIENT
8 ELIGIBILITY WORKERS AT FEDERALLY QUALIFIED HEALTH CENTERS TO SCREEN FOR
9 ELIGIBILITY AND AT HOSPITAL SITES AND LEVEL ONE TRAUMA CENTERS TO ENSURE THAT
10 PERSONS SEEKING HOSPITAL SERVICES ARE SCREENED ON A TIMELY BASIS FOR
11 ELIGIBILITY FOR THE SYSTEM, INCLUDING A PROCESS TO ENSURE THAT APPLICATIONS
12 FOR THE SYSTEM CAN BE ACCEPTED ON A TWENTY-FOUR HOUR BASIS, SEVEN DAYS A
13 WEEK.

14 (g) WITHHOLD PAYMENTS BASED ON THE ALLOWABLE SANCTIONS FOR ERRORS IN
15 ELIGIBILITY DETERMINATIONS OR REDETERMINATIONS OR FAILURE TO MEET PERFORMANCE
16 MEASURES REQUIRED BY THE INTERGOVERNMENTAL AGREEMENT.

17 (h) ~~Recoup from the department of economic security or Arizona works~~
18 ~~agency all federal fiscal sanctions that result from the department of~~
19 ~~economic security's or Arizona works agency's DEPARTMENT'S inaccurate~~
20 ~~eligibility determinations for these persons. THE DIRECTOR MAY OFFSET ALL~~
21 ~~OR PART OF A SANCTION IF THE DEPARTMENT SUBMITS A CORRECTIVE ACTION PLAN AND~~
22 ~~A STRATEGY TO REMEDY THE ERROR.~~

23 ~~3. Enter into an interagency agreement with the department of economic~~
24 ~~security or Arizona works agency established by title 46, chapter 2, article~~
25 ~~9 which shall require the department of economic security or Arizona works~~
26 ~~agency established by title 46, chapter 2, article 9 to notify the~~
27 ~~administration of persons determined eligible for the federal food stamp~~
28 ~~program (P.L. 95-113; 91 Stat. 958-979) for the purpose of determining~~
29 ~~eligibility for the system pursuant to section 36-2905.03.~~

30 4. By rule establish a procedure and time frames for the intake of
31 grievances and appeals, for the continuation of benefits and services during
32 the appeal process, ~~for the informal resolution of grievances and appeals and~~
33 ~~for a grievance process at the contractor level. NOTWITHSTANDING SECTIONS~~
34 ~~41-1092.02, 41-1092.03 AND 41-1092.05, THE ADMINISTRATION SHALL DEVELOP RULES~~
35 ~~TO ESTABLISH THE PROCEDURE AND TIME FRAME FOR THE INFORMAL RESOLUTION OF~~
36 ~~GRIEVANCES AND APPEALS. With the exception of grievances filed pursuant to~~
37 ~~section 36-2904, subsection H, a grievance shall be filed in writing with and~~
38 ~~received by the administration not later than sixty days after the date of~~
39 ~~the adverse action, decision or policy implementation being grieved. A~~
40 ~~policy implementation may be subject to a grievance procedure, but it may not~~
41 ~~be appealed for a hearing. The administration is not required to participate~~
42 ~~in a mandatory settlement conference if it is not a real party in interest.~~
43 ~~In any proceeding before the administration, including a grievance or appeal~~
44 ~~tribunal, persons may represent themselves or be represented by a duly~~

1 authorized agent who is not charging a fee. A legal entity may be
2 represented by an officer, partner or employee who is specifically authorized
3 by the legal entity to represent it in the particular proceeding.

4 5. Apply for and accept federal funds available under title XIX of the
5 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section
6 1396 (1980)) in support of the system. The application made by the director
7 pursuant to this paragraph shall be designed to qualify for federal funding
8 primarily on a prepaid capitated basis. Such funds may be used only for the
9 support of persons defined as eligible pursuant to title XIX of the social
10 security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396
11 (1980)) OR THE APPROVED SECTION 1115 WAIVER.

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

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

22 ~~D. The director shall adopt rules for use by the counties in
23 determining whether an applicant is a resident of this state and of the
24 county and is either a United States citizen, a qualified alien as prescribed
25 in section 36-2903.03 or eligible for state assisted emergency care under
26 section 36-2905.05. The rules shall require that state residency is not
27 established unless the requirements of paragraphs 1 and 2 of this subsection
28 are met or unless residency is proved pursuant to paragraph 3 of this
29 subsection:~~

30 ~~1. The applicant produces one of the following:~~

31 ~~(a) A recent Arizona rent or mortgage receipt or utility bill.~~

32 ~~(b) A current Arizona motor vehicle driver license.~~

33 ~~(c) A current Arizona motor vehicle registration.~~

34 ~~(d) A document showing that the applicant is employed in this state.~~

35 ~~(e) A document showing that the applicant has registered with a public
36 or private employment service in this state.~~

37 ~~(f) Evidence that the applicant has enrolled the applicant's children
38 in a school in this state.~~

39 ~~(g) Evidence that the applicant is receiving public assistance in this
40 state.~~

41 ~~(h) Evidence of registration to vote in this state.~~

42 ~~2. The applicant signs an affidavit attesting that all of the
43 following apply to the applicant:~~

1 ~~(a) The applicant does not own or lease a residence outside this~~
2 ~~state.~~

3 ~~(b) The applicant does not own or lease a motor vehicle registered~~
4 ~~outside this state.~~

5 ~~(c) The applicant is not receiving public assistance outside this~~
6 ~~state. As used in this subdivision, "public assistance" does not include~~
7 ~~unemployment insurance benefits.~~

8 ~~(d) The applicant is actively seeking employment in this state if he~~
9 ~~is able to work and is not employed.~~

10 ~~3. An applicant who does not meet the requirements of paragraph 1 or~~
11 ~~2 of this subsection may apply to have residency determined by a special~~
12 ~~eligibility officer who shall be appointed by the county board of~~
13 ~~supervisors. The special eligibility officer shall receive any proof of~~
14 ~~residency offered by the applicant and may inquire into any facts relevant~~
15 ~~to the question of residency. A determination of residency shall not be~~
16 ~~granted unless a preponderance of the credible evidence supports the~~
17 ~~applicant's intent to remain indefinitely in this state. A denial of a~~
18 ~~determination of residency may be appealed in the same manner as any other~~
19 ~~denial of eligibility for the system.~~

20 ~~4. An applicant who has relocated to this state from another state or~~
21 ~~foreign country within six months before the date of application for the~~
22 ~~purpose of obtaining state assisted medical care pursuant to this article~~
23 ~~shall have the applicant's residency determined by a special eligibility~~
24 ~~officer appointed pursuant to paragraph 3 of this subsection. The special~~
25 ~~eligibility officer shall require, at a minimum, compliance with paragraphs~~
26 ~~1 and 2 of this subsection. The special eligibility officer shall also~~
27 ~~receive any additional proof of residency offered by the applicant and may~~
28 ~~inquire into any facts relevant to the question of residency. A~~
29 ~~determination of residency shall not be made unless a preponderance of the~~
30 ~~credible evidence supports the applicant's intent to remain indefinitely in~~
31 ~~this state. A denial of the determination of residency may be appealed in~~
32 ~~the same manner as any other denial of eligibility for the system.~~

33 ~~E. In accordance with constitutional standards and pursuant to~~
34 ~~subsection D of this section, the director of the department of economic~~
35 ~~security shall establish and maintain residency standards for those public~~
36 ~~benefit programs related to eligibility in the system which are equivalent~~
37 ~~to those residency standards established for the purposes of this article.~~

38 ~~F. D. The director may adopt rules to do the following:~~

39 ~~1. Authorize advance payments based on estimated liability to a~~
40 ~~provider CONTRACTOR or a nonprovider NONCONTRACTING PROVIDER after the~~
41 ~~provider CONTRACTOR or nonprovider NONCONTRACTING PROVIDER has submitted a~~
42 ~~claim for services and before the claim is ultimately resolved. The rules~~
43 ~~shall specify that any advance payment shall be conditioned on the execution~~
44 ~~prior to BEFORE payment of a contract with the provider CONTRACTOR or~~

1 nonprovider ~~which~~ NONCONTRACTING PROVIDER THAT requires the administration
2 to retain a specified percentage, which shall be at least twenty per cent,
3 of the claimed amount as security and ~~which~~ THAT requires repayment to the
4 administration if the administration makes any overpayment.

5 2. Defer liability, in whole or in part, of ~~prepaid capitated contract~~
6 providers CONTRACTORS for care provided to members who are hospitalized on
7 the date of enrollment or under other circumstances. Payment shall be on a
8 capped fee-for-service basis for services other than hospital services and
9 at the rate established pursuant to subsection ~~F~~ G or ~~J~~ H of this section
10 for hospital services or at the rate paid by the health plan, whichever is
11 less.

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

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

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

23 1. The director shall adopt rules ~~which~~ THAT, for services rendered
24 from and after September 30, 1985 until October 1, 1986, define "adjusted
25 billed charges" as that reimbursement level ~~which~~ THAT has the effect of
26 holding constant whichever of the following is applicable:

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

29 (b) The schedule of rates and charges for a hospital ~~which~~ THAT became
30 effective after May 31, 1984 but ~~prior to~~ BEFORE July 2, 1984, if the
31 hospital's previous rate schedule became effective ~~prior to~~ BEFORE April 30,
32 1983.

33 (c) The schedule of rates and charges for a hospital ~~which~~ THAT became
34 effective after May 31, 1984 but ~~prior to~~ BEFORE July 2, 1984, limited to
35 five per cent over the hospital's previous rate schedule, and if the
36 hospital's previous rate schedule became effective on or after April 30, 1983
37 but ~~prior to~~ BEFORE October 1, 1983. For the purposes of this paragraph
38 "constant" means equal to or lower than.

39 2. The director shall adopt rules ~~which~~ THAT, for services rendered
40 from and after September 30, 1986, define "adjusted billed charges" as that
41 reimbursement level ~~which~~ THAT has the effect of increasing by four per cent
42 a hospital's reimbursement level in effect on October 1, 1985 as prescribed
43 in paragraph 1 of this subsection. Beginning January 1, 1991, the Arizona
44 health care cost containment system administration shall define "adjusted

1 billed charges" as the reimbursement level determined pursuant to this
2 section, increased by two and one-half per cent.

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

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

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

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

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

16 5. The director shall define by rule the method of determining when
17 a hospital bill will be considered received and when a hospital's billed
18 charges will be considered paid. Payment received by a hospital from the
19 administration pursuant to this subsection or from a provider CONTRACTOR
20 either by contract or pursuant to section 36-2904, subsection K- J shall be
21 considered payment of the hospital bill in full, except that a hospital may
22 collect any unpaid portion of its bill from other third party payors or in
23 situations covered by title 33, chapter 7, article 3.

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

27 1. For inpatient hospital stays, the administration shall use a
28 prospective tiered per diem methodology, using hospital peer groups if
29 analysis shows that cost differences can be attributed to independently
30 definable features that hospitals within a peer group share. In peer
31 grouping the administration may consider such factors as length of stay
32 differences and labor market variations. If there are no cost differences,
33 the administration shall implement a stop loss-stop gain or similar
34 mechanism. Any stop loss-stop gain or similar mechanism shall ensure that
35 the tiered per diem rates assigned to a hospital do not represent less than
36 ninety per cent of its 1990 base year costs or more than one hundred ten per
37 cent of its 1990 base year costs, adjusted by an audit factor, during the
38 period of March 1, 1993 through September 30, 1994. The tiered per diem
39 rates set for hospitals shall represent no less than eighty-seven and
40 one-half per cent or more than one hundred twelve and one-half per cent of
41 its 1990 base year costs, adjusted by an audit factor, from October 1, 1994
42 through September 30, 1995 and no less than eighty-five per cent or more than
43 one hundred fifteen per cent of its 1990 base year costs, adjusted by an
44 audit factor, from October 1, 1995 through September 30, 1996. For the

1 periods after September 30, 1996 no stop loss-stop gain or similar mechanisms
2 shall be in effect. An adjustment in the stop loss-stop gain percentage may
3 be made to ensure that total payments do not increase as a result of this
4 provision. If peer groups are used the administration shall establish
5 initial peer group designations for each hospital before implementation of
6 the per diem system. The administration may also use a negotiated rate
7 methodology. The tiered per diem methodology may include separate
8 consideration for specialty hospitals which THAT limit their provision of
9 services to specific patient populations, such as rehabilitative patients or
10 children. The initial per diem rates shall be based upon hospital claims and
11 encounter data for dates of service November 1, 1990 through October 31, 1991
12 and processed through May of 1992.

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

19 3. For outpatient hospital services, the administration shall
20 reimburse a hospital by applying a hospital specific outpatient
21 cost-to-charge ratio to the covered charges.

22 4. Except if submitted under an electronic claims submission system,
23 a hospital bill is considered received for purposes of this paragraph upon
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 provider CONTRACTOR either by contract or pursuant to
35 section 36-2904, subsection K- J is considered payment by the administration
36 or the provider CONTRACTOR of the administration's or provider's CONTRACTOR'S
37 liability for the hospital bill. A hospital may collect any unpaid portion
38 of its bill from other third party payors or in situations covered by title
39 33, chapter 7, article 3.

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

- 43 (a) ~~Except for members who are eligible pursuant to section 36-2901,~~
44 ~~paragraph 4, subdivisions (a), (c), (h) and (j),~~ If the hospital's bill is

1 paid within thirty days of the date the bill was received, the administration
2 shall pay ninety-nine per cent of the rate.

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

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

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

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

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

41 9. Beginning September 30, 1997, the administration shall establish
42 a separate graduate medical education program to reimburse hospitals that had
43 graduate medical education programs that were approved by the administration
44 as of October 1, 1999. The administration shall separately account for

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

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

21 ~~K. 1. The director may adopt rules which THAT specify enrollment~~
22 ~~procedures including notice to providers CONTRACTORS of enrollment. The~~
23 ~~rules may provide for varying time limits for enrollment in different~~
24 ~~situations. The rules shall provide for continuous enrollment of a pregnant~~
25 ~~woman who is determined eligible pursuant to section 11-297 or 36-2905 and~~
26 ~~whose condition of pregnancy is clinically verified in writing by a health~~
27 ~~care professional licensed pursuant to title 32, chapter 13, 15, 17 or 25 or~~
28 ~~chapter 6, article 7 of this title until the last day of the month after the~~
29 ~~month of the estimated date of delivery. The rules shall provide that as a~~
30 ~~condition of continuous enrollment pursuant to this subsection the woman must~~
31 ~~notify her county of residence and provide necessary verification of her~~
32 ~~pregnancy and estimated date of delivery before the end of her certification~~
33 ~~period. The rules shall specify the procedures by which the county shall~~
34 ~~notify the administration that a pregnant woman qualifies for continuous~~
35 ~~enrollment and shall specify procedures for the pregnant woman to notify the~~
36 ~~county of any change in her financial or clinical status that might~~
37 ~~disqualify her from continuous enrollment pursuant to this subsection.~~
38 ~~Pursuant to rules adopted by the director, a child born to a woman under~~
39 ~~continuous enrollment shall also be enrolled until the last day of the month~~
40 ~~after the month of the estimated date of delivery. This subsection does not~~
41 ~~prevent a person from qualifying for continued eligibility as otherwise~~
42 ~~provided in section 11-297 or this article. The administration shall specify~~
43 ~~in contract when a person who has been determined eligible will be enrolled~~
44 ~~with that provider CONTRACTOR and the date on which the provider CONTRACTOR~~

1 will be financially responsible for health and medical services to the
2 person.

3 ~~I.~~ J. The administration may make direct payments to hospitals for
4 hospitalization and medical care provided to a member in accordance with the
5 provisions of this article and rules. The director may adopt rules which
6 shall TO establish the procedures by which the administration shall pay
7 hospitals pursuant to this subsection if a provider CONTRACTOR fails to make
8 timely payment to a hospital. Such payment shall be at a level determined
9 pursuant to section 36-2904, subsection ~~J~~ I or ~~K~~ J. The director may
10 withhold payment due to a provider CONTRACTOR in the amount of any payment
11 made directly to a hospital by the administration on behalf of a provider
12 CONTRACTOR pursuant to this subsection.

13 ~~M.~~ K. The director shall establish a special unit within the
14 administration for the purpose of monitoring the third party payment
15 collections required by providers CONTRACTORS and nonproviders NONCONTRACTING
16 PROVIDERS pursuant to section 36-2903, subsection ~~C~~ B, paragraph 10 and
17 subsection ~~G~~ F and section 36-2915, subsection E. The director shall
18 determine by rule:

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

21 2. The percentage of third party payments THAT IS collected by a
22 provider CONTRACTOR or nonprovider ~~which~~ NONCONTRACTING PROVIDER AND THAT the
23 provider CONTRACTOR or nonprovider NONCONTRACTING PROVIDER may keep and the
24 percentage of such payments which THAT the provider CONTRACTOR or nonprovider
25 NONCONTRACTING PROVIDER may be required to pay to the administration. Both
26 providers and nonproviders are required to CONTRACTORS AND NONCONTRACTING
27 PROVIDERS MUST pay to the administration one hundred per cent of all third
28 party payments THAT ARE collected which AND THAT duplicate administration
29 fee-for-service payments. A provider CONTRACTOR that contracts with the
30 administration pursuant to section 36-2904, subsection A may be entitled to
31 retain a percentage of third party payments if the payments collected and
32 retained by a provider CONTRACTOR are reflected in reduced capitation
33 rates. A provider CONTRACTOR may be required to pay the administration a
34 percentage of third party payments THAT ARE collected by a provider
35 CONTRACTOR AND that are not reflected in reduced capitation rates.

36 ~~N.~~ L. Upon ON oral or written notice from the patient that the
37 patient believes the claims to be covered by the system, a provider
38 CONTRACTOR or nonprovider NONCONTRACTING PROVIDER of health and medical
39 services prescribed in section 36-2907 shall not do either of the following
40 unless the provider CONTRACTOR or nonprovider NONCONTRACTING PROVIDER has
41 verified through the administration that the person has been determined
42 ineligible, has not yet been determined eligible or was not, at the time
43 services were rendered, eligible or enrolled:

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

4 2. Refer or report a member or person who has been determined eligible
5 to a collection agency or credit reporting agency for the failure of the
6 member or person who has been determined eligible to pay charges for system
7 covered care or services unless specifically authorized by this article or
8 rules adopted pursuant to this article.

9 ~~Q.~~ M. The administration may conduct postpayment review of all claims
10 paid by the administration and may recoup any monies erroneously paid. The
11 director may adopt rules that specify procedures for conducting postpayment
12 review. ~~Prepaid capitated providers~~ A CONTRACTOR may conduct a postpayment
13 review of all claims paid by ~~prepaid capitated providers~~ THE CONTRACTOR and
14 may recoup monies that are erroneously paid.

15 ~~P.~~ N. The director or ~~his designees~~ THE DIRECTOR'S DESIGNEE may
16 employ and supervise personnel necessary to assist the director in performing
17 the functions of the administration.

18 ~~Q.~~ O. The administration may contract with ~~providers~~ CONTRACTORS for
19 obstetrical care who are eligible to provide services under title XIX of the
20 social security act.

21 ~~R.~~ P. Notwithstanding any law to the contrary, on federal approval
22 the administration may make disproportionate share payments to PRIVATE
23 hospitals AND STATE OPERATED INSTITUTIONS FOR MENTAL DISEASE beginning
24 October 1, 1991 in accordance with federal law and subject to legislative
25 appropriation. If at any time the administration receives written
26 notification from federal authorities of any change or difference in the
27 actual or estimated amount of federal funds available for disproportionate
28 share payments from the amount reflected in the legislative appropriation for
29 such purposes, the administration shall provide written notification of such
30 change or difference to the president and the minority leader of the senate,
31 the speaker and the minority leader of the house of representatives, the
32 director of the joint legislative budget committee, the legislative committee
33 of reference, ~~public hospitals receiving disproportionate share payments and~~
34 any hospital trade association within this state, within three working days
35 not including weekends after receipt of the notice of the change or
36 difference. In calculating disproportionate share payments as prescribed in
37 this section, the administration may use either a methodology based on claims
38 and encounter data that is submitted to the administration from ~~prepaid~~
39 ~~capitated providers~~ CONTRACTORS or a methodology based on data that is
40 reported to the administration by PRIVATE hospitals AND STATE OPERATED
41 INSTITUTIONS FOR MENTAL DISEASE. The selected methodology applies to all
42 PRIVATE hospitals AND STATE OPERATED INSTITUTIONS FOR MENTAL DISEASE
43 qualifying for disproportionate share payments.

1 ~~§~~ Q. Notwithstanding any law to the contrary, the administration may
2 receive confidential adoption information for the purposes of identifying
3 adoption related third party payors in order to recover the total costs for
4 prenatal care and the delivery of the child, including capitation,
5 reinsurance and any fee-for-service costs incurred by the administration on
6 behalf of an eligible person who the administration has reason to believe had
7 an arrangement to have the eligible person's newborn adopted. Except for the
8 sole purpose of identifying adoption related third party payors, the
9 administration shall not further disclose any information obtained pursuant
10 to this subsection and shall develop and implement safeguards to protect the
11 confidentiality of this information including limiting access to the
12 information to only those administration personnel whose official duties
13 require it. At no time shall the administration release to the adoptive
14 parents' or birth parents' insurance carrier personally identifying
15 information regarding the other party. A person who knowingly violates the
16 requirements of this subsection pertaining to confidentiality is guilty of
17 a class 6 felony.

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

21 ~~¶~~ S. The administration shall not seek maternity expenditure cost
22 recovery from a third party payor on arrangements involving the placement of
23 a newborn with special needs as defined in section 8-141, children in the
24 custody of the state or children placed with relatives.

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

29 Sec. 40. Section 36-2903.02, Arizona Revised Statutes, is amended to
30 read:

31 36-2903.02. Quality of health care monitoring standard;
32 development; adoption; use; additional
33 monitoring; costs

34 A. The administration shall develop by rule and ~~regulation~~ a standard
35 for providers CONTRACTORS to use in ~~monitoring~~ TO MONITOR the quality of
36 health care received by members. Each provider CONTRACTOR shall adopt and
37 use such THE standard DEVELOPED BY THE ADMINISTRATION.

38 B. The director shall periodically determine whether each provider
39 CONTRACTOR has properly adopted and implemented the quality of health care
40 monitoring standard. If the director determines that a provider CONTRACTOR
41 has not done so, the director shall undertake additional special efforts to
42 monitor and assess the quality of health care provided by that provider
43 CONTRACTOR for as long as the director deems necessary. The director shall
44 determine the cost incurred in undertaking such special efforts and shall

1 deduct that amount each month from any payment owed to that provider
2 CONTRACTOR for as long as the special efforts continue.

3 ~~C. For the purposes of this section "provider" means a person who
4 enters a provider contract pursuant to section 36-2906 and shall not be
5 construed to require subcontractors to adopt or implement a health care
6 quality standard.~~

7 Sec. 41. Section 36-2903.03, Arizona Revised Statutes, is amended to
8 read:

9 36-2903.03. United States citizenship and qualified alien
10 requirements for eligibility; definition

11 ~~A. Except as provided in subsection D of this section, persons A
12 PERSON WHO IS applying for eligibility under this chapter shall provide
13 verification of United States citizenship or documented verification of
14 qualified alien status, including the date of legal entry into the United
15 States.~~

16 ~~B. A qualified alien who entered the United States on or before August
17 21, 1996 may apply for eligibility pursuant to section 36-2901, paragraph 4-
18 6, subdivision (b) (a) and, if otherwise eligible for title XIX, may receive
19 all services pursuant to section 36-2907 IF THE QUALIFIED ALIEN MEETS AT
20 LEAST ONE OF THE FOLLOWING REQUIREMENTS:~~

21 ~~1. IS DESIGNATED AS ONE OF THE EXCEPTION GROUPS UNDER 8 UNITED STATES
22 CODE SECTION 1613(b).~~

23 ~~2. HAS BEEN A QUALIFIED ALIEN FOR AT LEAST FIVE YEARS.~~

24 ~~3. HAS BEEN CONTINUOUSLY PRESENT IN THE UNITED STATES SINCE AUGUST 21,
25 1996.~~

26 ~~C. Notwithstanding any other law, persons who were residing in the
27 United States under color of law on or before August 21, 1996, and who were
28 receiving services under this article based on eligibility criteria
29 established under the supplemental security income program, may apply for
30 state funded services and, if otherwise eligible for supplemental security
31 income-medical assistance only coverage except for United States citizenship
32 or legal alienage QUALIFIED ALIEN requirements, may be enrolled with the
33 system and receive full ALL services pursuant to section 36-2907.~~

34 ~~D. A qualified alien who entered the United States on or after August
35 22, 1996 may apply for eligibility pursuant to section 36-2901, paragraph 4,
36 subdivision (b) and, if otherwise eligible for title XIX, may receive
37 services pursuant to the following:~~

38 ~~1. A qualified alien who is designated as a member of one of the
39 exception groups under Public Law 104-193, section 403 or a minor who has
40 entered the United States as an adoptee of a United States citizen shall be
41 determined eligible for all title XIX services as specified in section
42 36-2907.~~

1 2. ~~A qualified alien who is not a member of one of the exception~~
2 ~~groups as defined in Public Law 104-193, section 403 shall receive only~~
3 ~~emergency services as defined in section 1903(v) of the social security act.~~

4 ~~E. D. A person who is not a citizen of the United States and A~~
5 ~~QUALIFIED ALIEN WHO DOES NOT MEET THE REQUIREMENTS OF SUBSECTION B OF THIS~~
6 ~~SECTION OR who IS A NONCITIZEN WHO does not claim and provide verification~~
7 ~~of qualified alien status may apply for title XIX eligibility under section~~
8 ~~36-2901, paragraph 4- 6, subdivision (b) (a) and, if otherwise eligible for~~
9 ~~title XIX, may receive only emergency services pursuant to section 1903(v)~~
10 ~~of the social security act. If ineligible for title XIX, the person may~~
11 ~~apply for eligibility under section 11-297, 36-2905 or 36-2905.03 and, if~~
12 ~~otherwise eligible except for citizenship or alien status under this section,~~
13 ~~may only receive emergency services under section 36-2905.05.~~

14 ~~F. E. In determining the eligibility for all qualified aliens~~
15 ~~pursuant to this chapter and sections 11-291 and 11-297, the income and~~
16 ~~resources of any person who executed an affidavit of support pursuant to~~
17 ~~section 213A of the immigration and nationality act on behalf of the~~
18 ~~qualified alien and the income and resources of the spouse, if any, of the~~
19 ~~sponsoring individual shall be counted at the time of application and for the~~
20 ~~redetermination of eligibility for the duration of the attribution period as~~
21 ~~specified in federal law.~~

22 ~~G. F. For purposes of this section, "qualified alien" means an~~
23 ~~individual who meets IS one of the following criteria:~~

24 1. ~~Defined as a qualified alien under Public Law 104-193, section 431~~
25 ~~8 UNITED STATES CODE SECTION 1641.~~

26 2. ~~Defined as a qualified alien by the attorney general of the United~~
27 ~~States under the authority of Public Law 104-208, section 501.~~

28 3. ~~AN INDIAN DESCRIBED IN 8 UNITED STATES CODE SECTION 1612 (b)(2)(E).~~

29 Sec. 42. Section 36-2903.04, Arizona Revised Statutes, is amended to
30 read:

31 36-2903.04. Prior wards of the state; eligibility determination

32 The administration shall determine the eligibility of any eligible
33 person as defined in section 36-2901, paragraph 4- 6, subdivision (b) (a),
34 item (iii) and shall redetermine eligibility on an annual basis.

35 Sec. 43. Section 36-2904, Arizona Revised Statutes, is amended to
36 read:

37 36-2904. Prepaid capitation coverage; requirements; long-term
38 care; dispute resolution; award of contracts;
39 notification; report

40 A. The administration may expend public funds appropriated for the
41 purposes of this article and shall execute prepaid capitated health services
42 contracts, pursuant to section 36-2906, with group disability insurers,
43 hospital and medical service corporations, health care services organizations
44 and any other appropriate public or private persons, including county-owned

1 and operated facilities, for health and medical services to be provided under
2 contract with providers CONTRACTORS. ~~Beginning October 1, 1997,~~ The
3 administration may assign liability for eligible persons and members through
4 contractual agreements with prepaid capitated providers CONTRACTORS. ~~In the~~
5 ~~event that~~ IF there is an insufficient number of qualified bids for prepaid
6 capitated health services contracts for the provision of hospitalization and
7 medical care within a county, the director may:

8 1. Execute discount advance payment contracts, pursuant to section
9 36-2906 and subject to section 36-2903.01, for hospital services.

10 2. Execute capped fee-for-service contracts for health and medical
11 services, other than hospital services. Any capped fee-for-service contract
12 shall provide for reimbursement at a level of not to exceed a capped
13 fee-for-service schedule adopted by the administration.

14 B. During any period in which services are needed and no contract
15 exists, the director may do either of the following:

16 1. Pay nonproviders NONCONTRACTING PROVIDERS for health and medical
17 services, other than hospital services, on a capped fee-for-service basis for
18 members and persons who are determined eligible. However, the state shall
19 not pay any amount for services which THAT exceeds a maximum amount set forth
20 in a capped fee-for-service schedule adopted by the administration.

21 2. Pay a hospital subject to the reimbursement level limitation
22 prescribed in section 36-2903.01.

23 If health and medical services are provided in the absence of a contract, the
24 director shall continue to attempt to procure by the bid process as provided
25 in section 36-2906 contracts for such services as specified in this
26 subsection.

27 C. Payments to providers CONTRACTORS shall be made monthly or
28 quarterly and may be subject to contract provisions requiring the retention
29 of a specified percentage of the payment by the director, a reserve fund or
30 other contract provisions by which adjustments to the payments are made based
31 on utilization efficiency, including incentives for maintaining quality care
32 and minimizing unnecessary inpatient services. Reserve funds withheld from
33 ~~provider contracts~~ CONTRACTORS shall be distributed to providers CONTRACTORS
34 who meet performance standards established by the director. Any reserve fund
35 established pursuant to this subsection shall be established as a separate
36 account within the Arizona health care cost containment system fund.

37 D. ~~In carrying out the duty to provide hospitalization and medical~~
38 ~~care to members,~~ The administration shall adopt rules for the payment of
39 NOMINAL copayments by members TO THE CONTRACTORS EXCEPT FOR SERVICES PROVIDED
40 IN EMERGENCIES. ~~and, except for emergency situations, may require the payment~~
41 ~~of deductibles, coinsurance or premiums by members who are eligible pursuant~~
42 ~~to section 36-2901, paragraph 4, subdivision (a), (b), (c), (h) or (j).~~ The
43 administration shall also adopt rules requiring the collection by system
44 providers of a copayment of five dollars from members eligible under section

1 ~~36-2901, paragraph 4, subdivisions (a), (c), (h) and (j) for each physician's~~
2 ~~office visit or home visit and a copayment of twenty-five dollars for the~~
3 ~~nonemergency use of the emergency room except in those circumstances when a~~
4 ~~primary care physician or primary care practitioner refers the member or~~
5 ~~eligible person to an emergency room for care. These rules shall provide for~~
6 ~~the waiver of copayments in appropriate circumstances for members who are~~
7 ~~eligible pursuant to section 36-2901, paragraph 4, subdivision (b). The~~
8 ~~rules shall define the provider as the collector of copayments and the~~
9 ~~administration or the counties, on behalf of the administration, as the~~
10 ~~collector of coinsurance, deductibles and premiums. Staff in the hospital~~
11 ~~shall advise the member or eligible person that if the visit to the emergency~~
12 ~~room is not for an emergency condition, as determined by the hospital, the~~
13 ~~member or eligible person shall be charged the required copayment for the~~
14 ~~nonemergency use of the emergency room.~~

15 E. EXCEPT AS PRESCRIBED IN SUBSECTION F OF THIS SECTION, a member
16 defined as eligible pursuant to section 36-2901, paragraph 4-6, subdivision
17 (b) (a) may select, to the extent practicable as determined by the
18 administration, from among the available providers CONTRACTORS of
19 hospitalization and medical care and may select a primary care physician or
20 primary care practitioner from among the primary care physicians and primary
21 care practitioners participating in the contract in which the member is
22 enrolled. THE ADMINISTRATION SHALL PROVIDE REIMBURSEMENT ONLY TO ENTITIES
23 THAT HAVE A PROVIDER AGREEMENT WITH THE ADMINISTRATION AND THAT HAVE AGREED
24 TO THE CONTRACTUAL REQUIREMENTS OF THAT AGREEMENT. EXCEPT AS PROVIDED IN
25 SECTIONS 36-2908 AND 36-2909, the system shall only provide reimbursement for
26 any health or medical services or costs of related services provided by or
27 under referral from any THE primary care physician or primary care
28 practitioner participating in the contract in which the member is enrolled.
29 The director shall establish requirements as to the minimum time period that
30 a member is assigned to specific providers CONTRACTORS in the system.

31 F. For a member defined as eligible pursuant to section 36-2901,
32 paragraph 4-6, subdivision (a), (c) or (h) ITEM (v) the director shall
33 implement a policy permitting choice of provider to the extent he deems
34 feasible ENROLL THE MEMBER WITH AN AVAILABLE CONTRACTOR LOCATED IN THE
35 GEOGRAPHIC AREA OF THE MEMBER'S RESIDENCE. If the director does not
36 implement a choice of provider policy, he may at the time eligibility is
37 determined enroll the member with an available provider located in the
38 geographic area of the member's residence. The member may select a primary
39 care physician or primary care practitioner from among the primary care
40 physicians or primary care practitioners participating in the contract in
41 which the member is enrolled. The system shall only provide reimbursement
42 for health or medical services or costs of related services provided by or
43 under referral from a primary care physician or primary care practitioner
44 participating in the contract in which the member is enrolled. The director

1 shall establish requirements as to the minimum time period that a member is
2 assigned to specific providers CONTRACTORS in the system.

3 G. If a person who has been determined eligible but who has not yet
4 enrolled in the system receives emergency services, the director shall
5 provide by rule for the enrollment of the person on a priority basis. If a
6 person requires system covered services on or after the date the person is
7 determined eligible for the system but before the date of enrollment, the
8 person is entitled to receive such services in accordance with rules adopted
9 by the director, and the administration shall pay for such services pursuant
10 to section 36-2903.01 or, as specified in contract, by WITH the prepaid
11 ~~capitated provider~~ CONTRACTOR pursuant to the subcontracted rate or this
12 section.

13 H. The administration shall not pay claims for system covered services
14 that are initially submitted more than six months after the date of the
15 service for which payment is claimed or that are submitted as clean claims
16 more than twelve months after the date of service for which payment is
17 claimed except for claims submitted for reinsurance pursuant to section
18 36-2906, subsection C, paragraph 6 ~~or services covered pursuant to subsection~~
19 ~~I of this section.~~ The administration shall not pay claims that are
20 submitted by ~~prepaid capitated providers~~ CONTRACTORS for reinsurance and that
21 are submitted more than twelve months after the date of service. The
22 administration shall not pay reinsurance claims that are submitted more than
23 twelve months after the date of service. The director may adopt rules or
24 require contractual provisions that prescribe requirements and time limits
25 for submittal of and payment for those claims. Notwithstanding any other
26 provision of this article, if a claim that gives rise to a ~~prepaid capitated~~
27 ~~provider's~~ CONTRACTOR'S claim for reinsurance or deferred liability is the
28 subject of an administrative grievance or appeal proceeding or other legal
29 action, the ~~prepaid capitated provider~~ CONTRACTOR shall have at least
30 thirty-five days after an ultimate decision is rendered to submit a claim for
31 reinsurance or deferred liability. ~~Prepaid capitated providers~~ CONTRACTORS
32 that contract with the administration pursuant to subsection A of this
33 section are not required to pay claims for system covered services that are
34 submitted more than six months after the date of the service for which
35 payment is claimed or that are submitted as clean claims more than twelve
36 months after the date of the service for which payment is claimed. In the
37 absence of a contract to the contrary, neither the administration nor ~~prepaid~~
38 ~~capitated providers~~ CONTRACTORS shall require ~~subcontracting providers~~
39 SUBCONTRACTED PROVIDERS OF CARE or ~~nonproviders~~ NONCONTRACTING PROVIDERS to
40 initially submit claims less than six months after the date of the service
41 for which payment is claimed or to submit clean claims less than twelve
42 months after the date of the service for which payment is claimed. A person
43 dissatisfied with the denial of a claim by the administration or a ~~prepaid~~
44 ~~capitated provider~~ CONTRACTOR has twelve months from the date of the service

1 for which payment is claimed to institute a grievance against the
2 administration or a prepaid capitated provider pursuant to section
3 36-2903.01, subsection B, paragraph 4. For purposes of this subsection:

4 1. "Clean claims" means claims that may be processed without obtaining
5 additional information from the provider of service SUBCONTRACTED PROVIDER
6 OF CARE, FROM A NONCONTRACTING PROVIDER or from a third party but does not
7 include claims under investigation for fraud or abuse or claims under review
8 for medical necessity.

9 2. "Date of service" for a hospital inpatient means the date of
10 discharge of the patient.

11 ~~I. In situations in which federal law requires coverage for a person
12 before the date of enrollment for persons eligible pursuant to section
13 36-2901, paragraph 4, subdivision (b), the administration shall pay for these
14 services in accordance with federal law at the level established pursuant to
15 subsections A and B of this section and section 36-2903.01 or the prepaid
16 capitated provider shall pay for these services, as specified in contract,
17 pursuant to the subcontracted rate or section 36-2904.~~

18 ~~I.~~ I. In any county having a population of five hundred thousand or
19 fewer persons, a hospital which THAT executes a subcontract other than a
20 capitation contract with a provider CONTRACTOR for the provision of hospital
21 and medical services pursuant to this article shall offer a subcontract to
22 any other provider CONTRACTOR providing services to that portion of the
23 county and to any other person that plans to become a provider CONTRACTOR in
24 that portion of the county. If such a hospital executes a subcontract other
25 than a capitation contract with a provider CONTRACTOR for the provision of
26 hospital and medical services pursuant to this article, the hospital shall
27 adopt uniform criteria to govern the reimbursement levels paid by all
28 providers CONTRACTORS with whom the hospital executes such a subcontract.
29 Reimbursement levels offered by hospitals to providers CONTRACTORS pursuant
30 to this subsection may vary among providers CONTRACTORS only as a result of
31 the number of bed days purchased by the provider CONTRACTORS, the amount of
32 financial deposit required by the hospital, if any, or the schedule of
33 performance discounts offered by the hospital to the provider CONTRACTOR for
34 timely payment of claims.

35 ~~K.~~ J. This subsection applies to inpatient hospital admissions and
36 to outpatient hospital services on and after March 1, 1993. The director may
37 negotiate at any time with a hospital on behalf of a provider CONTRACTOR for
38 services provided pursuant to this article. If a provider CONTRACTOR
39 negotiates with a hospital for services provided pursuant to this article,
40 the following procedures apply:

41 1. The director shall require any provider CONTRACTOR to reimburse
42 hospitals for services provided under this article based on reimbursement
43 levels that do not in the aggregate exceed those established pursuant to
44 section 36-2903.01 and under terms and conditions on which the provider

1 CONTRACTOR and the hospital agree. However, a hospital and a provider
2 CONTRACTOR may agree on a different payment methodology than the methodology
3 prescribed by the director pursuant to section 36-2903.01. The director by
4 rule shall prescribe:

5 (a) The time limits for any negotiation between the provider
6 CONTRACTOR and the hospital.

7 (b) The ability of the director to review and approve or disapprove
8 the reimbursement levels, ~~AND terms and conditions~~ agreed on by the provider
9 CONTRACTOR and the hospital.

10 (c) That if a provider CONTRACTOR and a hospital do not agree on
11 reimbursement levels, ~~AND terms and conditions~~ as required by this
12 subsection, the reimbursement levels established pursuant to section
13 36-2903.01 apply.

14 (d) That, except if submitted under an electronic claims submission
15 system, a hospital bill is considered received for purposes of subdivision
16 (f) of this paragraph upon ON initial receipt of the legible, error-free
17 claim form by the provider CONTRACTOR if the claim includes the following
18 error-free documentation in legible form:

19 (i) An admission face sheet.

20 (ii) An itemized statement.

21 (iii) An admission history and physical.

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

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

24 (vi) Operative reports, if applicable.

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

26 (e) That payment received by a hospital from a provider CONTRACTOR is
27 considered payment by the provider CONTRACTOR of the provider's CONTRACTOR'S
28 liability for the hospital bill. A hospital may collect any unpaid portion
29 of its bill from other third party payors or in situations covered by title
30 33, chapter 7, article 3.

31 (f) That a provider CONTRACTOR shall pay for services rendered on and
32 after October 1, 1997 under any reimbursement level according to paragraph
33 1 of this subsection subject to the following:

34 (i) ~~Except for members who are eligible pursuant to section 36-2901,~~
35 ~~paragraph 4, subdivisions (a), (c), (h) and (j),~~ If the hospital's bill is
36 paid within thirty days of the date the bill was received, the provider
37 CONTRACTOR shall pay ninety-nine per cent of the rate.

38 (ii) If the hospital's bill is paid after thirty days but within sixty
39 days of the date the bill was received, the provider CONTRACTOR shall pay one
40 hundred per cent of the rate.

41 (iii) If the hospital's bill is paid any time after sixty days of the
42 date the bill was received, the provider CONTRACTOR shall pay one hundred per
43 cent of the rate plus a fee of one per cent per month for each month or

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

3 2. In any county having a population of five hundred thousand or fewer
4 persons, a hospital that executes a subcontract other than a capitation
5 contract with a provider for the provision of hospital and medical services
6 pursuant to this article shall offer a subcontract to any other provider
7 providing services to that portion of the county and to any other person that
8 plans to become a provider in that portion of the county. If a hospital
9 executes a subcontract other than a capitation contract with a provider for
10 the provision of hospital and medical services pursuant to this article, the
11 hospital shall adopt uniform criteria to govern the reimbursement levels paid
12 by all providers with whom the hospital executes a subcontract.

13 ~~t.~~ K. If there is an insufficient number of, or an inadequate member
14 capacity in, contracts awarded to ~~prepaid capitated providers~~ CONTRACTORS,
15 the director, in order to deliver covered services to members enrolled or
16 expected to be enrolled in the system within a county, may negotiate and
17 award, without bid, a ~~prepaid capitated~~ contract with a health care services
18 organization holding a certificate of authority pursuant to title 20, chapter
19 4, article 9. The director shall require a health care services organization
20 contracting under this subsection to comply with section 36-2906.01. The
21 term of the contract shall not extend beyond the next bid and contract award
22 process as provided in section 36-2906 and shall be no greater than
23 capitation rates paid to ~~prepaid capitated providers~~ CONTRACTORS in the same
24 county or counties pursuant to section 36-2906. Contracts awarded pursuant
25 to this subsection are exempt from the requirements of title 41, chapter 23.

26 ~~M.~~ L. A ~~prepaid capitated provider~~ CONTRACTOR may require that A
27 subcontracting providers or ~~nonproviders~~ NONCONTRACTING PROVIDER shall be
28 paid for covered services, other than hospital services, according to the
29 capped fee-for-service schedule adopted by the director pursuant to
30 subsection A, paragraph 2 of this section or subsection B, paragraph 1 of
31 this section or at lower rates as may be negotiated by the ~~prepaid capitated~~
32 provider CONTRACTOR.

33 ~~N.~~ M. The director shall require any ~~prepaid capitated provider~~
34 CONTRACTOR to have a plan to notify members of reproductive age either
35 directly or through the parent or legal guardian, whichever is most
36 appropriate, of the specific covered family planning services available to
37 them and a plan to deliver those services to members who request them. The
38 director shall ensure that these plans include provisions for written
39 notification, other than the member handbook, and verbal notification during
40 a member's visit with the member's primary care physician or primary care
41 practitioner.

42 ~~O.~~ N. The director shall adopt a plan to notify members of
43 reproductive age who receive care from a ~~prepaid capitated provider~~
44 CONTRACTOR who elects not to provide family planning services of the specific

1 covered family planning services available to them and to provide for the
2 delivery of those services to members who request them. Notification may be
3 directly to the member, or through the parent or legal guardian, whichever
4 is most appropriate. The director shall ensure that the plan includes
5 provisions for written notification, other than the member handbook, and
6 verbal notification during a member's visit with the member's primary care
7 physician or primary care practitioner.

8 P. O. The director shall annually prepare a report representing THAT
9 REPRESENTS a statistically valid sample which AND THAT indicates the number
10 of children ages two and under by ~~prepaid capitated provider~~ CONTRACTOR who
11 received the immunizations recommended by the national centers for disease
12 control and prevention while enrolled as members. The report shall indicate
13 each type of immunization and the number and percentage of enrolled children
14 ages two and under who received each type of immunization. The report shall
15 be done by contract year and shall be delivered to the governor, the
16 president of the senate and the speaker of the house of representatives no
17 later than January 30 of each year.

18 Q. P. If the administration implements an electronic claims
19 submission system it may adopt procedures pursuant to subsection K- J,
20 paragraph 1 of this section requiring documentation different than prescribed
21 under subsection K- J, paragraph 1, subdivision (d) of this section.

22 Sec. 44. Repeal

23 Sections 36-2905, 36-2905.01, 36-2905.02, 36-2905.03 and 36-2905.05,
24 Arizona Revised Statutes, are repealed.

25 Sec. 45. Section 36-2905.04, Arizona Revised Statutes, is amended to
26 read:

27 36-2905.04. Eligibility by fraud; penalties; enforcement;
28 classification

29 A. A person shall not provide or cause to be provided false or
30 fraudulent information to the ~~county or~~ state as part of an application for
31 the system under section 36-2901, paragraph 4- 6, subdivision (a), ~~(b), (c),~~
32 ~~(h) or (j)~~.

33 B. A person who violates subsection A of this section, who is
34 determined eligible for the system and who would have been ineligible for the
35 system if the person had provided true and correct information is subject,
36 in addition to any other penalties that may be prescribed by federal or state
37 law, to a civil penalty of not to exceed the amount incurred by the system,
38 including capitation payments, on behalf of the person. In addition, the
39 person's eligibility may be discontinued in accordance with rules adopted by
40 the director.

41 C. In addition to the requirements in state law, the medicaid fraud
42 and abuse controls that are enacted under federal law apply to all persons
43 eligible for the system and all providers CONTRACTORS, NONCONTRACTING

1 PROVIDERS and nonproviders SUBCONTRACTED PROVIDERS that provide services to
2 persons who are eligible for the system.

3 D. The director shall make the determination to assess a civil penalty
4 and is responsible for collection of the penalty. The director may adopt
5 rules that prescribe procedures for the determination and collection of civil
6 penalties. The director may compromise civil penalties imposed under this
7 section in accordance with criteria established in rules.

8 E. The director shall adopt rules providing for the appeal of a
9 decision by a person adversely affected by a determination made by the
10 director under this section. The director's final decision is subject to
11 judicial review in accordance with title 12, chapter 7, article 6.

12 F. Amounts paid by the state and recovered under this section shall
13 be deposited in the state general fund, and any applicable federal share
14 shall be returned to the United States department of health and human
15 services.

16 G. If a civil penalty imposed pursuant to subsection D of this section
17 is not paid, the state or the administration may file an action to collect
18 the civil penalty in the superior court in Maricopa county. Matters that
19 were raised or could have been raised in a hearing before the director or in
20 an appeal pursuant to title 12, chapter 7, article 6 may not be raised as a
21 defense to the civil action. An action brought pursuant to this subsection
22 shall be initiated within six years after the date the claim is presented.

23 H. ~~Each county, The department of economic security and providers~~
24 CONTRACTORS, SUBCONTRACTED PROVIDERS AND NONCONTRACTING PROVIDERS shall
25 cooperate with the administration to prevent, discover and prosecute
26 eligibility fraud.

27 I. A person who knowingly aids or abets another person pursuant to
28 section 13-301, 13-302 or 13-303 in the commission of an offense under this
29 section or section 13-3713 is guilty of a class 5 felony.

30 Sec. 46. Section 36-2905.06, Arizona Revised Statutes, is amended to
31 read:

32 36-2905.06. Finger imaging; requirements; exemption

33 A. To prevent multiple enrollment for services provided by the system,
34 the administration shall work with the department of economic security to
35 expand that department's finger imaging eligibility program to specific
36 programs THAT ARE selected by the director of the administration AND that
37 provide services pursuant to this chapter.

38 B. By July 1, 2001, The administration shall make the following
39 subject to finger imaging during the enrollment process:

40 1. All programs where enrollment and eligibility screening occurs
41 OCCUR at a department of economic security facility.

42 2. Any program that provides members with pharmaceutical benefits.

43 3. Any other program selected by the director of the administration.

1 C. The director of the administration shall adopt rules to implement
2 the requirements of subsections A and B OF THIS SECTION, including rules to
3 exempt children, the elderly and any other group that the director determines
4 would be unduly burdened by a finger imaging requirement.

5 D. Any pregnant woman who is eligible ~~as defined~~ pursuant to section
6 36-2901, paragraph 4- 6, subdivision (b), ~~item (ii)~~ (a) or who is receiving
7 federal emergency services pursuant to section 36-2903.03 or ~~state emergency~~
8 ~~services pursuant to section 36-2905.05~~ is not subject to finger imaging.

9 Sec. 47. Section 36-2906, Arizona Revised Statutes, is amended to
10 read:

11 36-2906. Qualified plan health services contracts; proposals;
12 administration

13 A. The administration shall:

- 14 1. Supervise the administrator.
- 15 2. Review the proposals.
- 16 3. Award contracts.

17 B. ~~The director, in conjunction with the administrator,~~ shall prepare
18 and issue a request for proposal, including a proposed contract format, in
19 each of the counties of this state, at least once every five years, to
20 qualified group disability insurers, hospital and medical service
21 corporations, health care services organizations and any other qualified
22 public or private persons, including county-owned and operated health care
23 facilities, ~~for the provision of covered health and medical services to~~
24 ~~members under provider contracts.~~ THE CONTRACTS SHALL SPECIFY THE
25 ADMINISTRATIVE REQUIREMENTS, THE DELIVERY OF MEDICALLY NECESSARY SERVICES AND
26 THE SUBCONTRACTING REQUIREMENTS.

27 C. The director shall adopt rules regarding the request for proposal
28 process ~~which shall~~ THAT provide:

29 1. For definition of proposals in the following categories subject to
30 the following conditions:

31 (a) Inpatient hospital services.

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

34 (c) Pharmacy services.

35 (d) Laboratory, x-ray and related diagnostic medical services and
36 appliances.

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

40 3. AN ALLOWANCE FOR limitations on the number of high risk persons
41 which THAT must be included in any proposal.

42 4. For analysis of the proposals for each county ~~on an aggregate basis~~
43 GEOGRAPHIC SERVICE AREA AS DEFINED BY THE DIRECTOR to ensure the provision

1 of health and medical services which THAT are required to be provided
2 throughout the county GEOGRAPHIC SERVICE AREA pursuant to section 36-2907.

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

9 6. For the procurement of reinsurance for expenses incurred by any
10 provider CONTRACTOR or member of the system in providing services in excess
11 of amounts specified by the director in any contract year. The director
12 shall adopt rules to provide that the administrator may specify guidelines
13 on a case by case basis for the types of care and services which THAT may be
14 provided to a person whose care is covered by reinsurance. The rules shall
15 provide that if a provider CONTRACTOR does not follow specified guidelines
16 for care or services and if the care or services could be provided pursuant
17 to the guidelines at a lower cost the provider CONTRACTOR is entitled to
18 reimbursement as if the care or services specified in the guidelines had been
19 provided.

20 7. For the awarding of contracts to providers CONTRACTORS with
21 qualified proposals determined to be the most advantageous to the state for
22 each of the counties in this state with the objective that, to the extent
23 possible, each contract with a provider shall provide services to those
24 persons defined as eligible pursuant to section 36-2901, paragraph 4,
25 subdivisions (a), (b), (c) and (h) and other eligible persons. A contract
26 may be awarded which THAT provides services only to persons defined as
27 eligible pursuant to section 36-2901, paragraph 4-6, subdivision (d), (e),
28 (f) or (g) (b), (c), (d) OR (e). The director may provide by rule a second
29 round competitive proposal procedure for the director to request voluntary
30 price reduction of proposals from only those that have been tentatively
31 selected for award, prior to BEFORE the final award or rejection of
32 proposals. Those eligible persons, other than those persons defined as
33 eligible pursuant to section 36-2901, paragraph 4, subdivisions (a), (b), (c)
34 and (h), are not required by this chapter to obtain their health care
35 services at a county-owned and operated facility if such health care facility
36 is awarded a contract as a provider.

37 8. For the option of the administration to require on a
38 county-by-county basis REQUIREMENT that any proposal for a county IN A
39 GEOGRAPHIC SERVICE AREA provide for the full range of system covered
40 services. and the provision of services on a countywide basis. Such option
41 shall be exercised only if the director determines that such action is
42 necessary to prevent the arbitrary selection of patients designed to include
43 a disproportionate number of persons sharing similar health characteristics

1 ~~or is necessary to ensure that the county has full system benefit coverage~~
2 ~~for the entire geographic area of the county.~~

3 9. For the option of the administration to waive the requirement in
4 any request for proposal or in any contract awarded pursuant to a request for
5 proposal for a subcontract with a hospital for good cause in a county or area
6 including but not limited to situations when such hospital is the only
7 hospital in the health service area. In any situation where the subcontract
8 requirement is waived, no hospital may refuse to treat members of the system
9 admitted by primary care physicians or primary care practitioners with
10 hospital privileges in that hospital. In the absence of a subcontract, the
11 reimbursement level shall be at the levels specified in section 36-2904,
12 subsection ~~I~~ I or ~~K~~ J.

13 D. Reinsurance may be obtained against expenses in excess of a
14 specified amount on behalf of any individual for system covered emergency or
15 inpatient services either through the purchase of a reinsurance policy or
16 through a system self-insurance program as determined by the director.
17 Reinsurance may, subject to the approval of the director, be obtained against
18 expenses in excess of a specified amount on behalf of any individual for
19 outpatient services either through the purchase of a reinsurance policy or
20 through a system self-insurance program as determined by the director. ~~For~~
21 ~~purposes of reinsurance the director may utilize the department of~~
22 ~~administration or the administrator. Reinsurance shall be secured at the~~
23 ~~request of a county for expenditures made by the county in accordance with~~
24 ~~section 11-291 if such county contributes the full cost of the reinsurance~~
25 ~~premium.~~

26 E. Notwithstanding the other provisions of this section, the system
27 may procure, provide or coordinate system covered services by interagency
28 agreement with authorized agencies of this state or with a federal agency for
29 distinct groups of eligible persons, including ~~but not limited to persons~~
30 ~~eligible for crippled children's benefits~~ REHABILITATIVE SERVICES THROUGH THE
31 DEPARTMENT OF HEALTH SERVICES and persons eligible for ~~foster care medical~~
32 ~~benefits~~ COMPREHENSIVE MEDICAL AND DENTAL PROGRAM SERVICES THROUGH THE
33 DEPARTMENT.

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

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

1 1. Inpatient hospital services that are ordinarily furnished by a
2 hospital for the care and treatment of inpatients, ~~AND that are medically~~
3 ~~necessary and that are provided under the direction of a physician or a~~
4 primary care practitioner. For the purposes of this section, "inpatient
5 hospital services" excludes services in an institution for tuberculosis or
6 mental diseases UNLESS AUTHORIZED UNDER AN APPROVED SECTION 1115 WAIVER.

7 2. Outpatient health services ~~which are medically necessary and THAT~~
8 ARE ordinarily provided in hospitals, clinics, offices and other health care
9 facilities by licensed health care providers. Outpatient health services
10 include services provided by or under the direction of a physician or a
11 primary care practitioner but do not include occupational therapy, or speech
12 therapy for eligible persons who are twenty-one years of age or older.

13 3. Other laboratory and X-ray services ordered by a physician or a
14 primary care practitioner.

15 4. Medications ~~which are medically necessary and THAT ARE~~ ordered on
16 prescription by a physician or a dentist licensed pursuant to title 32,
17 chapter 11.

18 5. Emergency dental care and extractions FOR PERSONS WHO ARE AT LEAST
19 TWENTY-ONE YEARS OF AGE.

20 6. Medical supplies, equipment and prosthetic devices, not including
21 hearing aids, ordered by a physician or a primary care practitioner or
22 dentures ordered by a dentist licensed pursuant to title 32, chapter 11.
23 ~~Beginning on July 1, 1998, Suppliers of durable medical equipment shall~~
24 provide the administration with complete information about the identity of
25 each person who has an ownership or controlling interest in their business
26 and shall comply with federal bonding requirements in a manner prescribed by
27 the administration.

28 7. FOR PERSONS WHO ARE AT LEAST TWENTY-ONE YEARS OF AGE, treatment of
29 medical conditions of the eye excluding eye examinations for prescriptive
30 lenses and the provision of prescriptive lenses.

31 8. Early and periodic health screening and diagnostic services as
32 required by section 1905(r) of title XIX of the social security act, ~~as~~
33 ~~amended by section 6043 of the omnibus budget reconciliation act of 1989, for~~
34 ~~eligible persons MEMBERS WHO ARE under the age of twenty-one years with~~
35 ~~treatment benefits limited to those otherwise specified in this chapter OF~~
36 AGE..

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

1 who is enrolled with the prepaid capitated provider CONTRACTOR that elects
2 not to provide family planning services.

3 10. Podiatry services performed by a podiatrist licensed pursuant to
4 title 32, chapter 7 and ordered by a primary care physician or primary care
5 practitioner.

6 11. NONEXPERIMENTAL transplants as authorized in this paragraph that
7 are medically necessary and not experimental, as determined by the
8 administration. The following transplants are authorized: APPROVED FOR TITLE
9 XIX REIMBURSEMENT.

10 (a) For individuals eligible for services pursuant to section 36-2901,
11 paragraph 4, subdivision (b), medically necessary heart, liver, kidney,
12 cornea and autologous and allogeneic bone marrow transplants and
13 immunosuppressant medications for these transplants ordered on prescription
14 by a physician licensed pursuant to title 32, chapter 13 or 17.

15 (b) For individuals eligible for services pursuant to section 36-2901,
16 paragraph 4, subdivision (b), medically necessary lung and heart-lung
17 transplants and immunosuppressant medications for these transplants ordered
18 on prescription by a physician licensed pursuant to title 32, chapter 13 or
19 17 but only if monies are available pursuant to section 36-2921, subsection
20 A, paragraph 1.

21 (c) For individuals eligible for services pursuant to section 36-2901,
22 paragraph 4, subdivisions (a), (c) and (h), medically necessary kidney and
23 cornea transplants and immunosuppressant medications for these transplants
24 ordered on prescription by a physician licensed pursuant to title 32, chapter
25 13 or 17.

26 (d) For individuals eligible for services pursuant to section 36-2901,
27 paragraph 4, subdivisions (a), (c) and (h), medically necessary heart, liver,
28 heart-lung, lung and autologous and allogeneic bone marrow transplants and
29 immunosuppressant medications for these transplants ordered on prescription
30 by a physician licensed pursuant to title 32, chapter 13 or 17, but only if
31 monies are available pursuant to section 36-2921, subsection A, paragraph 1.

32 (e) For persons who are eligible for services pursuant to section
33 36-2901, paragraph 4, subdivision (a), (b), (c) and (h), any other transplant
34 authorized by the director but only if monies are available pursuant to
35 section 36-2921, subsection A, paragraph 1.

36 12. Medically necessary Ambulance and nonambulance transportation.

37 B. The system shall pay nonproviders NONCONTRACTING PROVIDERS only for
38 health and medical services as prescribed in subsection A of this section and
39 as prescribed by rule.

40 C. The director shall adopt such rules as are necessary to limit, to
41 the extent possible, the scope, duration and amount of services, including
42 maximum limitations for inpatient services which THAT are consistent with
43 federal regulations under title XIX of the social security act (P.L. 89-97;
44 79 Stat. 344; 42 United States Code section 1396 (1980)). To the extent

1 possible and practicable, these rules shall provide for the prior approval
2 of medically necessary services provided pursuant to this chapter.

3 D. The director shall make available home health services in lieu of
4 hospitalization pursuant to provider contracts awarded under this article.
5 For the purposes of this subsection, "home health services" means the
6 provision of nursing services, home health aide services or medical supplies,
7 equipment and appliances, which are provided on a part-time or intermittent
8 basis by a licensed home health agency within a member's residence based on
9 the orders of a physician or a primary care practitioner. ~~Beginning on~~
10 ~~July 1, 1998,~~ Home health agencies shall comply with the federal bonding
11 requirements in a manner prescribed by the administration.

12 E. The director shall adopt rules for the coverage of behavioral
13 health services for persons who are eligible under section 36-2901, paragraph
14 ~~4- 6, subdivision (b) (a) and persons who are eligible for services under~~
15 ~~section 1903(v) of the social security act.~~ The administration shall
16 contract with the department of health services for the delivery of all
17 medically necessary behavioral health services to persons who are eligible
18 under rules adopted pursuant to this subsection. The division of behavioral
19 health in the department of health services shall establish a diagnostic and
20 evaluation program to which other state agencies shall refer children who are
21 not already enrolled pursuant to this chapter and who may be in need of
22 behavioral health services. In addition to an evaluation, the division of
23 behavioral health shall also identify children who may be eligible under
24 section 36-2901, paragraph ~~4- 6, subdivision (b) (a) or section 36-2931,~~
25 paragraph 5 and shall refer the children to the appropriate agency
26 responsible for making the final eligibility determination. ~~Behavioral~~
27 ~~health services for persons who are eligible under section 36-2901, paragraph~~
28 ~~4, subdivisions (a), (c), (h) and (j) are limited to emergency care in~~
29 ~~settings approved by the director and in accordance with administration~~
30 ~~rules.~~

31 F. The director shall adopt rules for the provision of transportation
32 services ~~for members and persons who are entitled to retroactive emergency~~
33 ~~coverage under section 36-2909 and rules providing for copayment by members~~
34 ~~for transportation for other than emergency purposes. Prior authorization~~
35 ~~shall IS not be required for medically necessary ambulance transportation~~
36 ~~services rendered to members or eligible persons initiated by dialing~~
37 ~~telephone number 911 or other designated emergency response systems.~~

38 G. The director may adopt rules to allow the administration, at the
39 director's discretion, to utilize USE a second opinion procedure under which
40 surgery may not be eligible for coverage pursuant to this chapter without
41 documentation as to need by at least two physicians or primary care
42 practitioners.

43 H. If the director does not receive bids within the amounts budgeted
44 or if at any time the amount remaining in the Arizona health care cost

1 containment system fund is insufficient to pay for full contract services for
2 the remainder of the contract term, the administration may, upon, ON
3 notification to system providers and counties CONTRACTORS at least thirty
4 days in advance, MAY modify the list of services required under subsection
5 A of this section for persons defined as eligible other than those persons
6 defined pursuant to section 36-2901, paragraph 4- 6, subdivision (b)
7 (a). The director may also suspend services or may limit categories of
8 expense for services defined as optional pursuant to title XIX of the social
9 security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396
10 (1980)) for persons defined pursuant to section 36-2901, paragraph 4- 6,
11 subdivision (b) (a). Such reductions or suspensions shall DO not apply to
12 the continuity of care for persons already receiving such THESE services. Any
13 decision to reduce services for members other than those persons defined
14 pursuant to section 36-2901, paragraph 4, subdivisions (a), (b), (c) and (h)
15 shall be made independently from any other modification of services. If such
16 services are reduced, modified or suspended pursuant to this subsection,
17 counties shall not be required to provide the affected services to members
18 or eligible persons.

19 I. Additional, reduced or modified hospitalization and medical care
20 benefits may be provided under the system to enrolled members who are
21 eligible pursuant to section 36-2901, paragraph 4- 6, subdivision (d), (e),
22 (f) or (g) (b), (c), (d) OR (e).

23 J. All health and medical services provided under this article shall
24 be provided in the county of residence GEOGRAPHIC SERVICE AREA of the member,
25 except:

26 1. Emergency services and specialty services provided pursuant to
27 section 36-2908.

28 2. That the director may permit the delivery of health and medical
29 services in other than the county of residence GEOGRAPHIC SERVICE AREA in
30 this state or in an adjoining state if he THE DIRECTOR determines that
31 medical practice patterns justify the delivery of services in other than the
32 county of residence or a net reduction in transportation costs can reasonably
33 be expected. Notwithstanding THE DEFINITION OF PHYSICIAN AS PRESCRIBED IN
34 section 36-2901, paragraph 8, if services are procured from a physician or
35 primary care practitioner in an adjoining state, the physician or primary
36 care practitioner shall be licensed to practice in that state pursuant to
37 licensing statutes in that state similar to title 32, chapter 13, 15, 17 or
38 25 AND SHALL COMPLETE A PROVIDER AGREEMENT FOR THIS STATE.

39 K. Covered outpatient services shall be subcontracted by a primary
40 care physician or primary care practitioner to other licensed health care
41 providers to the extent practicable for purposes including, but not limited
42 to, making health care services available to underserved areas, reducing
43 costs of providing medical care and reducing transportation costs.

1 L. The director shall adopt rules which THAT prescribe the
2 coordination of medical care for persons who are eligible for both system
3 covered services and county services. The rules shall include provisions for
4 the transfer of patients, the transfer of medical records and the initiation
5 of medical care.

6 Sec. 50. Section 36-2907.04, Arizona Revised Statutes, is amended to
7 read:

8 36-2907.04. Family planning services

9 A woman whose eligibility under section 36-2901, paragraph 4- 6,
10 subdivision (b) (a), item (ii) ended no earlier than March 1, 1995 and who
11 is not otherwise enrolled in the system is eligible to receive voluntary
12 family planning services for two years, if approval of the waiver requesting
13 family planning services pursuant to this section is approved by the UNITED
14 STATES department of health and human services. This two year period begins
15 on the first day following the end of that woman's sixty day federal
16 eligibility period that begins on the last day of her pregnancy. Family
17 planning services under this section are limited to those available pursuant
18 to section 36-2907, subsection A, paragraph 9.

19 Sec. 51. Section 36-2907.06, Arizona Revised Statutes, is amended to
20 read:

21 36-2907.06. Qualifying community health centers; contracts;
22 requirements; definition

23 A. Subject to the availability of monies as prescribed in section
24 36-2921, the administration shall enter into an intergovernmental agreement
25 pursuant to title 11, chapter 7, article 3 with the department of health
26 services to contract with qualifying community health centers to provide
27 primary health care services to indigent or uninsured Arizonans. The
28 department of health services shall enter into one year contracts with
29 qualifying community health centers for the centers to provide the following
30 primary health care services:

31 1. Medical care provided through licensed primary care physicians and
32 licensed mid-level providers as defined in section 36-2171.

33 2. Prenatal care services.

34 3. Diagnostic laboratory and imaging services that are necessary to
35 complete a diagnosis and treatment, including referral services.

36 4. Pharmacy services that are necessary to complete treatment,
37 including referral services.

38 5. Preventive health services.

39 6. Preventive dental services.

40 7. Emergency services performed at the qualifying community health
41 center.

42 8. Transportation for patients to and from the qualifying community
43 health center if these patients would not receive care without this
44 assistance.

1 B. Each contract shall require that the qualifying community health
2 center provide the services prescribed in subsection A of this section to
3 persons who the center determines:

4 1. Are residents of this state.

5 2. Are without medical insurance policy coverage.

6 3. Do not have a family income of more than two hundred per cent of
7 the federal poverty guidelines as established annually by the United States
8 department of health and human services.

9 4. Have provided verification that the person is not eligible for
10 enrollment in the Arizona health care cost containment system pursuant to
11 this chapter.

12 5. Have provided verification that the person is not eligible for
13 medicare.

14 C. The department of health services shall directly administer the
15 program and issue requests for proposals for the contracts prescribed in this
16 section. Contracts established pursuant to subsection A or ~~G~~ of this section
17 shall be signed by the department and the contractor prior to BEFORE the
18 transmission of any tobacco tax and health care fund monies to the
19 contractor.

20 D. Persons who meet the eligibility criteria established in subsection
21 B or G of this section shall be charged for services based upon a sliding fee
22 schedule approved by the department of health services.

23 E. In awarding contracts the department of health services may give
24 preference to qualifying community health centers that have a sliding fee
25 schedule. Monies shall be used for the number of patients that exceeds the
26 number of uninsured sliding fee schedule patients that the qualifying
27 community health center served during fiscal year 1994. Each qualifying
28 community health center shall make its sliding fee schedule available to the
29 public on request. The contract shall require the qualifying community
30 health center to apply a sliding fee schedule to all of its uninsured
31 patients.

32 F. The department of health services may examine the records of each
33 qualifying community health center and conduct audits necessary to determine
34 that the eligibility determinations were performed accurately and to verify
35 the number of uninsured patients served by the qualifying community health
36 center as a result of receiving tobacco tax and health care fund monies by
37 the contract established pursuant to subsection A of this section.

38 ~~G. After the health care financing administration approves the~~
39 ~~children's health insurance program established pursuant to article 4 of this~~
40 ~~chapter, the department of health services shall contract with qualifying~~
41 ~~health centers to allow the qualifying health centers to deliver or arrange~~
42 ~~to provide the health benefits pursuant to this section to children who are~~
43 ~~determined eligible pursuant to section 36-2983 and who elect to receive~~
44 ~~direct, sliding fee scale medical and health care services from qualifying~~

1 ~~health centers pursuant to this section and with hospitals pursuant to~~
2 ~~section 36-2907.08. The qualifying health centers shall provide data the~~
3 ~~administration determines is sufficient to allow the state to apply for~~
4 ~~federal funding under the program established pursuant to article 4 of this~~
5 ~~chapter. For the purposes of this subsection, "qualifying health center"~~
6 ~~means a community based facility that arranges to provide or deliver medical~~
7 ~~care on a sliding fee scale through the employment of physicians,~~
8 ~~professional nurses, physicians assistants or other health care technical and~~
9 ~~paraprofessional personnel.~~

10 ~~H. G. Contracts established pursuant to subsection A or G of this~~
11 ~~section shall require qualifying community health center contractors and~~
12 ~~qualifying health centers as defined in subsection G of this section to~~
13 ~~submit information as required pursuant to section 36-2907.07 for program~~
14 ~~evaluations.~~

15 ~~f. H. For the purposes of this section "qualifying community health~~
16 ~~center" means a community based primary care facility that provides medical~~
17 ~~care in medically underserved areas as provided in section 36-2352, or in~~
18 ~~medically underserved areas or medically underserved populations as~~
19 ~~designated by the United States department of health and human services,~~
20 ~~through the employment of physicians, professional nurses, physician~~
21 ~~assistants or other health care technical and paraprofessional personnel.~~

22 ~~Sec. 52. Section 36-2907.08, Arizona Revised Statutes, is amended to~~
23 ~~read:~~

24 ~~36-2907.08. Basic children's medical services program;~~
25 ~~definition~~

26 ~~A. Beginning on October 1, 1996, the basic children's medical services~~
27 ~~program is established to provide grants to hospitals that exclusively serve~~
28 ~~the medical needs of children or that operate programs designed primarily for~~
29 ~~children. The director of the department of health services, pursuant to an~~
30 ~~intergovernmental agreement with the director of the Arizona health care cost~~
31 ~~containment system and subject to the availability of monies, shall implement~~
32 ~~and operate this program only to the extent that funding is available and has~~
33 ~~been specifically dedicated for the program.~~

34 ~~B. To receive a grant under this section, a hospital shall submit an~~
35 ~~application as prescribed by the director of the department of health~~
36 ~~services in a request for proposal that indicates to the director's~~
37 ~~satisfaction that the applicant agrees to:~~

38 ~~1. Use grant program monies to enhance the applicant's provision of~~
39 ~~additional medical services to children and to improve the applicant's~~
40 ~~ability to deliver inpatient, outpatient and specialized clinical services~~
41 ~~to indigent, uninsured or underinsured children who are not eligible to~~
42 ~~receive services under this article.~~

43 ~~2. Establish and enforce a sliding fee scale for children who are~~
44 ~~provided services with grant monies.~~

1 3. Account for monies collected pursuant to paragraph 2 of this
2 subsection separately from all other income it receives and to report this
3 income on a quarterly basis to the administration.

4 4. Use the grant to supplement monies already available to the
5 applicant.

6 5. Match the grant as prescribed by the director by rule with private
7 monies the applicant has pledged from private sources. The director shall
8 waive this requirement if the applicant is seeking the grant to qualify for
9 a private or public grant for the delivery of inpatient, outpatient or
10 specialized clinical care of indigent, uninsured or underinsured children who
11 are not eligible to receive services under this article.

12 6. Provide a mechanism to ensure that grant program monies are not
13 used for children who are eligible for services under this article.

14 7. Not use grant monies to fund the provision of emergency room
15 services.

16 C. By contract, the director of the department of health services
17 shall require a grantee to:

18 1. Annually account for all expenditures it makes with grant program
19 monies during the previous year.

20 2. Agree to cooperate with any audits or reviews conducted by this
21 state.

22 3. Agree to the requirements of this section and other conditions the
23 director determines to be necessary for the effective use of grant program
24 monies.

25 D. The director of the department of health services may limit either
26 or both the grant amount per contract or the number of contracts awarded. In
27 awarding contracts to qualified applicants the director shall consider:

28 1. The amount of monies available for the grant program.

29 2. The need for grant monies in the area served by the applicant as
30 stated by the applicant in the response to the request for proposals and as
31 researched by the administration.

32 3. The number of children estimated to be served by the applicant with
33 grant program monies.

34 4. The services that will be provided or made available with grant
35 program monies.

36 5. The percentages of grant monies that the applicant indicates will
37 be reserved for administrative expenditures, direct service expenditures and
38 medical care personnel costs.

39 6. The financial and programmatic ability of the applicant to meet the
40 contract's requirements.

41 E. If the department of health services determines that a hospital has
42 used grant monies in violation of this section it shall prohibit that
43 hospital from receiving additional grant program monies until the hospital
44 reimburses the department. The department shall impose an interest penalty

1 as prescribed by the director of the department of health services by
2 rule. The director shall deposit, pursuant to sections 35-146 and 35-147,
3 penalties collected under this section in the medically needy account of the
4 tobacco tax and health care fund.

5 F. The director of the department of health services may expend monies
6 from the medically needy account of the tobacco tax and health care fund
7 transferred pursuant to section 36-2921, subsection A, paragraph 7- 6 for the
8 purpose of funding evaluations of the grant program established by this
9 section. The director shall ensure that any evaluation is structured to meet
10 at least the base requirements prescribed in section 36-2907.07.

11 G. The director of the department of health services may expend monies
12 from the medically needy account of the tobacco tax and health care fund
13 transferred pursuant to section 36-2921, subsection A, paragraph 7- 6 for
14 administrative costs associated with the establishment or the operation of
15 the grant program. The amount withdrawn annually for grant program
16 administrative costs shall not exceed two per cent of the sum of any
17 transfers of monies made pursuant to section 36-2921 and any appropriation
18 of monies for the specified purpose of supporting the nonentitlement basic
19 children's medical services program established in this section.

20 H. The department of health services shall directly administer the
21 grant program and all contracts established pursuant to this section. The
22 director of the department of health services shall publish rules pursuant
23 to title 41, chapter 6 for the grant program before the issuance of the
24 initial grant program request for proposals. The director of the department
25 of health services and the contractor shall sign a contract before the
26 transmission of any tobacco tax and health care fund monies to the
27 contractor.

28 I. In administering the basic children's medical services program and
29 awarding contracts established pursuant to this section, the director of the
30 department of health services shall seek to efficiently and effectively
31 coordinate the delivery of services provided through the program with
32 services provided through other programs including those established pursuant
33 to chapter 2, article 3 of this title and sections 36-2907.05 and 36-2907.06.
34 The director shall seek to ensure that this coordination results in providing
35 for either or both the coverage of additional children or the provision of
36 additional medically necessary services to children instead of supplanting
37 existing service opportunities or duplicating existing programs with no
38 attendant increase in coverage.

39 J. For the purposes of this section, "grant program" refers to the
40 basic children's medical services program.

1 Sec. 53. Section 36-2907.10, Arizona Revised Statutes, is amended to
2 read:

3 36-2907.10. Transplants; extended eligibility

4 A. If during a redetermination process for eligibility pursuant to
5 this article a person who is enrolled and who is eligible pursuant to this
6 article for a medically necessary and appropriate transplant pursuant to
7 section 36-2907, subsection A, paragraph 11 is determined ineligible for
8 coverage pursuant to ~~section 36-2901, paragraph 4, subdivision (a), (c) or~~
9 ~~(h)~~ PURSUANT TO SECTION 36-2901.04 due to excess income or ineligible for
10 coverage pursuant to section 36-2901, paragraph 4- 6, subdivision (b) (a)
11 ITEM (i), (ii) OR (iii) and that person has not yet received the transplant,
12 the person may extend the person's eligibility. ~~The administration shall~~
13 ~~compute excess income based on the total spend down requirement for the~~
14 ~~household divided by the number of persons in the household.~~

15 B. In order to extend eligibility the person may SHALL enter into a
16 contractual agreement with a hospital to pay the amount of excess income
17 determined pursuant to this section. The hospital shall only be reimbursed
18 by the administration at the contracted rate of the transplantation surgery,
19 including up to one hundred days of posttransplantation care. The
20 administration shall deduct the amount of excess income that the person
21 agrees to pay the hospital before payment is made to the hospital for
22 transplant services authorized by this section. The amount of excess income
23 shall not be changed once the extended period of eligibility begins. The
24 administration is not responsible to pay any of the spend down amount if the
25 person does not pay the hospital. The contracting hospital shall submit a
26 copy of the person's contractual agreement with the hospital to the county
27 that ~~determines eligibility~~ ADMINISTRATION.

28 C. The administration shall authorize extended eligibility services
29 only for transplant candidates.

30 D. Extended eligibility pursuant to this section shall be IS FOR ONE
31 TWELVE-MONTH CONTINUOUS PERIOD OF TIME AND IS funded only pursuant to section
32 36-2907.12.

33 E. This section does not prohibit a person from applying for
34 eligibility pursuant to any other applicable law.

35 ~~F. A person who was eligible for services pursuant to section 36-2901,~~
36 ~~paragraph 4, subdivision (a), (b), (c) or (h) and who was eligible for a~~
37 ~~medically necessary and appropriate transplant as determined by the~~
38 ~~administration pursuant to section 36-2907, subsection A, paragraph 11 and~~
39 ~~whose eligibility ended at any time from March 22, 1995 through October 17,~~
40 ~~1995 because of excess income before receiving a transplant may also apply~~
41 ~~for extended eligibility pursuant to this section.~~

42 ~~G. A county is not liable for the provision of or payment for~~
43 ~~transplant services provided under this section, except that county health~~
44 ~~plans under contract with the administration are liable for all service or~~

1 ~~payment requirements stipulated in their contracts with the administration.~~
2 ~~The counties are responsible for making timely eligibility determinations~~
3 ~~pursuant to this section.~~

4 ~~H. F.~~ F. If the administration and a hospital that performed a
5 transplant surgery on a person who is eligible pursuant to this section do
6 not have a contracted rate, the administration shall not reimburse the
7 hospital more than the contracted rate established by the administration.

8 ~~I. G.~~ G. A person who has extended eligibility pursuant to section
9 36-2907.11 is not eligible for services pursuant to this section.

10 ~~J. H.~~ H. The extended eligibility of a person who is determined to be
11 no longer medically eligible for a transplant terminates at the end of the
12 month in which it is determined the person is not medically eligible for the
13 transplant unless the person is otherwise eligible for services pursuant to
14 section 36-2901, paragraph ~~4~~ 6, subdivision (a), (b), (c) or (h).

15 Sec. 54. Section 36-2907.11, Arizona Revised Statutes, is amended to
16 read:

17 36-2907.11. Retaining transplant status

18 A. If during a redetermination process for eligibility pursuant to
19 this article a person who is eligible for a medically necessary and
20 appropriate transplant as determined by the administration pursuant to
21 section 36-2907, subsection A, paragraph 11 is determined ineligible for
22 coverage pursuant to section ~~36-2901, paragraph 4, subdivision (a), (c) or~~
23 ~~(h)~~ 36-2901.04 due to excess income or ineligible for coverage pursuant to
24 section 36-2901, paragraph ~~4~~ 6, subdivision (b) (a), ITEM (i), (ii) OR (iii)
25 and that person has not yet received the transplant, the person may enter
26 into a contract with a hospital to pay the amount of excess income. For
27 purposes of this section, the administration shall compute excess income
28 based on the total spend down requirement for the household divided by the
29 number of persons in the household. The administration shall recompute
30 excess income pursuant to this section at the time the transplant becomes
31 available.

32 B. If the hospital enters into the contractual agreement with the
33 person, the hospital shall allow the person to retain the person's transplant
34 candidacy status as long as the person is medically eligible but the person
35 is not eligible for services pursuant to this article unless that person is
36 determined eligible pursuant to subsection D of this section.

37 C. A person who has extended eligibility pursuant to section
38 36-2907.10 is not eligible for services pursuant to this section.

39 D. Once a transplant is scheduled or performed the person shall
40 reapply for eligibility pursuant to section 36-2901, paragraph ~~4~~ 6,
41 subdivision (a), (b), (c) or (h) and, if a spend down of excess income is
42 necessary in order to be eligible for services pursuant to this article, the
43 administration shall compute this income pursuant to the process specified
44 in subsection A of this section. If the transplant is performed within

1 thirty days before the date of the eligibility determination by the county
2 pursuant to this section, the administration shall pay the hospital on a
3 retroactive basis at the contracted rate for costs of the transplant surgery,
4 including up to one hundred days of posttransplantation care. The
5 administration shall deduct the amount of excess income that the person has
6 agreed to pay the hospital before payment is made to the hospital for
7 transplant services pursuant to this section. The amount of excess income
8 shall not be recomputed after the date the person becomes eligible pursuant
9 to this section. The administration is not responsible for paying any spend
10 down amount if the person does not pay the hospital. The contracting
11 hospital shall submit a copy of the person's contractual agreement with the
12 hospital to the county that determines eligibility ADMINISTRATION.

13 E. Eligibility pursuant to this section shall be funded only pursuant
14 to section 36-2907.12.

15 F. This section does not prohibit a person from applying for
16 eligibility pursuant to any other applicable law.

17 ~~G. A person who was eligible for services pursuant to section 36-2901,
18 paragraph 4, subdivision (a), (b), (c) or (h) and who was eligible for a
19 medically necessary and appropriate transplant as determined by the
20 administration pursuant to section 36-2907, subsection A, paragraph 11 and
21 whose eligibility ended at any time from March 22, 1995 through October 17,
22 1995 because of excess income before receiving a transplant is also eligible
23 to retain transplant candidate status pursuant to this section.~~

24 ~~H. A county is not liable for the provision of or payment for
25 transplant services provided under this section, except that county health
26 plans under contract with the administration are liable for all service or
27 payment requirements stipulated in their contracts with the administration.
28 The counties are responsible for making timely eligibility determinations
29 pursuant to this section.~~

30 ~~I. G. If the administration and a hospital that performed a
31 transplant surgery on a person eligible pursuant to this section do not have
32 a contracted rate, the administration shall not reimburse the hospital more
33 than the contracted rate established by the administration.~~

34 Sec. 55. Section 36-2907.12, Arizona Revised Statutes, is amended to
35 read:

36 36-2907.12. Transplants; tobacco tax allocation

37 Subject to the availability of monies in the medically needy account
38 established by section 36-774, and after payment pursuant to section 36-2921,
39 subsection A, paragraph 1, the administration shall withdraw the amount
40 necessary to pay the state share of costs for providing eligibility for
41 transplant recipients who agree to enter into contractual agreements with
42 hospitals pursuant to section 36-2907.10 or 36-2907.11.

1 Sec. 56. Section 36-2908, Arizona Revised Statutes, is amended to
2 read:

3 36-2908. Provision of emergency and specialty services;
4 reimbursement

5 A. Subject to the provisions of section 36-2909, services provided to
6 members under this article, ~~or to persons defined in section 36-2901,~~
7 ~~paragraph 4, subdivisions (a), (b), (c), (h) and (j),~~ who have been
8 determined eligible but who have not yet enrolled in the system and who are
9 in need of medical services on an emergency basis after they have been
10 determined eligible, irrespective of county of residence, shall be
11 reimbursed, subject to subsection B of this section, in accordance with rules
12 adopted by the director if such services are not otherwise covered by a
13 provider contract.

14 B. Services provided on an emergency basis to members or to persons
15 after they have been determined eligible for such services but before they
16 have enrolled in the system without a demonstrated emergency need in
17 accordance with rules adopted by the director shall be reimbursed at no more
18 than the rate for the service provided in other than an emergency services
19 setting.

20 C. The director shall prescribe rules providing for the reimbursement
21 of specialty services provided outside of the county of residence of the
22 member if authorized by the member's primary care physician or primary care
23 practitioner.

24 D. Services provided pursuant to this section shall be provided in
25 accordance with rules adopted pursuant to section 36-2903.01,
26 subsection G E.

27 ~~E. Notwithstanding any provision of this chapter to the contrary, for~~
28 ~~persons certified as eligible pursuant to section 36-2901, paragraph 4,~~
29 ~~subdivision (a), (c) or (j) or pursuant to section 36-2905.03, subsection C,~~
30 ~~only emergency medical services as defined by the director by rule which are~~
31 ~~delivered to persons who have been determined eligible but who have not yet~~
32 ~~enrolled in the system shall be reimbursed.~~

33 Sec. 57. Section 36-2909, Arizona Revised Statutes, is amended to
34 read:

35 36-2909. Emergency hospital services; retroactive coverage;
36 costs

37 ~~A. The administration or the member's prepaid capitated provider,~~
38 ~~subject to section 36-2908, is retroactively liable for payment for care~~
39 ~~which was provided in the period of two days prior to the date that a county~~
40 ~~determines a person is eligible and complies with the notice provision set~~
41 ~~forth in rule. Effective October 1, 1997, the administration may assign~~
42 ~~liability for eligible persons and members through contractual arrangements~~
43 ~~with prepaid capitated providers. Such liability is for all costs of~~
44 ~~emergency hospitalization and medical care delivered by a hospital or a~~

1 ~~icensed outpatient treatment clinic to a member or person as defined in~~
2 ~~section 36-2901, paragraph 4, subdivisions (a), (c), (h) and (j) who has been~~
3 ~~determined eligible. Payment for such care shall be made at the levels~~
4 ~~specified in subsection D of this section. The director shall by rule define~~
5 ~~the specific manner by which the two day coverage period is calculated and~~
6 ~~determined. Uninterrupted care initiated on or before the coverage date as~~
7 ~~emergency care shall be considered as an emergency admission for purposes of~~
8 ~~coverage and reimbursement under this section until the person receiving such~~
9 ~~care is discharged or otherwise transferred pursuant to this section.~~

10 ~~B. A. When IF a member or an eligible person receives emergency~~
11 ~~hospitalization and medical care on or after the date of eligibility~~
12 ~~determination OR THE ELIGIBILITY EFFECTIVE DATE from a hospital which THAT~~
13 ~~does not have a contract to care for the person, the administration or the~~
14 ~~prepaid capitated provider CONTRACTOR is liable only for the costs of~~
15 ~~emergency hospitalization and medical care up to the time the person is~~
16 ~~discharged or until the time the person can be transferred. The~~
17 ~~administration or the prepaid capitated provider is also liable for further~~
18 ~~care in the following circumstances:~~

19 ~~1. When IF the attending physician reasonably determines that the~~
20 ~~condition of the person receiving emergency hospitalization and medical care~~
21 ~~is such that it is medically inadvisable to transfer the person.~~

22 ~~2. When IF the administration or the prepaid capitated provider~~
23 ~~CONTRACTOR does not transport the person from the hospital providing care~~
24 ~~after it has been determined that the person can be transferred.~~

25 ~~C. A person who has been determined eligible but has not yet enrolled~~
26 ~~and who is defined in section 36-2901, paragraph 4, subdivisions (a), (b),~~
27 ~~(c) and (h) and is receiving emergency hospitalization and medical care shall~~
28 ~~be enrolled with a prepaid capitated provider at the earliest possible time~~
29 ~~and transferred to that prepaid capitated provider's hospital as soon as the~~
30 ~~person's condition has stabilized. The administration and any prepaid~~
31 ~~capitated provider shall not be responsible for the costs of any~~
32 ~~hospitalization and medical care delivered by a hospital which does not have~~
33 ~~a contract to provide care to the person receiving care after the person~~
34 ~~receiving care has been determined to be transferrable, an attempt is made~~
35 ~~by the administration or the prepaid capitated provider to transfer the~~
36 ~~person and the person receiving care has refused to consent to the transfer.~~

37 ~~D. B. Except for charges for services subject to section 36-2908,~~
38 ~~subsection B, all charges incurred by an eligible person who has not yet~~
39 ~~enrolled for hospitalization and medical care under the provisions of~~
40 ~~subsection A or B of this section shall be ARE payable by the administration~~
41 ~~pursuant to section 36-2903.01, subsection I- G or J- H or as specified in~~
42 ~~contract by the prepaid capitated provider CONTRACTOR pursuant to the~~
43 ~~subcontracted rate or section 36-2904, subsection J- I or K- J.~~

1 ~~E.~~ C. As a condition to receiving reimbursement pursuant to
2 subsection ~~D~~ B of this section, a hospital which THAT is not a contractor
3 or subcontractor under the system must designate a primary care physician or
4 primary care practitioner to act as a coordinator of the services provided
5 to persons who have been determined eligible but have not yet enrolled, prior
6 to BEFORE the persons' enrollment, discharge or transfer.

7 ~~F.~~ D. Emergency hospitalization and medical care provided pursuant
8 to this section shall be in accordance with rules adopted pursuant to section
9 36-2903.01, subsection ~~G~~ E in order to qualify for reimbursement.

10 ~~G.~~ E. The director shall adopt rules which THAT provide that members
11 who have been determined eligible shall be enrolled with ~~prepaid capitated~~
12 providers CONTRACTORS as soon as practicable.

13 ~~H.~~ F. ~~Nothing in This section prevents~~ DOES NOT PREVENT the director
14 or the ~~prepaid capitated provider~~ CONTRACTOR from denying payment for
15 hospitalization or medical care that is not authorized or deemed medically
16 necessary in accordance with rules adopted by the director.

17 Sec. 58. Section 36-2910, Arizona Revised Statutes, is amended to
18 read:

19 36-2910. Notification to system of nonemergency services

20 A. Except as otherwise specifically provided by this article and
21 ~~except as otherwise provided pursuant to title XIX of the social security act~~
22 ~~(P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396a (1980))~~, the
23 system is financially responsible for only the costs of care provided by
24 system providers CONTRACTORS to members.

25 B. For purposes of eligibility determination and enrollment in the
26 system, the director may adopt rules and ~~regulations which~~ TO establish
27 ~~NOTIFICATION PROCEDURES for health care providers, nonproviders and counties~~
28 ~~notification procedures to provide notice to the system or to counties~~
29 CONTRACTORS AND NONCONTRACTING PROVIDERS of care provided to persons who may
30 be eligible or who have been determined eligible ~~or members~~. The director
31 may condition payment for such services on the compliance of a provider ~~or~~
32 nonprovider CONTRACTOR OR NONCONTRACTING PROVIDER with such THE notification
33 procedures. The director may adopt regulations which set forth RULES THAT
34 ESTABLISH procedures and notices for the transfer of patients MEMBERS between
35 providers, nonproviders and county systems CONTRACTORS AND NONCONTRACTING
36 PROVIDERS as such THE transfer relates to the system.

37 Sec. 59. Section 36-2911, Arizona Revised Statutes, is amended to
38 read:

39 36-2911. Payment of monthly premiums

40 A. The administration shall pay MEDICARE PART B PREMIUMS PURSUANT TO
41 FEDERAL LAW for and on behalf of each A member WHO IS ELIGIBLE PURSUANT TO
42 SECTION 36-2901, PARAGRAPH 6, SUBDIVISION (a), ITEM (i) OR (ii) AND WHO IS
43 enrolled pursuant to this article and article 2 of this chapter. ~~under title~~
44 ~~XVI of the social security act (42 United States Code chapter 7, subchapter~~

1 ~~XVI) such monthly premium as may be required to obtain coverage for the~~
2 ~~recipient under title XVIII, part B of the social security act, as amended~~
3 ~~(P.L. 89-97; 79 Stat. 291; 42 United States Code chapter 7, subchapter~~
4 ~~XVIII). The monthly premium shall be paid through a state plan adopted by~~
5 ~~the administration and approved by the federal government under section 1843~~
6 ~~of the social security act (42 United States Code section 1395v). This plan~~
7 ~~shall provide for coverage of all supplementary medical insurance premiums~~
8 ~~for eligible supplemental security income recipients and members enrolled~~
9 ~~pursuant to article 2 of this chapter included in the approved plan.~~

10 B. ~~Beginning July 1, 1990, The administration shall pay, on behalf of~~
11 ~~THE MEDICARE PART A HOSPITAL PREMIUM FOR each qualified disabled and working~~
12 ~~individual who is determined eligible pursuant to section 1905(s) of title~~
13 ~~XIX of the social security act, as amended by section 6408(d) of the omnibus~~
14 ~~budget reconciliation act of 1989, the monthly premium for hospital insurance~~
15 ~~benefits under part A of title XVIII of the social security act. The~~
16 ~~administration shall determine the eligibility of all persons who are~~
17 ~~qualified disabled and working individuals in accordance with section 6408(d)~~
18 ~~of the omnibus budget reconciliation act of 1989. The administration, in~~
19 ~~accordance with federal law, may require certain eligible qualified disabled~~
20 ~~and working individuals to contribute to the cost of the monthly premium.~~

21 C. ~~Beginning July 1, 1996, the administration may purchase part B~~
22 ~~medicare coverage for persons who would otherwise be eligible for medicare~~
23 ~~coverage in a health maintenance organization and who would have been~~
24 ~~eligible to receive services under sections 11-297 or 36-2905.~~

25 Sec. 60. Section 36-2912, Arizona Revised Statutes, is amended to
26 read:

27 36-2912. Healthcare group coverage; requirements for small
28 businesses and public employers; related
29 requirements

30 A. The administration shall establish a separate organization, known
31 as healthcare group, to coordinate, administer and regulate the delivery of
32 health care services to persons defined as eligible pursuant to section
33 36-2901, paragraph 4- 6, subdivisions (d), (e), (f) and (g) (b), (c), (d)
34 AND (e).

35 B. Employers with one eligible employee or up to an average of fifty
36 eligible employees under section 36-2901, paragraph 4- 6, subdivision
37 (ff) (d):

38 1. May contract with a healthcare group plan which THAT shall offer
39 coverage available pursuant to this section as the exclusive health benefits
40 plan if the employer has five or fewer full-time employees and enrolls one
41 hundred per cent of these employees into healthcare group. If an employer's
42 health benefits plan has been terminated or discontinued by a health benefits
43 carrier, the organization established pursuant to subsection A of this

1 section shall, subsequent to a contract with the employer, allow coverage to
2 begin immediately.

3 2. May contract with a healthcare group plan which THAT shall offer
4 coverage available pursuant to this section if the employer has six or more
5 employees and enrolls eighty per cent of these employees into healthcare
6 group.

7 3. Shall have a minimum of one and a maximum of fifty full-time
8 employees at the effective date of their first contract with the
9 organization.

10 C. Employees with proof of other existing health care coverage who
11 elect not to participate in healthcare group shall not be considered when
12 determining the percentage if the other health care coverage is either other
13 group health coverage through a spouse, parent or legal guardian or is
14 coverage available from a government subsidized health care program.

15 D. An employer shall not offer coverage made available pursuant to
16 this section to persons defined as eligible pursuant to section 36-2901,
17 paragraph 4- 6, subdivision ~~(d), (e), (f) or (g)~~ (b), (c), (d) OR (e) as a
18 substitute for a federally designated plan.

19 E. An employee or dependent defined as eligible pursuant to section
20 36-2901, paragraph 4- 6, subdivision ~~(d), (e), (f) or (g)~~ (b), (c), (d) OR
21 (e) may participate in the system on a voluntary basis only.

22 F. Notwithstanding subsection B, paragraph 2 of this section, the
23 administration shall adopt rules to allow a business that offers system
24 coverage pursuant to this section to continue coverage if it expands its
25 employment to include more than fifty employees.

26 G. The director of the organization shall:

27 1. Ensure that the organization developed to provide services to
28 persons defined as eligible pursuant to section 36-2901, paragraph 4- 6,
29 subdivision ~~(d), (e), (f) or (g)~~ (b), (c), (d) OR (e) operates separately
30 from the administration and that the full cost of any function performed by
31 the administration on behalf of that organization is reimbursed by the
32 organization or its contracted health plans, whichever is applicable.

33 2. Require that any health plan contracted to provide system covered
34 services to persons defined as eligible pursuant to section 36-2901,
35 paragraph 4- 6, subdivisions ~~SUBDIVISION (a), (b), (c), (h) and (j)~~ provide
36 separate audited reports on the assets, liabilities and financial status of
37 any corporate activity involving providing coverage pursuant to this section
38 to persons defined as eligible pursuant to section 36-2901, paragraph 4- 6,
39 subdivision ~~(d), (e), (f) or (g)~~ (b), (c), (d) OR (e).

40 3. Ensure that any health plan not contracted to provide system
41 covered services to persons defined as eligible pursuant to section 36-2901,
42 paragraph 4- 6, subdivisions ~~SUBDIVISION (a), (b), (c), (h) and (j)~~ has
43 complied with any applicable provisions of section 36-2906.01. The director

1 may make requests of the director of the department of insurance on behalf
2 of the organization pursuant to section 36-2906.01.

3 4. Not distribute any appropriated funds, unless specifically
4 authorized by the legislature, to the organization or to any of the
5 organization's contracted health plans.

6 5. Ensure that the organization's contracted health plans are required
7 to meet contract terms as are necessary in the judgment of the director to
8 ensure adequate performance by the health plan. Contract provisions shall
9 include, but are not limited to, the maintenance of deposits, performance
10 bonds, financial reserves or other financial security. The organization,
11 upon approval of the director, may waive requirements for the posting of
12 bonds or security for health plans which THAT have posted other security,
13 equal to or greater than that required by the organization, with the
14 administration or the department of insurance for the performance of health
15 service contracts if funds would be available to the organization from the
16 other security upon the health plan's default. In waiving, or approving
17 waivers of, any requirements established pursuant to this section, the
18 organization and the director shall ensure that it has taken into account all
19 the obligations to which a health plan's security is associated. The
20 director may also, on behalf of the organization, adopt rules which THAT
21 provide for the withholding or forfeiture of payments to be made to a
22 contracted health plan for the failure of the health plan to comply with
23 provisions of its contract or with provisions of adopted rules.

24 6. Adopt separate rules on behalf of the organization. These rules
25 shall stand alone and not be dependent upon any reference to rules adopted
26 by the administration for health plans providing system covered services to
27 persons defined as eligible pursuant to section 36-2901, paragraph 4- 6,
28 subdivisions SUBDIVISION (a), ~~(b)~~, ~~(c)~~, ~~(h)~~ and ~~(j)~~.

29 H. With respect to services provided by contracted health plans to
30 persons defined as eligible pursuant to section 36-2901, paragraph 4- 6,
31 subdivision ~~(d)~~, ~~(e)~~, ~~(f)~~ or ~~(g)~~ (b), (c), (d) OR (e), the contracted health
32 plan shall not be considered as payor of last resort and does not possess
33 lien or subrogation rights beyond those held by health care services
34 organizations licensed pursuant to title 20, chapter 4, article 9.

35 I. Health plans contracted to provide coverage to persons defined as
36 eligible pursuant to section 36-2901, paragraph 4- 6, subdivision ~~(d)~~, ~~(e)~~,
37 ~~(f)~~ or ~~(g)~~ (b), (c), (d) OR (e) shall ensure that the personnel employed or
38 contracted to interact with employer groups as agents or brokers are licensed
39 pursuant to title 20, chapter 2, article 3.

40 J. ~~Beginning on July 1, 1997~~ Each health plan shall offer a health
41 benefit plan on a guaranteed issuance basis to small employers as required
42 by this section. All small employers qualify for this guaranteed offer of
43 coverage. The health plan shall provide a health benefit plan to each small
44 employer without regard to health status-related factors if the small

1 employer agrees to make the premium payments and to satisfy any other
2 reasonable provisions of the plan that are not inconsistent with this
3 chapter. A health plan shall offer to all small employers a choice of all
4 health benefit plans that the health plan offers in the small group market
5 and that the health plan is actively marketing and shall accept any small
6 employer that applies for any of those products. In addition to the
7 requirements prescribed in section 36-2912.03, for any offering of any health
8 benefit plan to a small employer, as part of the health plan's solicitation
9 and sales materials, a health plan shall make a reasonable disclosure to the
10 employer of the availability of the information described in this subsection
11 and, on request of the employer, shall provide that information to the
12 employer. The health plan shall provide information concerning the
13 following:

- 14 1. Provisions of coverage relating to the following, if applicable:
15 (a) The health plan's right to change premium rates and the factors
16 that may affect changes in premium rates.
17 (b) Renewability of coverage.
18 (c) Any preexisting condition exclusion.
19 (d) The geographic areas served by the health plan.

20 2. The benefits and premiums available under all health benefit plans
21 for which the employer is qualified.

22 K. The health plan shall describe the information required by
23 subsection J of this section in language that is understandable by the
24 average small employer and with a level of detail that is sufficient to
25 reasonably inform a small employer of the employer's rights and obligations
26 under the health benefit plan. This requirement is satisfied if the health
27 plan provides each of the following for each product the health plan offers:

- 28 1. An outline of coverage that describes the benefits in summary form.
29 2. The rate or rating schedule that applies to the product,
30 preexisting condition exclusion or affiliation period.
31 3. The minimum employer contribution and group participation rules
32 that apply to any particular type of coverage.
33 4. In the case of a network plan, a map or listing of the areas
34 served.

35 L. A health plan is not required to disclose any information that is
36 proprietary and protected trade secret information under applicable law.

37 M. A health plan shall not refuse to accept for coverage a person who
38 on the date the employer applied for the coverage would have been eligible
39 for coverage and who has been continuously covered for a one year period
40 under a health benefit plan or other health insurance policy. A person is
41 deemed to be continuously covered for a one year period if the person is
42 insured at the beginning and end of the one year period and has had no breaks
43 in coverage during that period totaling more than thirty-one days. A health
44 plan shall not deny enrollment or impose a preexisting condition exclusion

1 against an eligible person who had creditable coverage for at least a one
2 year period if the person's prior coverage ended within sixty-three days
3 immediately before the enrollment date. A newborn child, adopted child or
4 child placed for adoption is continuously covered for a one year period if
5 the child was timely enrolled and otherwise would have met the definition of
6 an eligible individual as prescribed in this section, other than the required
7 period of creditable coverage under a health benefit plan offered by a health
8 plan, and the child is not subject to any preexisting condition exclusion or
9 limitation if the child has been continuously covered under a health benefit
10 plan since birth, adoption or placement for adoption.

11 N. At least sixty days before the date of expiration of a health
12 benefit plan, a health plan shall provide for written notice to the employer
13 of the terms for renewal of the plan. The notice shall include an
14 explanation of the extent to which any increase in premiums is due to actual
15 or expected claims experience of the individuals covered under the employer's
16 health benefit plan contract. A health plan may refuse to renew or may
17 terminate a health benefit plan only if:

18 1. The employer fails to pay premiums or contributions in accordance
19 with the terms of the health benefit plan of the health plan or the health
20 plan does not receive premium payments in a timely manner.

21 2. The employer committed an act or practice that constitutes fraud
22 or made an intentional misrepresentation of material fact under the terms of
23 the health benefit plan.

24 3. The employer has failed to comply with a material plan provision
25 relating to employer participation rules as prescribed in subsection B of
26 this section.

27 4. Repeated misuse of a provider network plan.

28 O. A health plan is not required to renew a health benefit plan with
29 respect to an employer or individual if the health plan provides notice to
30 the organization at least five business days before the health plan gives
31 notice to each employer or individual covered under a health benefit plan of
32 the intention to discontinue offering the health benefit plan and the health
33 plan provides notice of termination to each employer or individual covered
34 under a plan at least ninety days before the expiration date of the plan.

35 P. Except as provided in subsection Q of this section, a health
36 benefit plan may not deny, limit or condition the coverage or benefits based
37 on a person's health status-related factors or a lack of evidence of
38 insurability.

39 Q. A health benefit plan shall not exclude coverage for preexisting
40 conditions, except that:

41 1. A health benefit plan may exclude coverage for preexisting
42 conditions for a period of not more than twelve months or, in the case of a
43 late enrollee, eighteen months. The exclusion of coverage does not apply to
44 services that are furnished to newborns who were otherwise covered from the

1 time of their birth or to persons who satisfy the portability requirements
2 under this section.

3 2. The health plan shall reduce the period of any applicable
4 preexisting condition exclusion by the aggregate of the periods of creditable
5 coverage that apply to the individual.

6 R. On request of a health benefit plan, a person who provides coverage
7 during a period of continuous coverage with respect to a covered individual
8 shall promptly disclose the coverage provided to the covered individual, the
9 period of the coverage and the benefits provided under the coverage. The
10 health plan shall calculate creditable coverage according to the following:

11 1. The health plan shall give an individual credit for each portion
12 of each month the individual was covered by creditable coverage.

13 2. The health plan shall not count a period of creditable coverage for
14 an individual enrolled in a health benefit plan if after the period of
15 coverage and before the enrollment date there were sixty-three consecutive
16 days during which the individual was not covered under any creditable
17 coverage.

18 3. The health plan shall give credit in the calculation of creditable
19 coverage for any period that an individual is in a waiting period for any
20 health coverage.

21 S. The health plan shall not count a period of creditable coverage
22 with respect to enrollment of an individual if, after the most recent period
23 of creditable coverage and before the enrollment date, sixty-three
24 consecutive days lapse during all of which the individual was not covered
25 under any creditable coverage. The health plan shall not include in the
26 determination of the period of continuous coverage described in this section
27 any period that an individual is in a waiting period for health insurance
28 coverage offered by a health care insurer or is in a waiting period for
29 benefits under a health benefit plan offered by a health plan. In
30 determining the extent to which an individual has satisfied any portion of
31 any applicable preexisting condition period the health plan shall count a
32 period of creditable coverage without regard to the specific benefits covered
33 during that period. A health plan shall not impose any preexisting condition
34 exclusion in the case of an individual who is covered under creditable
35 coverage thirty-one days after the individual's date of birth. A health plan
36 shall not impose any preexisting condition exclusion in the case of a child
37 who is adopted or placed for adoption before age eighteen and who is covered
38 under creditable coverage thirty-one days after the adoption or placement for
39 adoption.

40 T. A health plan shall provide the certification described in
41 subsection U of this section without charge for creditable coverage occurring
42 after June 30, 1996 if the individual:

43 1. Ceases to be covered under a health benefit plan offered by a
44 health plan or otherwise becomes covered under a COBRA continuation

1 provision. A person who is covered by a health benefit plan that is offered
2 by a health plan and that is terminated or not renewed at the choice of the
3 employer with the replacement of the health benefit plan without a break in
4 coverage is not entitled to receive the certification prescribed in this
5 paragraph but is entitled to receive the certifications prescribed in
6 subsection U of this section.

7 2. Who was covered under a COBRA continuation provision ceases to be
8 covered under the COBRA continuation provision.

9 3. Requests certification from the health plan within twenty-four
10 months after the coverage under a health benefit plan offered by a health
11 plan ceases.

12 U. The certification provided by a health plan is a written
13 certification of:

14 1. The period of creditable coverage of the individual under the
15 health plan and any applicable coverage under a COBRA continuation provision.

16 2. Any applicable waiting period or affiliation period imposed on an
17 individual for any coverage under the health plan.

18 V. A health plan that issues health benefit plans in this state, as
19 applicable, shall issue and accept a written certification of the period of
20 creditable coverage of the individual that contains at least the following
21 information:

22 1. The date that the certificate is issued.

23 2. The name of the individual or dependent for whom the certificate
24 applies and any other information that is necessary to allow the issuer
25 providing the coverage specified in the certificate to identify the
26 individual, including the individual's identification number under the policy
27 and the name of the policyholder if the certificate is for or includes a
28 dependent.

29 3. The name, address and telephone number of the issuer providing the
30 certificate.

31 4. The telephone number to call for further information regarding the
32 certificate.

33 5. One of the following:

34 (a) A statement that the individual has at least eighteen months of
35 creditable coverage. For purposes of this subdivision, eighteen months means
36 five hundred forty-six days.

37 (b) Both the date that the individual first sought coverage, as
38 evidenced by a substantially complete application, and the date that
39 creditable coverage began.

40 6. The date creditable coverage ended, unless the certificate
41 indicates that creditable coverage is continuing from the date of the
42 certificate.

43 W. In addition to written certification of the period of creditable
44 coverage as described in this section, individuals may establish creditable

1 coverage through the presentation of documents or other means. In order to
2 make a determination that is based on the relevant facts and circumstances
3 of the amount of creditable coverage that an individual has, a health plan
4 shall take into account all information that the plan obtains or that is
5 presented to the plan on behalf of the individual.

6 X. A health plan shall provide any certification pursuant to this
7 section at the same time the health plan sends the notice required by the
8 applicable COBRA continuation provision. A health plan has satisfied the
9 certification requirement under this section if the health plan offering the
10 health benefit plan provides the prescribed certification in accordance with
11 this section within thirty days after the event that triggered the issuance
12 of the certification. Periods of creditable coverage for an individual are
13 established by presentation of the certifications in this section.

14 Y. Enrollees are eligible for medically necessary breast
15 reconstructions following a mastectomy performed by a contracted health plan
16 pursuant to this section.

17 Sec. 61. Section 36-2912.04, Arizona Revised Statutes, is amended to
18 read:

19 36-2912.04. Definitions

20 For the purposes of sections 36-2912, 36-2912.01, 36-2912.02 and
21 36-2912.03, unless the context otherwise requires:

22 1. "COBRA continuation provision" means:

23 (a) Section 4980B, except subsection (f)(1) as it relates to pediatric
24 vaccines, of the internal revenue code of 1986.

25 (b) Title I, subtitle B, part 6, except section 609, of the employee
26 retirement income security act of 1974.

27 (c) Title XXII of the public health service act.

28 (d) Any similar provision of the law of this state or any other state.

29 2. "Creditable coverage" means coverage solely for an individual,
30 other than limited benefits coverage, under any of the following:

31 (a) An employee welfare benefit plan that provides medical care to
32 employees or the employees' dependents directly or through insurance,
33 reimbursement or otherwise pursuant to the employee retirement income
34 security act of 1974.

35 (b) A church plan as defined in the employee retirement income
36 security act of 1974.

37 (c) A health benefits plan issued by a health plan as defined in
38 section 20-2301.

39 (d) Part A or part B of title XVIII of the social security act.

40 (e) Title XIX of the social security act, other than coverage
41 consisting solely of benefits under section 1928.

42 (f) Title 10, chapter 55 of the United States Code.

43 (g) A medical care program of the Indian health service or of a tribal
44 organization.

1 (h) A health benefits risk pool operated by any state of the United
2 States.

3 (i) A health plan offered pursuant to title 5, chapter 89 of the
4 United States Code.

5 (j) A public health plan as defined by federal law.

6 (k) A health benefit plan pursuant to section 5(e) of the peace corps
7 act (22 United States Code section 2504(e)).

8 (l) A policy or contract, including short-term limited duration
9 insurance, issued on an individual basis by an insurer, a health care
10 services organization, a hospital service corporation, a medical service
11 corporation or a hospital, medical, dental and optometric service corporation
12 or made available to persons defined as eligible under section 36-2901,
13 paragraph 4-6, subdivisions ~~(d), (e), (f) and (g)~~ (b), (c), (d) AND (e).

14 (m) A policy or contract issued by a health care insurer or a health
15 plan to a member of a bona fide association.

16 3. "Full-time employee" means a person who works for an employer for
17 a minimum of thirty-two hours per week or is self-employed for at least
18 thirty-two hours per week.

19 4. "Genetic information" means information about genes, gene products
20 and inherited characteristics that may derive from the individual or a family
21 member, including information regarding carrier status and information
22 derived from laboratory tests that identify mutations in specific genes or
23 chromosomes, physical medical examinations, family histories and direct
24 analysis of genes or chromosomes.

25 5. "Health benefit plan" means coverage offered under this section.

26 6. "Health status-related factor" means any factor in relation to the
27 health of the individual or a dependent of the individual enrolled or to be
28 enrolled in a health plan including:

29 (a) Health status.

30 (b) Medical condition, including physical and mental illness.

31 (c) Claims experience.

32 (d) Receipt of health care.

33 (e) Medical history.

34 (f) Genetic information.

35 (g) Evidence of insurability, including conditions arising out of acts
36 of domestic violence as defined in section 20-448.

37 (h) The existence of a physical or mental disability.

38 7. "Late enrollee" means an employee or dependent who requests
39 enrollment in a health benefit plan after the initial enrollment period that
40 is provided under the terms of the health benefit plan if the initial
41 enrollment period is at least thirty-one days. Coverage for a late enrollee
42 begins on the date the person becomes a dependent if a request for enrollment
43 is received within thirty-one days after the person becomes a dependent. An
44 employee or dependent shall not be considered a late enrollee if:

1 (a) The person:

2 (i) At the time of the initial enrollment period was covered under a
3 public or private health insurance policy or any other health benefits plan.

4 (ii) Lost coverage under a public or private health insurance policy
5 or any other health benefit plan due to the employee's termination of
6 employment or eligibility, the reduction in the number of hours of
7 employment, the termination of the other plan's coverage, the death of the
8 spouse, legal separation or divorce or the termination of employer
9 contributions toward the coverage.

10 (iii) Requests enrollment within thirty-one days after the termination
11 of creditable coverage that is provided under a COBRA continuation provision.

12 (iv) Requests enrollment within thirty-one days after the date of
13 marriage.

14 (b) The person is employed by an employer that offers multiple health
15 benefits plans and the person elects a different plan during an open
16 enrollment period.

17 (c) The person becomes a dependent of a covered person through
18 marriage, birth, adoption or placement for adoption and requests enrollment
19 no later than thirty-one days after becoming a dependent.

20 8. "Organization" means an entity developed by the administration
21 pursuant to section 36-2912, subsection A.

22 9. "Preexisting condition" means a condition, regardless of the cause
23 of the condition, for which medical advice, diagnosis, care or treatment was
24 recommended or received within not more than six months before the date of
25 the enrollment of the individual under a health benefit plan issued by a
26 health plan. A genetic condition is not a preexisting condition in the
27 absence of a diagnosis of the condition related to the genetic information
28 and shall not result in a preexisting condition limitation or preexisting
29 condition exclusion.

30 10. "Preexisting condition limitation" or "preexisting condition
31 exclusion" means a limitation or exclusion of benefits for a preexisting
32 condition under a health benefit plan offered by a health plan.

33 11. "Small employer" means an employer who employs at least one but not
34 more than fifty eligible employees on a typical business day during any one
35 calendar year.

36 12. "Taft-Hartley trust" means a jointly-managed trust, as allowed by
37 29 United States Code sections 141 through 187, that contains a plan of
38 benefits for employees and that is negotiated in a collective bargaining
39 agreement governing the wages, hours and working conditions of the employees,
40 as allowed by 29 United States Code section 157.

41 13. "Waiting period" means the period that must pass before a potential
42 participant or beneficiary in a health benefit plan offered by a health plan
43 is eligible to be covered for benefits as determined by the individual's
44 employer.

1 Sec. 62. Section 36-2913, Arizona Revised Statutes, is amended to
2 read:

3 36-2913. Systems funds; funding

4 A. The Arizona health care cost containment system fund, long-term
5 care system fund and the third party liability fund are established. The
6 funds shall be used to pay administrative and program costs associated with
7 the operation of the system established pursuant to this article and the
8 long-term care system established pursuant to article 2 of this chapter.

9 B. Separate accounts, including but not limited to a reserve fund, may
10 be established within the funds. Different accounts within the funds shall
11 be established in order to separately account for expense and income activity
12 associated with the system established pursuant to this article and article
13 2 of this chapter.

14 C. The Arizona health care cost containment system fund and long-term
15 care system fund shall be comprised of:

16 1. Monies paid by each of the counties of this state of the amounts
17 determined or withheld by the state treasurer pursuant to section 11-292.

18 ~~2. Monies received pursuant to section 36-2905.01, subsection f.~~

19 ~~3.~~ 2. Monies paid by each county resolving to participate in the
20 system equal to the actual cost, as limited by the board of supervisors,
21 together with employee contributions of providing hospitalization and medical
22 care under the system to full-time officers and employees of the county and
23 its departments and agencies.

24 ~~4.~~ 3. Monies paid by this state equal to the actual cost, as limited
25 by section 38-651, together with employee contributions of providing
26 hospitalization and medical care under the system to full-time officers and
27 employees of this state, of its departments and agencies and of cities, towns
28 and school districts of this state.

29 ~~5.~~ 4. Monies drawn against appropriations made by this state for the
30 costs of operating the Arizona health care cost containment system or the
31 long-term care system. Monies shall be drawn against appropriations and
32 transferred from the fund from which they were appropriated on an as needed
33 basis only.

34 ~~6.~~ 5. Gifts, donations and grants from any source.

35 ~~7.~~ 6. Federal monies made available to this state for the operation
36 of the Arizona health care cost containment system or the long-term care
37 system.

38 ~~8.~~ 7. Interest paid on monies deposited in the fund.

39 ~~9.~~ 8. Monies paid by the owners of eligible businesses in this state,
40 including employee contributions, for the actual cost of providing
41 hospitalization and medical care under the system to their full-time
42 employees together with interest paid on monies deposited in the fund.
43 Administrative costs of the system to operate the eligible businesses program
44 are subject to legislative appropriation.

1 ~~10.~~ 9. Reimbursements for data collection.

2 D. The third party liability fund is comprised of monies paid by third
3 party payors and lien and estate recoveries.

4 E. All monies in the funds other than monies appropriated by the state
5 shall not lapse.

6 F. All monies drawn against appropriations made by this state
7 remaining in the funds at the end of the fiscal year shall revert to the fund
8 from which they were appropriated and drawn, and the appropriation shall
9 lapse in accordance with section 35-190. Notwithstanding the provisions of
10 section 35-191, subsection B, the period for administrative adjustments shall
11 extend for only six months for appropriations made for system covered
12 services.

13 G. Notwithstanding sections 35-190 and 35-191, all approved claims for
14 system covered services presented after the close of the fiscal year in which
15 they were incurred shall be paid either in accordance with subsection F of
16 this section or in the current fiscal year with the monies available in the
17 funds established by this section.

18 H. Claims for system covered services which THAT are determined valid
19 by the director pursuant to section 36-2904, subsection H and the
20 department's grievance and appeal procedure shall be paid from the funds
21 established by this section.

22 I. For purposes of this section, system covered services exclude
23 administrative charges for operating expenses.

24 J. All payments for claims from the funds established by this section
25 shall be accounted for by the administration by the fiscal year in which the
26 claims were incurred, regardless of the fiscal year in which the payments
27 were made.

28 K. Notwithstanding any other law, county owned or contracted providers
29 are subject to all claims processing and payment requirements or limitations
30 of this chapter which THAT are applicable to non-county NONCOUNTY providers.

31 Sec. 63. Section 36-2915, Arizona Revised Statutes, is amended to
32 read:

33 36-2915. Lien of administration on damages recovered by injured
34 person; perfection, recording, assignment and notice
35 of lien

36 A. The administration is entitled to a lien for the charges for
37 hospital or medical care and treatment of an injured person for which the
38 administration or a provider CONTRACTOR is responsible, on any and all claims
39 of liability or indemnity for damages accruing to the person to whom hospital
40 or medical service is rendered, or to the legal representative of such
41 person, on account of injuries giving rise to such claims and which
42 necessitated such hospital or medical care and treatment.

43 B. In order to perfect a lien granted by this section, the director
44 or his THE DIRECTOR'S authorized representative shall, before or within sixty

1 days from the date of notification to the administration of the hospital
2 discharge or rendering of medical care and treatment, SHALL record in the
3 office of the recorder of the county in which the injuries were incurred a
4 verified statement in writing setting forth the name and address of the
5 patient as they appear on the records of the administration, the name and
6 address of the administration, the dates of admission to and discharge of the
7 patient from the hospital or the dates on which medical care and treatment
8 were provided to the patient, the amount estimated to be due for hospital or
9 medical care and treatment, and, to the best of the director's knowledge, the
10 names and addresses of all persons, firms or corporations and their insurance
11 carriers alleged by the injured person or his THAT PERSON'S legal
12 representative to be liable for damages arising from the injuries for which
13 he was hospitalized or for which medical care and treatment were provided.
14 However, the director or his THE DIRECTOR'S authorized representative is not
15 required to include the address of the patient in the verified statement if
16 the administration's records indicate that the patient's injuries may have
17 resulted from an offense against the patient as defined in section 13-105.
18 The director or his THE DIRECTOR'S authorized representative shall also,
19 within five days after recording the lien, SHALL mail a copy of the lien,
20 postage prepaid, to the patient and to each person, firm or corporation,
21 including insurance carriers, alleged to be liable for liability or indemnity
22 damages, at the address given in the statement. The recording of the lien
23 is notice of the lien to all persons, firms or corporations, including
24 insurance carriers, liable for liability or indemnity damages, whether or not
25 they are named in the lien.

26 C. The recorder shall endorse on a lien recorded as provided by this
27 section the date and hour of receipt and such facts as are necessary to
28 indicate that it has been recorded.

29 D. The lien may be assigned in whole or in part to a provider which
30 CONTRACTOR THAT is responsible for hospital or medical services.

31 E. The director shall establish by rule procedures for a provider
32 CONTRACTOR and a nonprovider NONCONTRACTING PROVIDER to notify the
33 administration concerning the delivery of hospital or medical services to a
34 person who may have claims for damages.

35 F. Notwithstanding any other law, a lien or claim provided for by this
36 article has priority over a lien of the department of economic security
37 pursuant to section 36-596.01, a lien of the counties pursuant to section
38 11-291, a health care provider lien pursuant to title 33, chapter 7, article
39 3 and a claim against a third party payor, including a claim or lien for
40 medical expenses incurred by an applicant that were deducted from the
41 calculation of income pursuant to section 11-297, subsection E or section
42 36-2905, subsection E. A lien of the department of economic security
43 pursuant to section 36-596.01 and a lien of the counties pursuant to section
44 11-291 has priority over a health care provider lien pursuant to title 33,

1 chapter 7, article 3 and a claim against a third party payor, ~~including a~~
2 ~~claim or lien for medical expenses incurred by an applicant that were~~
3 ~~deducted from the calculation of income pursuant to section 11-297,~~
4 ~~subsection E or section 36-2905, subsection E.~~

5 G. A lien authorized pursuant to this chapter may be amended to
6 reflect current charges. However, if the administration is given notice of
7 an impending settlement of the patient's MEMBER'S claim at least fifteen
8 working days prior to BEFORE the final settlement of that claim, the lien may
9 not be amended after the time of final settlement.

10 H. A public entity shall compromise a claim it has pursuant to this
11 section or section 11-291, 12-962, 36-596, 36-596.01, 36-2903, 36-2935 or
12 36-2956 if, after considering the factors listed in subsection I of this
13 section, the compromise provides a settlement of the claim which THAT is fair
14 and equitable.

15 I. In determining the extent of the compromise of the claim required
16 by subsection H of this section, the public entity shall consider the
17 following factors:

18 1. The nature and extent of the patient's injury or illness.

19 2. The sufficiency of insurance or other sources of indemnity
20 available to the patient.

21 3. Any other factor relevant for a fair and equitable settlement under
22 the circumstances of a particular case.

23 J. Notwithstanding any other law, for the purpose of recovering monies
24 from third party payors as provided by this section, a lien that includes a
25 cover sheet pursuant to subsection K of this section and that is filed by an
26 entity under contract with the administration, a health plan or a program
27 contractor, or the authorized representatives of these entities, is
28 considered filed by the state for the purposes of payment of county recorder
29 fees pursuant to section 11-475, subsection A, paragraph 3.

30 K. A health plan, a program contractor, an entity under contract with
31 the administration or an authorized representative of the health plan,
32 program contractor or entity shall include a cover sheet, as prescribed by
33 the administration, when filing a lien on behalf of the administration
34 pursuant to this section. The cover sheet shall be signed by the director
35 on the administration's letterhead with the statutory authority of the health
36 plan, program contractor, entity or authorized representative of the health
37 plan, program contractor or entity to file a lien on behalf of the
38 administration.

39 Sec. 64. Section 36-2917, Arizona Revised Statutes, is amended to
40 read:

41 36-2917. Review committees; immunity; confidentiality;
42 definition

43 A. Any person who, in good faith and without malice and in connection
44 with duties or functions of a review committee of the system, takes an action

1 or makes a decision or recommendation as a member, agent or employee of a
2 review committee of the system or related to the duties or functions of a
3 review committee of the system or who furnishes records, information or
4 assistance that is related to the duties of a review committee is not subject
5 to liability for civil damages in consequence of that action. The court
6 shall determine the presence of malice by clear and convincing evidence. This
7 section does not relieve a person of liability that arises from that person's
8 medical treatment of a patient.

9 B. The information considered by a review committee of the system or
10 related to the duties or functions of a review committee of the system and
11 the records of their actions and proceedings are confidential and are not
12 subject to subpoena or order to produce except as provided in subsection C
13 of this section and in proceedings before an appropriate state licensing or
14 certifying agency. A member of a review committee of the system or its staff
15 engaged in assisting such committee or any other person assisting or
16 furnishing information to such committee shall not be subpoenaed to testify
17 in any judicial or quasi-judicial proceeding if the subpoena is based solely
18 on those activities.

19 C. This section does not affect a patient's claim to privilege or
20 prevent the subpoena of a patient's medical records that are otherwise
21 subject to discovery. The contents and records of review committee
22 procedures are confidential and inadmissible in court.

23 D. Information considered by a review committee of the system and the
24 records of its actions and proceedings may be transmitted by the director to
25 an appropriate state licensing or certifying agency. Information considered
26 by a review committee of the system or related to the duties or functions of
27 a review committee of the system and the records of its actions and
28 proceedings ~~which~~ THAT are used pursuant to subsection B of this section or
29 transmitted pursuant to this subsection by a state licensing or certifying
30 agency shall be kept confidential and shall be subject to the same provisions
31 concerning discovery and use in legal actions as are the original information
32 and records in the possession and control of a review committee of the system
33 or related to the duties and functions of a review committee of the system.

34 E. ~~Nothing contained in This section shall be construed to~~ DOES NOT
35 prevent the director from supervising or monitoring providers CONTRACTORS as
36 otherwise provided for in this chapter or rules adopted pursuant to this
37 chapter.

38 F. ~~As used in~~ FOR THE PURPOSES OF this section, "review committee of
39 the system" means any organizational structure of the administration, or of
40 a provider CONTRACTOR contracting with the administration pursuant to section
41 36-2906, the purpose of which is one or more of the following:

- 42 1. To evaluate and improve the quality of health care.

1 2. To review and investigate the conduct of licensed health care
2 providers in order to determine whether disciplinary action should be
3 imposed.

4 3. To encourage proper and efficient utilization of health care
5 services and facilities.

6 Sec. 65. Section 36-2918, Arizona Revised Statutes, is amended to
7 read:

8 36-2918. Prohibited acts; penalties; subpoena power

9 A. ~~No~~ A person may NOT present or cause to be presented to this state
10 or to a provider that contracts with the administration pursuant to section
11 ~~36-2904~~, subsection A CONTRACTOR:

12 1. A claim for a medical or other item or service that the person
13 knows or has reason to know was not provided as claimed.

14 2. A claim for a medical or other item or service that the person
15 knows or has reason to know is false or fraudulent.

16 3. A claim for payment ~~which~~ THAT the person knows or has reason to
17 know may not be made by the system because:

18 (a) The person was terminated or suspended from participation in the
19 program on the date for which the claim is being made.

20 (b) The item or service claimed is substantially in excess of the
21 needs of the individual or of a quality that fails to meet professionally
22 recognized standards of health care.

23 (c) The patient was not a member on the date for which the claim is
24 being made.

25 4. A claim for a physician's service or an item or service incidental
26 to a physician's service, by a person who knows or has reason to know that
27 the individual who furnished or supervised the furnishing of the service:

28 (a) Was not licensed as a physician.

29 (b) Obtained ~~his~~ THE license through a misrepresentation of material
30 fact.

31 (c) Represented to the patient at the time the service was furnished
32 that the physician was certified in a medical specialty by a medical
33 specialty board if the individual was not certified.

34 5. A request for payment ~~which~~ THAT the person knows or has reason to
35 know is in violation of an agreement between the person and this state or the
36 administration.

37 B. A person who violates a provision of subsection A of ~~this section~~
38 is subject, in addition to any other penalties that may be prescribed by
39 FEDERAL OR STATE law, to a civil penalty of not to exceed two thousand
40 dollars for each item or service claimed and is subject to an assessment of
41 not to exceed twice the amount claimed for each item or service.

42 C. The director or ~~his~~ THE DIRECTOR'S designee shall make the
43 determination to assess civil penalties and is responsible for the collection
44 of penalty and assessment amounts. The director shall adopt rules that

1 prescribe procedures for the determination and collection of civil penalties
2 and assessments. Civil penalties and assessments imposed under this section
3 may be compromised by the director or his THE DIRECTOR'S designee in
4 accordance with criteria established in rules. The director or his
5 DIRECTOR'S designee may make this determination in the same proceeding to
6 exclude the person from system participation.

7 D. A person adversely affected by a determination of the director or
8 his THE DIRECTOR'S designee under this section may appeal that decision in
9 accordance with provider grievance provisions set forth in rule. The final
10 decision is subject to judicial review in accordance with title 12, chapter
11 7, article 6.

12 E. Amounts recovered under this section shall be deposited in the
13 state general fund. The amount of such penalty or assessment may be deducted
14 from any amount then or later owing by the administration or this state to
15 the person against whom the penalty or assessment has been imposed.

16 F. If a civil penalty or assessment imposed pursuant to subsection C
17 ~~of this section~~ is not paid, this state or the administration shall file an
18 action to collect the civil penalty or assessment in the superior court in
19 Maricopa county. Matters that were raised or could have been raised in a
20 hearing before the director or in an appeal pursuant to title 12, chapter 7,
21 article 6 may not be raised as a defense to the civil action. An action
22 brought pursuant to this subsection shall be initiated within six years after
23 the date the claim was presented.

24 G. PURSUANT TO AN INVESTIGATION OF PROHIBITED ACTS OR FRAUD AND ABUSE
25 INVOLVING THE SYSTEM, THE DIRECTOR, AND ANY PERSON DESIGNATED BY THE DIRECTOR
26 IN WRITING, MAY EXAMINE ANY PERSON UNDER OATH AND ISSUE A SUBPOENA TO ANY
27 PERSON TO COMPEL THE ATTENDANCE OF A WITNESS. THE ADMINISTRATION BY SUBPOENA
28 MAY COMPEL THE PRODUCTION OF ANY RECORD IN ANY FORM NECESSARY TO SUPPORT AN
29 INVESTIGATION OR AN AUDIT. THE ADMINISTRATION SHALL SERVE THE SUBPOENAS IN
30 THE SAME MANNER AS SUBPOENAS IN A CIVIL ACTION. IF THE SUBPOENAED PERSON
31 DOES NOT APPEAR OR DOES NOT PRODUCE THE RECORD, THE DIRECTOR OR THE
32 DIRECTOR'S DESIGNEE BY AFFIDAVIT MAY APPLY TO THE SUPERIOR COURT IN THE
33 COUNTY IN WHICH THE CONTROVERSY OCCURRED AND THE COURT IN THAT COUNTY SHALL
34 PROCEED AS THOUGH THE FAILURE TO COMPLY WITH THE SUBPOENA HAD OCCURRED IN AN
35 ACTION IN THE COURT IN THAT COUNTY.

36 Sec. 66. Section 36-2918.01, Arizona Revised Statutes, is amended to
37 read:

38 36-2918.01. Duty to report fraud or abuse; immunity

39 A. All contractors, ~~providers~~ SUBCONTRACTED PROVIDERS OF CARE and
40 ~~nonproviders~~ NONCONTRACTING PROVIDERS shall ~~advise~~ NOTIFY the director or the
41 director's designee immediately in a written report of any cases of suspected
42 fraud or abuse. The director shall review the report and conduct a
43 preliminary investigation to determine if there is sufficient basis to
44 warrant a full investigation. If the findings of a preliminary investigation

1 give the director reason to believe that an incident of fraud or abuse has
2 occurred, the matter shall be referred to the attorney general.

3 B. Any person making a complaint or furnishing a report, information
4 or records in good faith pursuant to this section is immune from any civil
5 liability by reason of that action unless that person has been charged with
6 or is suspected of the fraud or abuse reported.

7 C. Any provider CONTRACTOR, SUBCONTRACTED PROVIDER OF CARE OR
8 NONCONTRACTING PROVIDER who fails to report pursuant to this section commits
9 an act of unprofessional conduct and is subject to disciplinary action by the
10 provider's licensing APPROPRIATE PROFESSIONAL REGULATORY board or department.

11 Sec. 67. Section 36-2920, Arizona Revised Statutes, is amended to
12 read:

13 36-2920. Monthly financial report

14 A. The director shall submit a monthly report to the president of the
15 senate and the speaker of the house of representatives of the following:

16 1. The actual year to date expenditures and projected annual
17 expenditures.

18 2. The actual member months by rate code.

19 3. The actual ~~case load~~ CASELOAD, showing separately the ~~case load~~
20 CASELOAD for categorical, medically needy, medically indigent TITLE XIX and
21 qualified medicare beneficiary populations.

22 4. The number of vacant positions, by division.

23 5. Monies recovered monthly from third party payors.

24 6. Monies received under agreements pursuant to section 36-2925 and
25 the actual year to date expenditures.

26 B. The report shall be submitted on or before the twenty-fifth day of
27 the following month.

28 Sec. 68. Section 36-2921, Arizona Revised Statutes, is amended to
29 read:

30 36-2921. Tobacco tax allocation

31 A. Subject to the availability of monies in the medically needy
32 account established pursuant to section 36-774 the administration shall use
33 the monies in the account in the following order:

34 ~~1. The administration shall withdraw the amount necessary to pay the~~
35 ~~state share of costs for providing health care services to any person who is~~
36 ~~eligible pursuant to section 36-2901, paragraph 4, subdivisions (a), (c) and~~
37 ~~(h) and who becomes eligible for a heart, lung, heart-lung, liver or~~
38 ~~autologous and allogeneic bone marrow transplant pursuant to section 36-2907,~~
39 ~~subsection A, paragraph 11, subdivision (d) as determined by the~~
40 ~~administrator and to any person who is eligible pursuant to section 36-2901,~~
41 ~~paragraph 4, subdivision (b) and who becomes eligible for a lung or~~
42 ~~heart-lung transplant pursuant to section 36-2907, subsection A, paragraph~~
43 ~~11, subdivision (b), as determined by the administrator.~~

1 ~~2.~~ 1. Beginning on August 1, 1995 and on the first day of each month
2 until July 1, 1998, the sum of one million two hundred fifty thousand dollars
3 shall be transferred from the medically needy account to the medical services
4 stabilization fund for uses as prescribed in section 36-2922.

5 ~~3.~~ 2. The administration shall withdraw the sum of nine million two
6 hundred fifty-one thousand one hundred dollars in fiscal year 1998-1999 for
7 deposit in the children's health insurance program fund established by
8 section 36-2995 to pay the state share of the children's health insurance
9 program established pursuant to article 4 of this chapter.

10 ~~4.~~ 3. From and after August 1, 1995 and each year thereafter, the
11 administration shall transfer the following monies to the department of
12 health services to be allocated as follows if the department awards a
13 contract:

14 (a) Five million dollars, for the mental health grant program
15 established pursuant to section 36-3414.

16 (b) Six million dollars, for primary care services established
17 pursuant to section 36-2907.05.

18 (c) Five million dollars, for grants to the qualifying community
19 health centers established pursuant to section 36-2907.06, subsection A.

20 ~~5.~~ 4. The administration shall transfer up to five hundred thousand
21 dollars for fiscal years 1997-1998, 1998-1999 and 1999-2000 for pilot
22 programs providing detoxification services in counties having a population
23 of five hundred thousand persons or less according to the most recent United
24 States decennial census.

25 ~~6.~~ 5. The administration shall transfer up to two hundred fifty
26 thousand dollars annually for fiscal years 1995-1996, 1996-1997, 1997-1998,
27 1998-1999 and 1999-2000 for telemedicine pilot programs designed to
28 facilitate the provision of medical services to persons living in medically
29 underserved areas as provided in section 36-2352.

30 ~~7.~~ 6. The administration shall transfer up to two hundred fifty
31 thousand dollars annually beginning in fiscal year 1996-1997 for contracts
32 by the department of health services with nonprofit organizations that
33 primarily assist in the management of end stage renal disease and related
34 problems. Contracts shall not include payments for transportation of
35 patients for dialysis.

36 ~~8.~~ 7. Contingent on the existence of a premium sharing demonstration
37 project fund, beginning October 1, 1996 and until September 30, 1999, the
38 administration shall withdraw the sum of twenty million dollars in each of
39 fiscal years 1996-1997, 1997-1998 and 1998-1999 for deposit in the premium
40 sharing demonstration project fund established by section 36-2923 to provide
41 health care services to any person who is eligible for an Arizona health care
42 cost containment system premium sharing demonstration program enacted by the
43 legislature. The Arizona health care cost containment system premium sharing
44 demonstration program enacted by the legislature shall not be an entitlement

1 program. Beginning on October 1, 1997, the administration shall annually
2 withdraw monies from the medically needy account not to exceed four per cent
3 of the sum of any monies transferred pursuant to this paragraph for
4 administrative costs associated with the premium sharing demonstration
5 project. Administrative costs in excess of two per cent shall be funded from
6 the interest payments from the twenty million dollars withdrawn from the
7 medically needy account to fund the premium sharing program pursuant to this
8 paragraph.

9 ~~9.~~ 8. Subject to the availability of monies, the Arizona health care
10 cost containment system administration shall transfer to the department of
11 health services up to five million dollars in fiscal years 1996-1997 and
12 1997-1998 and two million five hundred thousand dollars in fiscal year
13 1998-1999 for providing nonentitlement funding for a basic children's medical
14 services program established by section 36-2907.08. The administration may
15 also withdraw and transfer to the department amounts for program evaluation
16 and for administrative costs as prescribed in section 36-2907.08.

17 ~~10.~~ 9. Subject to the availability of monies, the sum of one million
18 dollars shall be transferred annually to the health crisis fund for use as
19 prescribed in section 36-797.

20 ~~11.~~ 10. Subject to the availability of monies, the Arizona health care
21 cost containment system administration shall transfer to the aging and adult
22 administration in the department of economic security the sum of five hundred
23 thousand dollars annually beginning in fiscal year 1997-1998 for services
24 provided pursuant to section 46-192, subsection A, paragraph 4. Services
25 shall be used for persons who meet the low income eligibility criteria
26 developed by the aging and adult administration.

27 ~~12.~~ 11. Subject to the availability of monies, the Arizona health care
28 cost containment system administration shall transfer to the department of
29 health services the sum of two hundred thousand dollars annually beginning
30 in fiscal year 1998-1999 for contracts entered into pursuant to section
31 36-132, subsection D, with hospitals that are licensed by the department of
32 health services and that perform nonrenal organ transplant operations. These
33 contracts shall not include payments for transportation to and from treatment
34 facilities.

35 ~~13.~~ 12. Subject to the availability of monies, the Arizona health care
36 cost containment system administration shall annually transfer to the
37 department of health services the sum of one hundred eleven thousand two
38 hundred dollars to implement the rural private primary care provider loan
39 repayment program established pursuant to section 36-2174. The department
40 shall not use these monies for administrative costs. The transfers made
41 pursuant to this paragraph are exempt from the provisions of section 35-190
42 relating to lapsing of appropriations.

1 B. The department of health services shall establish an accounting
2 procedure to ensure that all funds transferred pursuant to this section are
3 maintained separately from any other funds.

4 C. The administration shall annually withdraw monies from the
5 medically needy account in the amount necessary to reimburse the department
6 of health services for administrative costs to implement each program
7 established pursuant to subsection A of this section not to exceed four per
8 cent of the amount transferred for each program.

9 D. The administration shall annually withdraw monies from the
10 medically needy account in the amount necessary to reimburse the department
11 of health services for the evaluations as prescribed by section 36-2907.07.

12 ~~E. The administration shall annually report, no later than November~~
13 ~~1, to the director of the joint legislative budget committee the annual~~
14 ~~revenues deposited in the medically needy account and the estimated~~
15 ~~expenditures needed in the subsequent year to provide funding for services~~
16 ~~provided in subsection A, paragraph 1 of this section. The administration~~
17 ~~shall immediately report to the director of the joint legislative budget~~
18 ~~committee if at any time the administration estimates that the amount~~
19 ~~available in the medically needy account will not be sufficient to fund the~~
20 ~~maximum allocations established in this section.~~

21 Sec. 69. Section 36-2922, Arizona Revised Statutes, is amended to
22 read:

23 36-2922. Medical services stabilization fund; definition

24 A. Subject to the availability of monies as prescribed in section
25 36-2921, the medical services stabilization fund is established. The
26 administration shall administer the fund as directed by the joint legislative
27 budget committee pursuant to subsection E of this section.

28 B. The fund shall be used only to offset increases in the cost of
29 providing levels of services established pursuant to this article provided
30 ~~to persons who are determined to be medically indigent pursuant to section~~
31 ~~11-297, medically needy pursuant to section 36-2905 or low income children~~
32 ~~pursuant to section 36-2905.03 as authorized pursuant to this section.~~

33 C. Notwithstanding chapter 6, article 8 of this title, the fund may
34 also be used to offset increases in the cost of providing levels of services
35 established pursuant to this article to persons eligible for those services
36 pursuant to section 36-2901, paragraph 4-6, subdivision (b) (a) if the
37 increase results from a decrease in federal funding for levels of service
38 including a decrease in the federal match rate for levels of service provided
39 to persons eligible pursuant to section 36-2901, paragraph 4-6, subdivision
40 (b) (a).

41 D. If, during a fiscal year, the administration determines that the
42 amount the legislature appropriated for that fiscal year for services
43 provided to persons who are determined to be eligible for services pursuant
44 to section 36-2901, paragraph 4-6, subdivision (a), (b), (c) or (h) is

1 insufficient to pay for unanticipated increases in the cost of providing
2 those services, the administration shall provide written notice of the
3 deficiency to the chairperson of the joint legislative budget committee and
4 the director of the governor's office of strategic planning and budgeting
5 with evidence supporting the determination of deficiency.

6 E. On receiving notice under subsection D of this section, the
7 chairperson of the joint legislative budget committee shall call a public
8 committee meeting to review the evidence of the deficiency presented by the
9 administration. After reviewing the evidence, the committee may recommend
10 to the administration to withdraw an amount from the fund that is equal to
11 the deficiency to pay the increases in the cost of providing levels of
12 service.

13 F. For the purposes of this section "levels of service" means the
14 provider payment methodology, eligibility criteria and covered services
15 established pursuant to this article and in effect on July 1, 1993.

16 Sec. 70. Section 36-2923, Arizona Revised Statutes, is amended to
17 read:

18 36-2923. Premium sharing demonstration project fund; purpose;
19 expenditures; nonlapsing; investment; definition

20 A. A premium sharing demonstration project fund is established for
21 costs associated with an Arizona health care cost containment system premium
22 sharing demonstration project that is to provide uninsured persons access to
23 medical services provided by system providers. The fund consists of monies
24 deposited from the medically needy account of the tobacco tax and health care
25 fund pursuant to section 36-2921, subsection A, paragraph 8-7 and premiums
26 collected from demonstration project participants. The administration shall
27 administer the fund as a continuing appropriation.

28 B. Beginning on October 1, 1997, if a premium sharing demonstration
29 project is established, the administration shall spend monies in the fund
30 through the first quarter of fiscal year 2001-2002 to cover demonstration
31 project expenditures. The administration may continue to make expenditures
32 from the fund, subject to the availability of monies in the fund, for
33 covering program costs incurred but not processed by the administration
34 during the fiscal years in which the program officially operated.

35 C. The director may withdraw not more than seventy-five thousand
36 dollars from the fund for the fifteen month period beginning July 1, 1996 and
37 ending September 30, 1997 to cover administrative expenditures related to the
38 development of a premium sharing demonstration project proposal or any
39 premium sharing demonstration project analysis requested by a committee of
40 the legislature.

41 D. Monies in the fund are continuously appropriated through September
42 30, 2001 and are exempt from the provisions of section 35-190 relating to
43 lapsing of appropriations, except that all unexpended and unencumbered monies

1 remaining on October 1, 2002 revert to the medically needy account of the
2 tobacco tax and health care fund.

3 E. On notice from the administrator, the state treasurer shall invest
4 and divest monies in the fund as provided by section 35-313, and monies
5 earned from investment shall be credited to the fund.

6 F. For purposes of this section, unless otherwise noted, "fund" means
7 the premium sharing demonstration project fund.

8 Sec. 71. Title 36, chapter 29, article 1, Arizona Revised Statutes,
9 is amended by adding section 36-2928, to read:

10 36-2928. Budget neutrality compliance fund; nonlapsing

11 A. THE BUDGET NEUTRALITY COMPLIANCE FUND IS ESTABLISHED CONSISTING OF
12 THIRD PARTY LIABILITY RECOVERIES PURSUANT TO SECTION 36-2913, COUNTY
13 CONTRIBUTIONS DEPOSITED PURSUANT TO SECTION 11-292, SUBSECTION P AND SECTION
14 11-300, SUBSECTION D AND APPROPRIATIONS. THE ADMINISTRATION SHALL ADMINISTER
15 THE FUND. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED AND DO NOT REVERT
16 TO THE STATE GENERAL FUND.

17 B. ON NOTICE FROM THE ADMINISTRATION, THE STATE TREASURER SHALL INVEST
18 AND DIVEST MONIES IN THE FUND AS PROVIDED BY SECTION 35-313, AND MONIES
19 EARNED FROM INVESTMENT SHALL BE CREDITED TO THE ARIZONA TOBACCO LITIGATION
20 SETTLEMENT FUND ESTABLISHED BY SECTION 36-2901.02.

21 C. THE ADMINISTRATION SHALL USE ANY REMAINING FUND MONIES TO PAY FOR
22 EXPENDITURES MADE PURSUANT TO SECTION 36-2901.02, SUBSECTION B, PARAGRAPH 1
23 IF SUFFICIENT MONIES ARE NOT AVAILABLE IN THE ARIZONA TOBACCO LITIGATION
24 SETTLEMENT FUND ESTABLISHED BY SECTION 36-2901.02, EXCEPT THAT THE
25 ADMINISTRATION SHALL USE FUND MONIES DEPOSITED PURSUANT TO SECTION 11-292,
26 SUBSECTION Q FOR ANY DIRECT AND INDIRECT ELIGIBILITY COSTS ASSOCIATED WITH
27 THE EXPANSION OF PROGRAM SERVICES.

28 D. ON OR BEFORE JUNE 30 OF EACH YEAR, THE ADMINISTRATION SHALL
29 TRANSFER FROM THE ARIZONA TOBACCO LITIGATION SETTLEMENT FUND ESTABLISHED BY
30 SECTION 36-2901.02 AN AMOUNT NECESSARY TO REIMBURSE THE FUND ESTABLISHED
31 PURSUANT TO THIS SECTION FOR ITS EXPENDITURES MADE TO COVER COSTS ASSOCIATED
32 WITH THE EXPANDED DEFINITION OF ELIGIBILITY PURSUANT TO SECTION 36-2901.01.

33 E. NOTWITHSTANDING SUBSECTION C OF THIS SECTION, IN FISCAL YEAR
34 2001-2002, THE ADMINISTRATION SHALL USE FIFTY-THREE MILLION SEVEN HUNDRED
35 THOUSAND DOLLARS OF FUND MONIES FOR MAINTENANCE OF EFFORT FOR THE STATE MATCH
36 FOR PERSONS WHO ARE DETERMINED ELIGIBLE PURSUANT TO SECTION 36-2901.01 OR
37 36-2901.04. BEGINNING IN FISCAL YEAR 2002-2003 AND EACH FISCAL YEAR
38 THEREAFTER, THE ADMINISTRATION SHALL ADJUST THIS AMOUNT FOR INFLATION BASED
39 ON THE GDP PRICE DEFLATOR AS DEFINED IN SECTION 41-563.

40 Sec. 72. Section 36-2934, Arizona Revised Statutes, is amended to
41 read:

1 36-2934. Eligibility criteria; qualifications for coverage;
2 liquidation of assets

3 A. A person meets the eligibility criteria of this article AND THE
4 SECTION 1115 WAIVER if the person satisfies one of the following:

5 1. Is eligible pursuant to section 36-2901, paragraph 4- 6,
6 subdivision (b) (a), ITEM (i) OR (ii) on the date of application for medical
7 assistance under this article AND MEETS THE RESOURCE REQUIREMENTS PRESCRIBED
8 BY FEDERAL LAW.

9 2. Would be eligible for supplemental security income for the aged,
10 blind or disabled or aid to families with dependent children but is not
11 receiving cash payment.

12 3. Would be eligible for supplemental security income for the aged,
13 blind or disabled or ~~aid to families with dependent children~~ UNDER SECTION
14 1931(b) OF THE SOCIAL SECURITY ACT except for his THE PERSON'S institutional
15 status.

16 4. Is in a medical institution for a period of not less than thirty
17 consecutive days and except for his THE PERSON'S income he THE PERSON would
18 be eligible for supplemental security income for the aged, blind or disabled
19 or aid to families with dependent children and his THE PERSON'S gross income
20 prior to BEFORE deductions does not exceed three hundred per cent of the
21 supplemental security income benefit rate established by section 1611(b)(1)
22 of the social security act.

23 5. Would be eligible for medical assistance under the state plan if
24 he THE PERSON was institutionalized and a determination has been made that
25 except for the provision of home and community based services he THE PERSON
26 would require the level of care provided in a hospital, skilled nursing
27 facility or intermediate care facility.

28 B. In addition to meeting the requirements of subsection A of this
29 section, a person may not have, within the time specified in federal law
30 before filing an application for eligibility pursuant to section 36-2933,
31 transferred or assigned for less than fair consideration assets as defined
32 by federal law for the purpose of meeting the eligibility criteria pursuant
33 to this section. If a transfer or assignment occurred, the administration
34 may deny eligibility for a period in accordance with federal law. Transfers
35 that are permitted under federal law shall not serve to disqualify a person
36 from eligibility for services pursuant to this article. This subsection also
37 applies to persons who are eligible pursuant to section 36-2901, paragraph
38 4- 6, subdivision (b) (a) and who receive medical assistance under article
39 1 of this chapter.

40 C. In addition to meeting the requirements of subsection A, paragraph
41 3 of this section, the director may require that a person's net income shall
42 not exceed a state income standard established by the director, which is less
43 than three hundred per cent of the supplemental security income benefit rate
44 established by section 1611 of the social security act.

1 D. Notwithstanding any other provision of this section, a person shall
2 not receive services under this article who is not eligible pursuant to title
3 XIX of the social security act OR THE SECTION 1115 WAIVER.

4 E. The administration shall periodically review the eligibility
5 pursuant to this section of each member in accordance with federal law.

6 F. The administration shall determine a person's eligibility pursuant
7 to this section within the time periods required or allowed by federal law.

8 G. An applicant shall provide the administration with a statement in
9 accordance with federal law containing at least the following information:

10 1. The amount of personal and real property in which the applicant has
11 an interest.

12 2. All income which THAT the applicant received during the period
13 immediately prior to BEFORE application.

14 3. Any assets as defined by federal law assigned or transferred by the
15 applicant within the time prescribed by federal law immediately prior to
16 BEFORE filing the application for eligibility pursuant to section 36-2933.

17 4. Any further information the director by rule requires to determine
18 eligibility.

19 H. A designated representative, as defined pursuant to rules adopted
20 by the director, or a public employee who prepares and signs, or assists in
21 preparing, an application for benefits under this article on behalf of an
22 applicant is not civilly liable for good faith acts and omissions.

23 Sec. 73. Section 36-2935, Arizona Revised Statutes, is amended to
24 read:

25 36-2935. Estate recovery program; liens

26 The director shall adopt rules in accordance with state and federal law
27 to allow the administration to file a claim against a member's estate to
28 recover paid assistance. The administration is also entitled to a lien on
29 a member's property to recover paid assistance the member receives. As
30 nearly as is possible, the administration shall recover charges pursuant to
31 the procedures prescribed in sections 36-2915 and 36-2916. If both the
32 administration and a county have valid liens for paid assistance provided to
33 the same member, the value of the property shall be divided between the
34 administration and the county pro rata according to the amounts of their
35 respective liens. The administration shall impose liens in a manner
36 consistent with federal law. This section also applies to persons who are
37 eligible pursuant to section 36-2901, paragraph 4- 6, subdivision (b) (a) and
38 who receive medical assistance under article 1 of this chapter.

39 Sec. 74. Section 36-2939, Arizona Revised Statutes, is amended to
40 read:

41 36-2939. Long-term care system services

42 A. The following services shall be provided by the program contractors
43 to members determined to need institutional services pursuant to this
44 article:

1 1. Nursing facility services other than services in an institution for
2 tuberculosis or mental disease.

3 2. Notwithstanding any other law, behavioral health services if these
4 services are not duplicative of long-term care services provided as of
5 January 30, 1993 under this subsection and are authorized by the program
6 contractor through the long-term care case management system. If the
7 administration is the program contractor, the administration may authorize
8 these services.

9 3. Hospice services. For the purposes of this paragraph "hospice"
10 means a program of palliative and supportive care for terminally ill members
11 and their families or caregivers.

12 4. Case management services as provided in section 36-2938.

13 5. Health and medical services as provided in section 36-2907.

14 B. In addition to the services prescribed in subsection A of this
15 section, the department, as a program contractor, shall provide the following
16 services if appropriate to members who are defined as developmentally
17 disabled pursuant to section 36-551 and are determined to need institutional
18 services pursuant to this article:

19 1. Intermediate care facility for mental retardation services for a
20 member who has a developmental disability as defined in section 36-551. For
21 purposes of this article, such facility shall meet all federally approved
22 standards and may only include the Arizona training program facilities, a
23 state owned and operated service center, state owned or operated community
24 residential settings or existing licensed facilities operated by this state
25 or under contract with the department on or before July 1, 1988.

26 2. Home and community based services which may be provided in a
27 member's home or an alternative residential setting as prescribed in section
28 36-591 or other behavioral health alternative residential facilities licensed
29 by the department of health services and approved by the director of the
30 Arizona health care cost containment system administration and which may
31 include:

32 (a) Home health, which means the provision of nursing services or home
33 health aide services or medical supplies, equipment and appliances, which are
34 provided on a part-time or intermittent basis by a licensed home health
35 agency within a member's residence based on a physician's orders and in
36 accordance with federal law. Physical therapy, occupational therapy, or
37 speech and audiology services provided by a home health agency may be
38 provided in accordance with federal law. Beginning on July 1, 1998, home
39 health agencies shall comply with federal bonding requirements in a manner
40 prescribed by the administration.

41 (b) Home health aide, which means a service that provides intermittent
42 health maintenance, continued treatment or monitoring of a health condition
43 and supportive care for activities of daily living provided within a member's
44 residence.

1 (c) Homemaker, which means a service that provides assistance in the
2 performance of activities related to household maintenance within a member's
3 residence.

4 (d) Personal care, which means a service that provides assistance to
5 meet essential physical needs within a member's residence.

6 (e) Developmentally disabled day care, which means a service that
7 provides planned care supervision and activities, personal care, activities
8 of daily living skills training and habilitation services in a group setting
9 during a portion of a continuous twenty-four hour period.

10 (f) Habilitation, which means the provision of physical therapy,
11 occupational therapy, speech or audiology services or training in independent
12 living, special developmental skills, sensory-motor development, behavior
13 intervention, and orientation and mobility in accordance with federal law.

14 (g) Respite care, which means a service that provides short-term care
15 and supervision available on a twenty-four hour basis.

16 (h) Transportation, which means a service that provides or assists in
17 obtaining transportation for the member.

18 (i) Other services OR LICENSED OR CERTIFIED SETTINGS approved by the
19 director.

20 C. In addition to services prescribed in subsection A of this section,
21 home and community based services may be provided in a member's home, in an
22 adult foster care home as prescribed in section 36-401, in an assisted living
23 home or a residential unit as defined in section 36-401 or in a level one or
24 level two behavioral health alternative residential facility approved by the
25 director by program contractors to all members who are not defined as
26 developmentally disabled pursuant to section 36-551 and are determined to
27 need institutional services pursuant to this article. The director may also
28 approve other licensed residential facilities as appropriate on a case by
29 case basis for traumatic brain injured members. Home and community based
30 services may include the following:

31 1. Home health, which means the provision of nursing services or home
32 health aide services or medical supplies, equipment and appliances, which are
33 provided on a part-time or intermittent basis by a licensed home health
34 agency within a member's residence based on a physician's orders and in
35 accordance with federal law. Physical therapy, occupational therapy, or
36 speech and audiology services provided by a home health agency may be
37 provided in accordance with federal law. Beginning on July 1, 1998, home
38 health agencies shall comply with federal bonding requirements in a manner
39 prescribed by the administration.

40 2. Home health aide, which means a service that provides intermittent
41 health maintenance, continued treatment or monitoring of a health condition
42 and supportive care for activities of daily living provided within a member's
43 residence.

1 3. Homemaker, which means a service that provides assistance in the
2 performance of activities related to household maintenance within a member's
3 residence.

4 4. Personal care, which means a service that provides assistance to
5 meet essential physical needs within a member's residence.

6 5. Adult day health, which means a service that provides planned care
7 supervision and activities, personal care, personal living skills training,
8 meals and health monitoring in a group setting during a portion of a
9 continuous twenty-four hour period. Adult day health may also include
10 preventive, therapeutic and restorative health related services that do not
11 include behavioral health services.

12 6. Habilitation, which means the provision of physical therapy,
13 occupational therapy, speech or audiology services or training in independent
14 living, special developmental skills, sensory-motor development, behavior
15 intervention, and orientation and mobility in accordance with federal law.

16 7. Respite care, which means a service that provides short-term care
17 and supervision available on a twenty-four hour basis.

18 8. Transportation, which means a service that provides or assists in
19 obtaining transportation for the member.

20 9. Home delivered meals, which means a service that provides for a
21 nutritious meal containing at least one-third of the recommended dietary
22 allowance for an individual and which is delivered to the member's residence.

23 10. Other services OR LICENSED OR CERTIFIED SETTINGS approved by the
24 director.

25 D. The amount of money expended by program contractors on home and
26 community based services pursuant to subsection C of this section shall be
27 limited by the director in accordance with the federal monies made available
28 to this state for home and community based services pursuant to subsection
29 C of this section. The director shall establish methods for the allocation
30 of monies for home and community based services to program contractors and
31 shall monitor expenditures on home and community based services by program
32 contractors.

33 E. Notwithstanding subsections A, B, C and F of this section, no
34 service may be provided that does not qualify for federal monies available
35 under title XIX of the social security act OR THE SECTION 1115 WAIVER.

36 F. In addition to services provided pursuant to subsections A, B and
37 C of this section, the director may implement a demonstration project to
38 provide home and community based services to special populations, including
39 disabled persons who are eighteen years of age or younger, medically fragile,
40 reside at home and would be eligible for supplemental security income for the
41 aged, blind or disabled or the state supplemental payment program, except for
42 the amount of their parent's income or resources. In implementing this
43 project, the director may provide for parental contributions for the care of
44 their child.

1 Sec. 75. Section 36-2971, Arizona Revised Statutes, is amended to
2 read:

3 36-2971. Definitions

4 In this article, unless the context otherwise requires:

5 1. "Administration" means the Arizona health care cost containment
6 system administration.

7 2. "CONTRACTOR" MEANS A PERSON OR ENTITY THAT HAS A PREPAID CAPITATED
8 CONTRACT WITH THE ADMINISTRATION PURSUANT TO SECTION 36-2904 TO PROVIDE
9 HEALTH CARE TO MEMBERS UNDER THIS ARTICLE EITHER DIRECTLY OR THROUGH
10 SUBCONTRACTS WITH PROVIDERS.

11 ~~3.~~ 3. "Department" means the department of economic security.

12 ~~4.~~ 4. "Director" means the director of the Arizona health care cost
13 containment system administration.

14 ~~5.~~ 5. "Dual eligible" means a person who is determined eligible
15 pursuant to this article and who is also determined eligible pursuant to
16 section 36-2901, paragraph 4- 6, subdivision (b) (a) or section 36-2931,
17 paragraph 5.

18 ~~5.~~ "Eligible person" means a person who is defined as a qualified
19 medicare beneficiary pursuant to section 1905(p) of title XIX of the social
20 security act and whose income does not exceed one hundred per cent of the
21 federal poverty guidelines.

22 ~~6.~~ "Federal poverty guidelines" means the guidelines published
23 annually by the United States department of health and human services.

24 ~~7.~~ 6. "Member" means an eligible person who enrolls in the system AND
25 WHO IS DEFINED AS A QUALIFIED MEDICARE BENEFICIARY PURSUANT TO SECTION
26 1905(p) OF TITLE XIX OF THE SOCIAL SECURITY ACT AND WHOSE INCOME DOES NOT
27 EXCEED ONE HUNDRED PER CENT OF THE FEDERAL POVERTY GUIDELINES.

28 ~~8.~~ 7. "Noncontracting provider" means a person who provides services
29 as prescribed in section 36-2939 and who does not have a subcontract with a
30 CONTRACTOR OR program contractor.

31 ~~9.~~ "Nonprovider" means a person who provides hospital or medical
32 services as prescribed in section 36-2907 and who does not have a contract
33 or subcontract within the system.

34 ~~10.~~ 8. "Primary care physician" means a physician who is a family
35 practitioner, general practitioner, pediatrician, general internist, or
36 obstetrician or gynecologist.

37 ~~11.~~ 9. "Primary care practitioner" means a nurse practitioner
38 certified pursuant to title 32, chapter 15 or a physician assistant certified
39 pursuant to title 32, chapter 25. Nothing in This paragraph shall DOES NOT
40 expand the scope of practice for nurse practitioners as defined pursuant to
41 title 32, chapter 15, or for physician assistants as defined pursuant to
42 title 32, chapter 25.

1 chapter. Services shall be delivered in accordance with program waivers
2 granted by the health care financing administration FEDERAL LAW AND THE
3 SECTION 1115 WAIVER for articles 1 and 2 of this chapter.

4 C. The administration shall coordinate benefits provided under this
5 article to members so that costs for services payable by the system are costs
6 avoided or recovered from a third party payor. The director may require that
7 providers, nonproviders, program contractors, CONTRACTORS and noncontracting
8 providers are responsible for the coordination of benefits for services
9 provided pursuant to this article. Benefit coordination requirements for
10 noncontracting providers and nonproviders are limited to coordination of
11 benefits with standard health insurance and disability or medicare
12 supplemental health insurance policies and similar programs for health
13 coverage. The director shall require members to assign to the system rights
14 to all types of medical benefits to which the member is entitled.

15 D. Notwithstanding section 36-2911, the administration PROGRAM
16 CONTRACTORS OR CONTRACTORS shall coordinate the payment of PAY all premiums,
17 deductibles and coinsurance amounts for the member to obtain coverage or
18 secure services as required by title XIX of the social security act, as
19 amended by section 4501 of the omnibus budget reconciliation act of 1990 THE
20 ADMINISTRATION. For members not enrolled with a provider CONTRACTOR or
21 program contractor the administration may pay the premiums, deductibles and
22 coinsurance amounts.

23 Sec. 77. Section 36-2973, Arizona Revised Statutes, is amended to
24 read:

25 36-2973. Qualified medicare beneficiary only; eligibility
26 determination; application; enrollment

27 A. The administration shall determine the eligibility of all eligible
28 persons APPLICANTS who are MAY BE ELIGIBLE AS qualified medicare
29 beneficiaries only. The administration shall ensure that the calculation of
30 income and resource eligibility requirements is in accordance with the
31 amendments to title XIX of the social security act, as set forth in title III
32 of the medicare catastrophic coverage act of 1988 and the omnibus budget
33 reconciliation act of 1990 FEDERAL LAW AND THE SECTION 1115 WAIVER. On
34 determination of qualified medicare beneficiary only eligibility, the
35 administration shall enroll the eligible person MEMBER in the system.

36 B. The administration may enroll the eligible person MEMBER who has
37 been determined eligible as a qualified medicare beneficiary only in a
38 fee-for-service arrangement or with a provider. The director may enter into
39 a contract with a medicare risk contractor which THAT, in accordance with
40 section 1876 of the social security act, has a contract with the health care
41 financing administration and may pay premiums for enrollment of that eligible
42 person MEMBER.

43 C. ~~If a person who is enrolled in the system pursuant to section~~
44 ~~36-2905 or 11-297 is determined eligible pursuant to this section, the~~

1 ~~person's eligibility pursuant to section 36-2901, paragraph 4, subdivisions~~
2 ~~(a) and (c) shall be terminated and the person is entitled to receive title~~
3 ~~XVIII services only.~~

4 Sec. 78. Section 36-2974, Arizona Revised Statutes, is amended to
5 read:

6 36-2974. Dual eligibles; qualifications for coverage;
7 enrollment

8 A. For purposes of this section all providers CONTRACTORS and program
9 contractors are required to provide services to members.

10 B. For a member who is dually eligible the director may implement a
11 policy permitting a choice of providers CONTRACTORS or program contractors
12 to the extent ~~he~~ THE DIRECTOR deems feasible consistent with program waivers
13 THE SECTION 1115 WAIVER and federal law. If the director does not implement
14 a choice of provider CONTRACTOR policy, ~~he~~ THE DIRECTOR may enroll the
15 member, at the time eligibility is determined, with an available provider
16 CONTRACTOR or program contractor located in the geographic area of the
17 member's residence.

18 C. The department shall assist the administration in the screening of
19 all persons who are applying to become eligible pursuant to section 36-2901,
20 paragraph 4- 6, subdivision (b) (a) and who are entitled to services under
21 title XVIII but not title XVI of the social security act to determine if the
22 person meets the eligibility criteria of this section. If a person is
23 determined to be eligible pursuant to section 36-2901, paragraph 4- 6,
24 subdivision (b) (a) and this article, the administration shall make the
25 person dually eligible. On determination of dual eligibility the
26 administration shall enroll the person pursuant to this article and notify
27 the person of the dual eligibility.

28 D. The administration shall screen all persons who are entitled to
29 services under title XVIII of the social security act and who are applying
30 to become eligible pursuant to section 36-2901, paragraph 4- 6, subdivision
31 (b) (a), as prescribed by title XVI of the social security act or section
32 36-2931, paragraph 5, to determine if the person meets the eligibility
33 criteria of this section. If a person is determined to be eligible pursuant
34 to section 36-2901, paragraph 4- 6, subdivision (b) (a) or section 36-2931,
35 paragraph 5 and this article, the administration shall make the person dually
36 eligible. On determination of dual eligibility by the administration, the
37 administration shall enroll the person pursuant to this article and notify
38 the person of the dual eligibility.

39 E. Calculation of income and resource eligibility requirements by the
40 department and the administration pursuant to this section shall be in
41 accordance with title XIX of the social security act, as amended.

42 F. ~~Payment of PROGRAM CONTRACTORS AND CONTRACTORS SHALL PAY MEDICARE~~
43 ~~deductibles, and coinsurance AND COPAYMENT amounts for services provided to~~
44 ~~dual eligibles pursuant to this article is limited to AND AS REQUIRED BY THE~~

1 ADMINISTRATION FOR services that are provided by or under referral from a
2 primary care physician or primary care practitioner.

3 Sec. 79. Section 36-2975, Arizona Revised Statutes, is amended to
4 read:

5 36-2975. Specified low income medicare beneficiary; eligibility

6 The administration shall determine the eligibility of all persons who
7 are specified low income medicare beneficiaries in accordance with section
8 ~~4501 of the omnibus budget reconciliation act of 1990~~ FEDERAL LAW. The
9 administration shall pay the monthly premiums under part B of title XVIII of
10 the social security act on behalf of each specified low income medicare
11 beneficiary.

12 Sec. 80. Section 36-2976, Arizona Revised Statutes, is amended to
13 read:

14 36-2976. Qualifying individuals

15 A. The administration shall determine the eligibility of all persons
16 who are determined to be qualifying individuals pursuant to section 36-2971,
17 paragraphs ~~15~~ 12 and ~~16~~ 13.

18 B. The administration shall pay the medicare part B monthly premiums
19 on behalf of each qualifying individual 1 and shall pay the medicare part B
20 monthly amount that is attributable to home health coverage for each
21 qualifying individual 2.

22 Sec. 81. Section 36-2982, Arizona Revised Statutes, is amended to
23 read:

24 36-2982. Children's health insurance program; administration;
25 nonentitlement; enrollment limitation; eligibility

26 A. The children's health insurance program is established for children
27 who are eligible pursuant to section 36-2981, paragraph 6. The
28 administration shall administer the program. All covered services shall be
29 provided by health plans that have contracts with the administration pursuant
30 to section 36-2906, by a qualifying plan or by either tribal facilities or
31 the Indian health service for Native Americans who are eligible for the
32 program and who elect to receive services through the Indian health service
33 or a tribal facility.

34 B. This article does not create a legal entitlement for any applicant
35 or member who is eligible for the program. Total enrollment is limited based
36 on the annual appropriations made by the legislature and the enrollment cap
37 prescribed in section 36-2985.

38 C. Beginning on October 1, 1997, the director shall take all steps
39 necessary to implement the administrative structure for the program and to
40 begin delivering services to persons within sixty days after approval of the
41 state plan by the United States department of health and human services.

42 D. The administration shall perform eligibility determinations for
43 persons applying for eligibility and annual redeterminations for continued
44 eligibility pursuant to this article.

1 E. The administration shall adopt rules for the collection of
2 copayments from members whose income does not exceed one hundred fifty per
3 cent of the federal poverty level and for the collection of copayments and
4 premiums from members whose income exceeds one hundred fifty per cent of the
5 federal poverty level. The director shall adopt rules for disenrolling a
6 member if the member does not pay the premium required pursuant to this
7 section.

8 F. Before enrollment, a member, or if the member is a minor, that
9 member's parent or legal guardian, shall select an available health plan in
10 the member's geographic service area or a qualifying health plan offered in
11 the county, and may select a primary care physician or primary care
12 practitioner from among the available physicians and practitioners
13 participating with the contractor in which the member is enrolled. The
14 contractors shall only reimburse costs of services or related services
15 provided by or under referral from a primary care physician or primary care
16 practitioner participating in the contract in which the member is enrolled,
17 except for emergency services that shall be reimbursed pursuant to section
18 36-2987. The director shall establish requirements as to the minimum time
19 period that a member is assigned to specific contractors. ~~An eligible child,
20 or that child's parent or guardian, may elect to receive direct, sliding fee
21 scale medical and health care services from qualifying health centers
22 pursuant to section 36-2907.06, subsection G, and from hospitals pursuant to
23 section 36-2907.08. An eligible child, or that child's parent or guardian,
24 who elects direct services shall not be enrolled with a qualifying plan
25 unless the child, or that child's parent or guardian, elects to receive
26 services pursuant to this article.~~

27 G. Eligibility for the program shall be counted as creditable coverage
28 as defined in section 20-1379.

29 H. On application for eligibility for the program, the member, or if
30 the member is a minor, the member's parent or guardian, shall receive an
31 application for and a program description of the premium sharing
32 demonstration project if the member resides in a county chosen to participate
33 in that project.

34 I. Notwithstanding section 36-2983, the administration may purchase
35 for a member employer sponsored group health insurance with state and federal
36 monies available pursuant to this article, subject to any restrictions
37 imposed by the federal health care financing administration. This subsection
38 does not apply to members who are eligible for health benefits coverage under
39 a state health benefits plan based on a family member's employment with a
40 public agency in this state.

41 Sec. 82. Section 36-2983, Arizona Revised Statutes, is amended to
42 read:

1 36-2983. Eligibility for the program

2 A. The administration shall establish a streamlined eligibility
3 process for applicants to the program and shall issue a certificate of
4 eligibility at the time eligibility for the program is determined.
5 Eligibility shall be based on gross household income for a member as defined
6 in section 36-2981. The administration shall not apply a resource test in
7 the eligibility determination or redetermination process.

8 B. The administration shall use a simplified eligibility form that may
9 be mailed to the administration. Once a completed application is received,
10 including adequate verification of income, the administration shall expedite
11 the eligibility determination and enrollment on a prospective basis.

12 C. The date of eligibility is the first day of the month following a
13 determination of eligibility if the decision is made by the twenty-fifth day
14 of the month. A person who is determined eligible for the program after the
15 twenty-fifth day of the month is eligible for the program the first day of
16 the second month following the determination of eligibility.

17 ~~D. Each person who applies for services pursuant to section 11-297,~~
18 ~~36-2905 or 36-2905.03 shall be screened for potential eligibility for~~
19 ~~services provided pursuant to this article. If the person appears to be~~
20 ~~eligible for services the screening agency shall make a referral to the~~
21 ~~administration.~~

22 ~~E.~~ D. An applicant for the program who appears to be eligible
23 pursuant to section 36-2901, paragraph 4- 6, subdivision (b) (a) shall have
24 a social security number or shall apply for a social security number within
25 thirty days after the applicant submits an application for the program.

26 ~~F.~~ E. In order to be eligible for the program, a person shall be a
27 resident of this state and shall meet title XIX requirements for United
28 States citizenship or qualified alien status in the manner prescribed in
29 section 36-2903.03.

30 ~~G.~~ F. In determining the eligibility for all qualified aliens
31 pursuant to this article, the income and resources of a person who executed
32 an affidavit of support pursuant to section 213A of the immigration and
33 nationality act on behalf of the qualified alien and the income and resources
34 of the spouse, if any, of the sponsoring individual shall be counted at the
35 time of application and for the redetermination of eligibility for the
36 duration of the attribution period as specified in federal law.

37 ~~H.~~ G. Pursuant to federal law, a person is not eligible for the
38 program if that person is:

39 1. Eligible for title XIX or other federally operated or financed
40 health care insurance programs, except the Indian health service.

41 2. Covered by any group health plan or other health insurance coverage
42 as defined in section 2791 of the public health service act. Group health
43 plan or other health insurance coverage does not include coverage to persons

1 who are defined as eligible pursuant to section ~~36-2901~~, paragraph 4,
2 subdivision ~~(a)~~, ~~(c)~~ or ~~(h)~~ or the premium sharing program.

3 3. A member of a family that is eligible for health benefits coverage
4 under a state health benefit plan based on a family member's employment with
5 a public agency in this state.

6 4. An inmate of a public institution or a patient in an institution
7 for mental diseases. This paragraph does not apply to services furnished in
8 a state operated mental hospital or to residential or other twenty-four hour
9 therapeutically planned structured services.

10 ~~f~~. H. A child who is covered under an employer's group health
11 insurance plan or through family or individual health care coverage shall not
12 be enrolled in the program. If the health insurance coverage is voluntarily
13 discontinued for any reason, except for the loss of health insurance due to
14 loss of employment or other involuntary reason, the child is not eligible for
15 the program for a period of six months from the date that the health care
16 coverage was discontinued.

17 ~~g~~. I. Pursuant to federal law, a private insurer, as defined by the
18 secretary of the United States department of health and human services, shall
19 not limit enrollment by contract or any other means based on the presumption
20 that a child may be eligible for the program.

21 Sec. 83. Section 36-2986, Arizona Revised Statutes, is amended to
22 read:

23 36-2986. Administration; powers and duties of director

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

27 1. Contract administration and oversight of contractors.

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

33 3. Establishment of peer review and utilization review functions for
34 all contractors.

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

36 5. Establishment and management of a comprehensive system for assuring
37 quality of care.

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

40 7. Development of an outreach program. The administration shall
41 coordinate with public and private entities to provide outreach services for
42 children under this article. Priority shall be given to those families who
43 are moving off welfare. Outreach activities shall include strategies to
44 inform communities, including tribal communities, about the program, ensure

1 a wide distribution of applications and provide training for other entities
2 to assist with the application process.

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

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

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

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

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

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

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

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

43 E. Subject to existing law relating to privilege and protection, the
44 director shall prescribe by rule the types of information that are

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

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

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

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

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

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

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

7 L. The director shall:

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

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

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

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

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

30 Sec. 84. Section 36-2987, Arizona Revised Statutes, is amended to
31 read:

32 36-2987. Reimbursement for the program

33 A. For inpatient hospital services, the administration shall reimburse
34 the Indian health service or a tribal facility for ~~inpatient hospital~~
35 services based on the reimbursement rates for the Indian health service as
36 published annually in the federal register. For outpatient services, the
37 administration shall reimburse the Indian health service or a tribal facility
38 based on the capped fee-for-service schedule established by the director. If
39 congress authorizes one hundred per cent pass-through of title XXI monies for
40 services provided in an Indian health service facility or a tribal facility,
41 the administration shall reimburse the Indian health service or the tribal
42 facility with this enhanced federal funding based on the reimbursement rates
43 for the Indian health service or the tribal facility as published annually
44 in the federal register.

1 B. Contractors shall reimburse inpatient and outpatient services based
2 on the reimbursement methodology established in section 36-2904 or the
3 hospital reimbursement pilot program established by this state.

4 C. For services rendered on and after October 1, 1998, the
5 administration and the contractors shall pay a hospital's rate established
6 according to this section subject to the following:

7 1. If the hospital's bill is paid within thirty days after the date
8 the bill was received, the administration shall pay ninety-nine per cent of
9 the rate.

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

13 3. If the hospital's bill is paid any time after sixty days after the
14 date the bill was received, the administration shall pay one hundred per cent
15 of the rate plus a fee of one per cent a month for each month or portion of
16 a month following the sixtieth day of receipt of the bill until the date of
17 payment.

18 D. The administration and the contractors shall pay claims pursuant
19 to the methodology, definitions and time frames specified for clean claims
20 in section 36-2904, subsection H.

21 E. The director shall specify enrollment procedures including notice
22 to contractors of enrollment. The administration shall specify in contract
23 when a person who has been determined eligible will be enrolled with a
24 contractor and the date on which the contractor will be financially
25 responsible for health and medical services to the person.

26 F. The director shall monitor any third party payment collections
27 collected by contractors and noncontracting providers according to the same
28 procedures specified for title XIX pursuant to section 36-2903.01, subsection
29 M- K.

30 G. On oral or written notice from the member, or the member's parent
31 or legal guardian, that the member, parent or legal guardian believes a claim
32 should be covered by the program, a contractor or noncontracting provider
33 shall not do either of the following unless the contractor or noncontracting
34 provider has verified through the administration that the person is
35 ineligible for the program, has not yet been determined eligible or, at the
36 time services were rendered, was not eligible or enrolled in the program:

37 1. Charge, submit a claim to or demand or otherwise collect payment
38 from a member or person who has been determined eligible.

39 2. Refer or report a member or person who has been determined eligible
40 to a collection agency or credit reporting agency for the failure of the
41 member or person who has been determined eligible to pay charges for covered
42 services unless specifically authorized by this article or rules adopted
43 pursuant to this article.

1 H. The administration may conduct postpayment review of all payments
2 made by the administration and may recoup any monies erroneously paid. The
3 director may adopt rules that specify procedures for conducting postpayment
4 review. Contractors may conduct a postpayment review of all claims paid to
5 providers and may recoup monies that are erroneously paid.

6 I. 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 program.

9 Sec. 85. Section 36-2989, Arizona Revised Statutes, is amended to
10 read:

11 36-2989. Covered health and medical services; modifications;
12 related delivery of service requirements

13 A. Except as provided in this section, the director shall establish
14 a specific health benefits coverage package that is as nearly as practicable
15 the same as the least expensive health benefits coverage plan or plans that
16 are offered through a health care services organization available to state
17 employees under section 38-651. The package shall include the following
18 covered services:

19 1. Inpatient hospital services that are ordinarily furnished by a
20 hospital for the care and treatment of inpatients, that are medically
21 necessary and that are provided under the direction of a physician or a
22 primary care practitioner. For the purposes of this paragraph, inpatient
23 hospital services exclude services in an institution for tuberculosis or
24 mental diseases unless authorized by federal law.

25 2. Outpatient health services that are medically necessary and
26 ordinarily provided in hospitals, clinics, offices and other health care
27 facilities by licensed health care providers. For the purposes of this
28 paragraph, "outpatient health services" includes services provided by or
29 under the direction of a physician or a primary care practitioner.

30 3. Other laboratory and X-ray services ordered by a physician or a
31 primary care practitioner.

32 4. Medications that are medically necessary and ordered on
33 prescription by a physician, a primary care practitioner or a dentist
34 licensed pursuant to title 32, chapter 11.

35 5. Medical supplies, equipment and prosthetic devices.

36 6. Treatment of medical conditions of the eye including one eye
37 examination each year for prescriptive lenses and the provision of one set
38 of prescriptive lenses each year for members.

39 7. Medically necessary dental services.

40 8. Well child services, immunizations and prevention services.

41 9. Family planning services that do not include abortion or abortion
42 counseling. If a contractor elects not to provide family planning services,
43 this election does not disqualify the contractor from delivering all other
44 covered health and medical services under this article. In that event, the

1 administration may contract directly with another contractor, including an
2 outpatient surgical center or a noncontracting provider, to deliver family
3 planning services to a member who is enrolled with a contractor who elects
4 not to provide family planning services.

5 10. Podiatry services that are performed by a podiatrist licensed
6 pursuant to title 32, chapter 7 and that are ordered by a primary care
7 physician or primary care practitioner.

8 11. Medically necessary pancreas, heart, liver, kidney, cornea, lung
9 and heart-lung transplants and autologous and allogeneic bone marrow
10 transplants and immunosuppressant medications for these transplants ordered
11 on prescription by a physician licensed pursuant to title 32, chapter 13 or
12 17.

13 12. Medically necessary emergency transportation.

14 13. Inpatient and outpatient behavioral health services. Inpatient
15 behavioral health services are limited to not more than thirty days for each
16 twelve month period from the date of initial enrollment or the
17 redetermination of eligibility. Outpatient behavioral services are limited
18 to not more than thirty visits for each twelve month period from the date of
19 initial enrollment or the redetermination of eligibility.

20 B. The administration shall pay noncontracting providers only for
21 health and medical services as prescribed in subsection A of this section.

22 C. To the extent possible and practicable, the administration and
23 contractors shall provide for the prior approval of medically necessary
24 services provided pursuant to this article.

25 D. The director shall make available home health services in lieu of
26 hospitalization pursuant to contracts awarded under this article.

27 E. Behavioral health services shall be provided to members through the
28 administration's intergovernmental agreement with the division of behavioral
29 health in the department of health services. The division of behavioral
30 health in the department of health services shall use its established
31 diagnostic and evaluation program for referrals of children who are not
32 already enrolled pursuant to this article and who may be in need of
33 behavioral health services. In addition to an evaluation, the division of
34 behavioral health shall also identify children who may be eligible under
35 section 36-2901, paragraph 4- 6, subdivision (b) (a) or section 36-2931,
36 paragraph 5 and shall refer the children to the appropriate agency
37 responsible for making the final eligibility determination. ~~Members who are~~
38 ~~eighteen years of age and who are not seriously mentally ill shall be~~
39 ~~referred to the contractors for behavioral health services.~~

40 F. The director shall adopt rules for the provision of transportation
41 services for members. Prior authorization is not required for medically
42 necessary ambulance transportation services rendered to members initiated by
43 dialing telephone number 911 or other designated emergency response systems.

1 G. The director may adopt rules to allow the administration to use a
2 second opinion procedure under which surgery may not be eligible for coverage
3 pursuant to this article without documentation as to need by at least two
4 physicians or primary care practitioners.

5 H. All health and medical services provided under this article shall
6 be provided in the ~~county of residence~~ GEOGRAPHIC SERVICE AREA of the member,
7 except:

8 1. Emergency services and specialty services.

9 2. The director may permit the delivery of health and medical services
10 in other than the ~~county of residence~~ GEOGRAPHIC SERVICE AREA in this state
11 or in an adjoining state if it is determined that medical practice patterns
12 justify the delivery of services in ~~other than the county of residence~~ or a
13 net reduction in transportation costs can reasonably be expected.
14 Notwithstanding section 36-2981, paragraph 8 or 11, if services are procured
15 from a physician or primary care practitioner in an adjoining state, the
16 physician or primary care practitioner shall be licensed to practice in that
17 state pursuant to licensing statutes in that state that are similar to title
18 32, chapter 13, 15, 17 or 25.

19 I. Covered outpatient services shall be subcontracted by a primary
20 care physician or primary care practitioner to other licensed health care
21 providers to the extent practicable for purposes of making health care
22 services available to underserved areas, reducing costs of providing medical
23 care and reducing transportation costs.

24 J. The director shall adopt rules that prescribe the coordination of
25 medical care for members and that include a mechanism to transfer members and
26 medical records and initiate medical care.

27 K. The director shall adopt rules for the reimbursement of specialty
28 services provided to the member if authorized by the member's primary care
29 physician or primary care practitioner.

30 Sec. 86. Repeal

31 Section 36-2997, Arizona Revised Statutes, is repealed.

32 Sec. 87. Section 36-3408, Arizona Revised Statutes, is amended to
33 read:

34 36-3408. Eligibility for behavioral health service system;
35 screening process; required information

36 A. Any person who requests behavioral health services pursuant to
37 this chapter or the person's parent or legal guardian shall comply with a
38 preliminary financial screening and eligibility process developed by the
39 department of health services in coordination with the Arizona health care
40 cost containment system administration and administered at the initial intake
41 level. If the results indicate that the person may be title XIX eligible,
42 in order to continue to receive services pursuant to this chapter, the
43 applicant shall submit a completed application within ten working days to the
44 social security administration, the department of economic security or the

1 Arizona health care cost containment system ADMINISTRATION, which shall
2 determine the applicant's eligibility pursuant to section 36-2901, paragraph
3 ~~4~~ 6, subdivision (b) (a) or section 36-2931, paragraph 5 for health and
4 medical or long-term care services. If the person is in need of emergency
5 services provided pursuant to this chapter, the person may begin to receive
6 these services immediately provided that within five days from the date of
7 service a financial screening is initiated.

8 B. Applicants, except applicants for seriously mentally ill services,
9 who refuse to cooperate in the financial screening and eligibility process
10 are not eligible for services pursuant to this chapter. A form explaining
11 loss of benefits due to refusal to cooperate shall be signed by the
12 applicant. Refusal to cooperate shall not be construed to mean the
13 applicant's inability to obtain documentation required for eligibility
14 determination.

15 C. The department of economic security shall, in coordination with the
16 department of health services, provide on-site eligibility determinations at
17 appropriate program locations subject to legislative appropriation.

18 D. This section only applies to persons who receive services that are
19 provided pursuant to this section and that are paid for in whole or in part
20 with state funds.

21 E. A person who requests treatment services under this chapter shall
22 provide personally identifying information required by the department of
23 health services.

24 Sec. 88. Section 36-3411, Arizona Revised Statutes, is amended to
25 read:

26 36-3411. Behavioral health services; timely reimbursement;
27 penalties

28 A. The division shall ensure that behavioral health service providers
29 are reimbursed within ninety days after the service provider submits a clean
30 claim to a regional behavioral health authority.

31 B. Any contract issued by or on behalf of the division for the
32 provision of behavioral health services shall include language outlining
33 provisions for penalties for noncompliance with contract requirements.

34 C. If the regional behavioral health authority does not reimburse a
35 provider as required by this section, the director shall subject the regional
36 behavioral health authority to the penalty provisions prescribed in the
37 contract which shall not exceed the interest charges prescribed in section
38 44-1201, subsection A. The director shall impose any financial penalties
39 levied upon the regional behavioral health authority through a reduction in
40 the amount of funds payable to the regional behavioral health authority for
41 administrative expenses.

42 D. The ninety day deadline imposed by this section is suspended while
43 a formal grievance regarding the legitimacy of a claim is pending.

1 E. The department or a regional behavioral health authority shall not
2 pay claims for covered services that are initially submitted more than nine
3 months after the date of the services for which payment is claimed or that
4 are submitted as clean claims more than twelve months after the date of
5 service for which payment is claimed. A person dissatisfied with the denial
6 of a claim by the department or by the regional behavioral health authority
7 has twelve months from the date of the service for which payment is claimed
8 to institute a grievance against the department or regional behavioral health
9 authority.

10 F. For claims paid by the department, either directly or through a
11 third party payor, the director may impose a penalty on a regional behavioral
12 health authority or a service provider who submits a claim to the department
13 for payment more than one time after the same claim had been previously
14 denied by the department without having attempted to address the reason given
15 for the denial. The penalty imposed by the director shall not exceed the
16 average cost incurred by the department for processing a claim and shall be
17 levied upon the regional behavioral health authority or service provider
18 through reducing any future payment or payments until the amount of the
19 penalty has been paid.

20 G. This section does not apply to services provided by a hospital
21 pursuant to section 36-2903.01, subsection ~~F~~ G or ~~F~~ H, or section 36-2904,
22 subsection ~~F~~ I or ~~K~~ J.

23 Sec. 89. Section 36-3414, Arizona Revised Statutes, is amended to
24 read:

25 36-3414. Medically needy account monies

26 A. Subject to the availability of monies as prescribed in section
27 36-2921, the Arizona health care cost containment system administration shall
28 enter into an intergovernmental agreement pursuant to title 11, chapter 7,
29 article 3, with the department to establish contracts to fund services to
30 indigent, uninsured or underinsured children, adults and seriously mentally
31 ill persons who do not meet the eligibility requirements of section 36-2901,
32 subsection ~~B~~, paragraph 4, SUBDIVISION (a). In administering the contracts,
33 the department:

34 1. Shall designate that tobacco tax and health care fund monies be
35 used to supplement funds appropriated, or otherwise available, for behavioral
36 health services to children, adults and the seriously mentally ill.

37 2. Shall give preference to those proposals that minimize expenditures
38 for administration and overhead and maximize the amount of funds available
39 for the delivery of direct care or services.

40 3. May fund either ongoing services or demonstration projects designed
41 to implement specific services on a trial basis or implement innovative means
42 for the delivery of services.

1 4. Shall require a contract established pursuant to this section
2 to be signed by the department and the contractor prior to the transmission
3 of any tobacco tax and health care fund monies to the contractor.

4 5. Shall adopt standards for the type and delivery of behavioral
5 health services to be provided pursuant to this section.

6 B. Contracts established pursuant to this section shall require
7 contractors to implement fee requirements pursuant to section 36-3409 and
8 submit information at the director's request that the director determines to
9 be necessary for the program evaluations required by section 36-2907.07.

10 Sec. 90. Section 41-1377, Arizona Revised Statutes, is amended to
11 read:

12 41-1377. Scope of investigations

13 A. On receiving a complaint the ombudsman-citizens aide may
14 investigate administrative acts of agencies that the ombudsman-citizens aide
15 has reason to believe may be:

16 1. Contrary to law.

17 2. Unreasonable, unfair, oppressive, arbitrary, capricious, an abuse
18 of discretion or unnecessarily discriminatory, even though they may be in
19 accordance with law.

20 3. Based on a mistake of fact.

21 4. Based on improper or irrelevant grounds.

22 5. Unsupported by an adequate statement of reasons.

23 6. Performed in an inefficient or discourteous manner.

24 7. Otherwise erroneous.

25 B. On receiving a complaint the ombudsman-citizens aide may
26 investigate to find an appropriate remedy.

27 C. On receiving a complaint the ombudsman-citizens aide may refuse to
28 investigate an administrative act of an agency that otherwise qualifies for
29 investigation under subsection A of this section if:

30 1. There is presently available an adequate remedy for the grievance
31 stated in the complaint.

32 2. The complaint relates to a matter that is outside the duties of the
33 ombudsman-citizens aide.

34 3. The complaint relates to an administrative act that the complainant
35 has had knowledge of for an unreasonable time period before filing the
36 complaint.

37 4. The complainant does not have a sufficient personal interest in the
38 subject matter of the complaint.

39 5. The complaint is trivial or made in bad faith.

40 6. The resources of the office of ombudsman-citizens aide are
41 insufficient to adequately investigate the complaint.

42 D. The ombudsman-citizens aide shall refuse to investigate complaints
43 filed by a person in the custody of the state department of corrections.

1 E. On receiving a complaint that involves confidential information as
2 defined in section 42-2001, the ombudsman-citizens aide shall either:

3 1. Work with the department of revenue problem resolution officer or
4 an employee of the department of revenue who is authorized to access
5 confidential taxpayer information.

6 2. Obtain a power of attorney from the taxpayer to access confidential
7 information specific to the complainant in a form acceptable to the
8 department of revenue.

9 F. On receiving a complaint that involves confidential information
10 relating to section 36-2903, subsection ~~J~~ I, section 36-2917, section
11 36-2932, subsection F or section 36-2972, the ombudsman-citizens aide shall
12 either:

13 1. Work with the Arizona health care cost containment system
14 administration employee who is authorized to access confidential information.

15 2. Obtain a power of attorney from the complainant to access
16 confidential information specific to the complainant in a form acceptable to
17 the Arizona health care cost containment system administration.

18 G. On receiving a complaint that involves confidential information
19 relating to sections 36-507, 36-509 and 36-2220, the ombudsman-citizens aide
20 shall either:

21 1. Work with the department of health services employee who is
22 authorized to access confidential information.

23 2. Obtain a power of attorney from the complainant to access
24 confidential information specific to the complainant in a form acceptable to
25 the department of health services.

26 Sec. 91. Section 41-1378, Arizona Revised Statutes, is amended to
27 read:

28 41-1378. Complaint; investigation; investigative authority;
29 violation; classification

30 A. All complaints shall be addressed to the ombudsman-citizens aide.
31 If an agency receives correspondence between a complainant and the
32 ombudsman-citizens aide, it shall hold that correspondence in trust and shall
33 promptly forward the correspondence, unopened, to the ombudsman-citizens
34 aide.

35 B. Within thirty days of receipt of the complaint, the
36 ombudsman-citizens aide shall notify the complainant of the decision to
37 investigate or not to investigate the complaint. If the ombudsman-citizens
38 aide decides not to investigate and if requested by the complainant, the
39 ombudsman-citizens aide shall provide the reasons for not investigating in
40 writing.

41 C. The ombudsman-citizens aide shall not charge any fees for
42 investigations or complaints.

43 D. In an investigation, the ombudsman-citizens aide may:

1 1. Make inquiries and obtain information considered necessary subject
2 to the restrictions in section 41-1377.

3 2. Enter without notice to inspect agency premises with agency staff
4 on the premises.

5 3. Hold hearings.

6 4. Notwithstanding any other law, have access to all state agency
7 records, including confidential records, except:

8 (a) Sealed court records without a subpoena.

9 (b) Active criminal investigation records.

10 (c) Records that could lead to the identity of confidential police
11 informants.

12 (d) Attorney work product and communications that are protected under
13 the attorney-client privilege.

14 (e) Confidential information as defined in section 42-2001 except as
15 provided in section 42-2003, subsection M.

16 (f) Information protected by section 6103(d), 6103(p)(8) or 7213 of
17 the internal revenue code.

18 (g) Confidential information relating to section 36-2903, subsection
19 ~~I~~, section 36-2917, section 36-2932, subsection F or section 36-2972.

20 (h) Confidential information relating to sections 36-507, 36-509 and
21 36-2220.

22 5. Issue subpoenas if necessary to compel the attendance and testimony
23 of witnesses and the production of books, records, documents and other
24 evidence to which the ombudsman-citizens aide may have access pursuant to
25 paragraph 4 of this subsection. The ombudsman-citizens aide may only issue
26 a subpoena if the ombudsman-citizens aide has previously requested testimony
27 or evidence and the person or agency to which the request was made has failed
28 to comply with the request in a reasonable amount of time.

29 E. It is contrary to the public policy of this state for any state
30 agency or any individual acting for a state agency to take any adverse action
31 against an individual in retaliation because the individual cooperated with
32 or provided information to the ombudsman-citizens aide or the
33 ombudsman-citizens aide's staff.

34 F. If requested by the complainants or witnesses, the
35 ombudsman-citizens aide shall maintain confidentiality with respect to those
36 matters necessary to protect the identities of the complainants or witnesses.
37 The ombudsman-citizens aide shall ensure that confidential records are not
38 disclosed by either the ombudsman-citizens aide or staff to the
39 ombudsman-citizens aide. The ombudsman-citizens aide shall maintain the
40 confidentiality of an agency record. With respect to requests made pursuant
41 to title 39, chapter 1, article 2 or other requests for information, the
42 ombudsman-citizens aide shall maintain all records THAT ARE RECEIVED FROM A
43 CUSTODIAL AGENCY in the same manner that ~~the ombudsman-citizens aide receives~~

1 ~~from the custodial agency as those on AS the custodial agency WOULD IF IT HAD~~
2 ~~RECEIVED THE REQUEST.~~

3 G. The ombudsman-citizens aide or any staff member or other employee
4 of the ombudsman-citizens aide who knowingly divulges or makes known in any
5 manner not permitted by law any particulars of any record, document or
6 information for which the law restricts disclosure is guilty of a class 5
7 felony.

8 Sec. 92. Section 41-1954, Arizona Revised Statutes, is amended to
9 read:

10 41-1954. Powers and duties

11 A. In addition to the powers and duties of the agencies listed in
12 section 41-1953, subsection D the department shall:

13 1. Administer the following services:

14 (a) Employment services, which shall include manpower programs and
15 work training, field operations, technical services, unemployment
16 compensation, community work and training and other related functions in
17 furtherance of programs under the social security act, as amended, the
18 Wagner-Peyser act, as amended, the federal unemployment tax act, as amended,
19 33 United States Code, the family support act of 1988 (P.L. 100-485) and
20 other related federal acts and titles.

21 (b) Individual and family services, which shall include a section on
22 aging, services to children, youth and adults and other related functions in
23 furtherance of social service programs under the social security act, as
24 amended, title IV, grants to states for aid and services to needy families
25 with children and for child-welfare services, title XX, grants to states for
26 services, the older Americans act, as amended, the family support act of 1988
27 (P.L. 100-485) and other related federal acts and titles.

28 (c) Income maintenance services, which shall include categorical
29 assistance programs, special services unit, child support collection
30 services, establishment of paternity services, maintenance and operation of
31 a state case registry of child support orders, a state directory of new
32 hires, a support payment clearinghouse and other related functions in
33 furtherance of programs under the social security act, title IV, grants to
34 states for aid and services to needy families with children and for
35 child-welfare services, title XX, grants to states for services, as amended,
36 and other related federal acts and titles.

37 (d) Rehabilitation services, which shall include vocational
38 rehabilitation services and sections for the blind and visually impaired,
39 communication disorders, correctional rehabilitation and other related
40 functions in furtherance of programs under the vocational rehabilitation act,
41 as amended, the Randolph-Sheppard act, as amended, and other related federal
42 acts and titles.

43 (e) Administrative services, which shall include the coordination of
44 program evaluation and research, interagency program coordination and

1 in-service training, planning, grants, development and management,
2 information, legislative liaison, budget, licensing and other related
3 functions.

4 (f) Manpower planning, which shall include a state manpower planning
5 council for the purposes of the federal-state-local cooperative manpower
6 planning system and other related functions in furtherance of programs under
7 the comprehensive employment and training act of 1973, as amended, and other
8 related federal acts and titles.

9 (g) Economic opportunity services, which shall include the furtherance
10 of programs prescribed under the economic opportunity act of 1967, as
11 amended, and other related federal acts and titles.

12 (h) Mental retardation and other developmental disability programs,
13 with emphasis on referral and purchase of services. The program shall
14 include educational, rehabilitation, treatment and training services and
15 other related functions in furtherance of programs under the developmental
16 disabilities services and facilities construction act, Public Law 91-517, and
17 other related federal acts and titles.

18 (i) Nonmedical home and community based services and functions
19 including department designated case management, housekeeping services, chore
20 services, home health aid, personal care, visiting nurse services, adult day
21 care or adult day health, respite sitter care, attendant care, home delivered
22 meals and other related services and functions.

23 2. Provide a coordinated system of initial intake, screening,
24 evaluation and referral of persons served by the department.

25 3. Adopt rules it deems necessary or desirable to further the
26 objectives and programs of the department.

27 4. Formulate policies, plans and programs to effectuate the missions
28 and purposes of the department.

29 5. Employ, determine the conditions of employment and prescribe the
30 duties and powers of administrative, professional, technical, secretarial,
31 clerical and other persons as may be necessary in the performance of its
32 duties, contract for the services of outside advisors, consultants and aides
33 as may be reasonably necessary and reimburse department volunteers,
34 designated by the director, for expenses in transporting clients of the
35 department on official business.

36 6. Make contracts and incur obligations within the general scope of
37 its activities and operations subject to the availability of funds.

38 7. Contract with or assist other departments, agencies and
39 institutions of the state, local and federal governments in the furtherance
40 of its purposes, objectives and programs.

41 8. Be designated as the single state agency for the purposes of
42 administering and in furtherance of each federally supported state plan.

1 9. Accept and disburse grants, matching funds and direct payments from
2 public or private agencies for the conduct of programs which are consistent
3 with the overall purposes and objectives of the department.

4 10. Provide information and advice on request by local, state and
5 federal agencies and by private citizens, business enterprises and community
6 organizations on matters within the scope of its duties subject to the
7 departmental rules on the confidentiality of information.

8 11. Establish and maintain separate financial accounts as required by
9 federal law or regulations.

10 12. Advise with and make recommendations to the governor and the
11 legislature on all matters concerning its objectives.

12 13. Have an official seal which shall be judicially noticed.

13 14. Annually estimate the current year's population of each county,
14 city and town in this state, using the periodic census conducted by the
15 United States department of commerce, or its successor agency, as the basis
16 for such estimates and deliver such estimates to the economic estimates
17 commission prior to BEFORE December 15.

18 15. Estimate the population of any newly annexed areas of a political
19 subdivision as of July 1 of the fiscal year in which the annexation occurs
20 and deliver such estimates as promptly as is feasible after the annexation
21 occurs to the economic estimates commission.

22 16. Establish and maintain a statewide program of services for persons
23 who are both hearing impaired and visually impaired and coordinate
24 appropriate services with other agencies and organizations to avoid
25 duplication of these services and to increase efficiency. The department of
26 economic security shall enter into agreements for the utilization of the
27 personnel and facilities of the department of economic security, the
28 department of health services and other appropriate agencies and
29 organizations in providing these services.

30 17. Establish and charge fees for deposit in the department of economic
31 security prelayoff assistance services fund to employers who voluntarily
32 participate in the services of the department which provide job service and
33 retraining for persons who have been or are about to be laid off from
34 employment. The department shall charge only those fees necessary to cover
35 the costs of administering the job service and retraining services.

36 18. Establish a focal point for addressing the issue of hunger in
37 Arizona and provide coordination and assistance to public and private
38 nonprofit organizations which aid hungry persons and families throughout this
39 state. Specifically such activities shall include:

40 (a) Collecting and disseminating information regarding the location
41 and availability of surplus food for distribution to needy persons, the
42 availability of surplus food for donation to charity food bank organizations,
43 and the needs of charity food bank organizations for surplus food.

1 (b) Coordinating the activities of federal, state, local and private
2 nonprofit organizations which THAT provide food assistance to the hungry.

3 (c) Accepting and disbursing federal monies, and any state monies
4 appropriated by the legislature, to private nonprofit organizations in
5 support of the collection, receipt, handling, storage, and distribution of
6 donated or surplus food items.

7 (d) Providing technical assistance to private nonprofit organizations
8 which THAT provide or intend to provide services to the hungry.

9 (e) Developing a state plan on hunger which, at a minimum, identifies
10 the magnitude of the hunger problem in this state, the characteristics of the
11 population in need, the availability and location of charity food banks and
12 the potential sources of surplus food, assesses the effectiveness of the
13 donated food collection and distribution network and other efforts to
14 alleviate the hunger problem, and recommends goals and strategies to improve
15 the status of the hungry. The state plan on hunger shall be incorporated
16 into the department's state comprehensive plan prepared pursuant to section
17 41-1956.

18 (f) Establishing a special purpose advisory council on hunger pursuant
19 to section 41-1981.

20 19. Establish an office to address the issue of homelessness and to
21 provide coordination and assistance to public and private nonprofit
22 organizations which THAT prevent homelessness or aid homeless individuals and
23 families throughout this state. These activities shall include:

24 (a) Promoting and participating in planning for the prevention of
25 homelessness and the development of services to homeless persons.

26 (b) Identifying and developing strategies for resolving barriers in
27 state agency service delivery systems that inhibit the provision and
28 coordination of appropriate services to homeless persons and persons in
29 danger of being homeless.

30 (c) Assisting in the coordination of the activities of federal, state
31 and local governments and the private sector which THAT prevent homelessness
32 or provide assistance to homeless people.

33 (d) Assisting in obtaining and increasing funding from all appropriate
34 sources to prevent homelessness or assist in alleviating homelessness.

35 (e) Serving as a clearinghouse on information regarding funding and
36 services available to assist homeless persons and persons in danger of being
37 homeless.

38 (f) Developing an annual state comprehensive homeless assistance plan
39 to prevent and alleviate homelessness.

40 (g) Submitting an annual report by January 1, 1992 and each year
41 thereafter to the governor, the president of the senate and the speaker of
42 the house of representatives on the status of homelessness and efforts to
43 prevent and alleviate homelessness.

1 20. Cooperate with the Arizona Mexico commission in the governor's
2 office and with researchers at universities in this state to collect data on
3 issues that are within the scope of the department's duties and that relate
4 to quality of life, trade and economic development in this state in a manner
5 that will help the Arizona Mexico commission to assess the economic
6 competitiveness of this state and of the state of Sonora, Mexico.

7 B. If the department has responsibility for the care, custody or
8 control of a child or is paying the cost of care for a child, it may serve
9 as representative payee to receive and administer social security and
10 veterans administration benefits and other benefits payable to such child.
11 Notwithstanding any law to the contrary, the department:

12 1. Shall deposit, pursuant to sections 35-146 and 35-147, such monies
13 as it receives to be retained separate and apart from the state general fund
14 on the books of the department of administration.

15 2. May use such monies to defray the cost of care and services
16 expended by the department for the benefit, welfare and best interests of the
17 child and invest any of the monies that the director determines are not
18 necessary for immediate use.

19 3. Shall maintain separate records to account for the receipt,
20 investment and disposition of funds received for each child.

21 4. ~~Shall, upon~~ ON termination of the department's responsibility for
22 the child, SHALL release any funds remaining to the child's credit in
23 accordance with the requirements of the funding source or in the absence of
24 such requirements shall release the remaining funds to:

25 (a) The child, if the child is at least eighteen years of age or is
26 emancipated.

27 (b) The person responsible for the child if the child is a minor and
28 not emancipated.

29 C. ~~Nothing in~~ Subsection B of this section shall DOES NOT pertain to
30 benefits payable to or for the benefit of a child receiving services under
31 title 36.

32 D. Volunteers reimbursed for expenses pursuant to subsection A,
33 paragraph 5 of this section are not eligible for workers' compensation under
34 title 23, chapter 6.

35 E. In implementing the temporary assistance for needy families program
36 pursuant to Public Law 104-193, the department shall provide for cash
37 assistance to two parent families if both parents are able to work only upon
38 documented participation by both parents in work activities described in
39 title 46, chapter 2, article 5, except that payments may be made to families
40 who do not meet the participation requirements if:

41 1. It is determined on an individual case basis that they have
42 emergency needs.

43 2. The family is determined to be eligible for diversion from
44 long-term cash assistance pursuant to title 46, chapter 2, article 5.

1 F. The department shall provide for cash assistance under temporary
2 assistance for needy families pursuant to Public Law 104-193 to two parent
3 families for no longer than six months if both parents are able to work,
4 except that additional assistance may be provided on an individual case basis
5 to families with extraordinary circumstances. The department shall establish
6 by rule the criteria to be used to determine eligibility for additional cash
7 assistance.

8 G. The department may establish a representative payee program to
9 provide representative payee services to manage social security or
10 supplemental security income benefits for persons who are receiving general
11 assistance benefits pursuant to section 46-233 and who require the services
12 of a representative payee to manage social security or supplemental security
13 income benefits. The department may use not more than an average of eight
14 hundred fifty dollars for any one person annually from monies appropriated
15 for general assistance benefits for the purpose of paying persons or agencies
16 to provide representative payee services.

17 H. The department shall adopt the following discount medical payment
18 system no later than October 1, 1993 for persons who the department
19 determines are eligible and who are receiving rehabilitation services
20 pursuant to subsection A, paragraph 1, subdivision (d) of this section:

21 1. For inpatient hospital admissions and outpatient hospital services
22 the department shall reimburse a hospital according to the tiered per
23 diem rates and outpatient cost-to-charge ratios established by the Arizona
24 health care cost containment system pursuant to section 36-2903.01,
25 subsection ~~J~~ H.

26 2. The department's liability for a hospital claim under this
27 subsection is subject to availability of funds.

28 3. A hospital bill is considered received for purposes of paragraph
29 5 of this subsection upon initial receipt of the legible, error-free claim
30 form by the department if the claim includes the following error-free
31 documentation in legible form:

32 (a) An admission face sheet.

33 (b) An itemized statement.

34 (c) An admission history and physical.

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

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

37 (f) Operative reports, if applicable.

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

39 4. The department shall require that the hospital pursue other third
40 party payors ~~prior to~~ BEFORE submitting a claim to the department. Payment
41 received by a hospital from the department pursuant to this subsection is
42 considered payment by the department of the department's liability for the
43 hospital bill. A hospital may collect any unpaid portion of its bill from

1 other third party payors or in situations covered by title 33, chapter 7,
2 article 3.

3 5. For inpatient hospital admissions and outpatient hospital services
4 rendered on and after October 1, 1997, if the department receives the claim
5 directly from the hospital, the department shall pay a hospital's rate
6 established according to this section subject to the following:

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

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

12 (c) If the hospital's bill is paid any time after sixty days of the
13 date the bill was received, the department shall pay one hundred per cent of
14 the rate plus a fee of one per cent per month for each month or portion of
15 a month following the sixtieth day of receipt of the bill until the date of
16 payment.

17 6. For medical services other than those for which a rate has been
18 established pursuant to section 36-2903.01, subsection J-H, the department
19 shall pay according to the Arizona health care cost containment system capped
20 fee-for-service schedule adopted pursuant to section 36-2904, subsection M-
21 L or any other established fee schedule the department determines reasonable.

22 1. The department shall not pay claims for services pursuant to this
23 section which THAT are submitted more than nine months after the date of
24 service for which the payment is claimed.

25 J. To assist in the location of persons or assets for the purpose of
26 establishing paternity, establishing, modifying or enforcing child support
27 obligations and other related functions, the department has access, including
28 automated access if the records are maintained in an automated data base, to
29 records of state and local government agencies, including:

30 1. Vital statistics, including records of marriage, birth and divorce.

31 2. State and local tax and revenue records, including information on
32 residence address, employer, income and assets.

33 3. Records concerning real and titled personal property.

34 4. Records of occupational and professional licenses.

35 5. Records concerning the ownership and control of corporations,
36 partnerships and other business entities.

37 6. Employment security records.

38 7. Records of agencies administering public assistance programs.

39 8. Records of the motor vehicle division of the department of
40 transportation.

41 9. Records of the state department of corrections.

42 10. Any system used by a state agency to locate a person for motor
43 vehicle or law enforcement purposes, including access to information
44 contained in the Arizona criminal justice information system.

1 K. Notwithstanding subsection J of this section, the department or its
2 agents shall not seek or obtain information on the assets of an individual
3 unless paternity is presumed pursuant to section 25-814 or established.

4 L. Access to records of the department of revenue pursuant to
5 subsection J of this section shall be provided in accordance with section
6 42-2003.

7 M. The department also has access to certain records held by private
8 entities with respect to child support obligors or obligees, or individuals
9 against whom such an obligation is sought. The information shall be obtained
10 as follows:

11 1. In response to a child support subpoena issued by the department
12 pursuant to section 25-520, the names and addresses of these persons and the
13 names and addresses of the employers of these persons, as appearing in
14 customer records of public utilities and cable television companies.

15 2. Information on these persons held by financial institutions.

16 N. Pursuant to department rules, the department may compromise or
17 settle any support debt owed to the department if the director or an
18 authorized agent determines that it is in the best interest of the state and
19 after considering each of the following factors:

20 1. The obligor's financial resources.

21 2. The cost of further enforcement action.

22 3. The likelihood of recovering the full amount of the debt.

23 O. Notwithstanding any law to the contrary, a state or local
24 governmental agency or private entity is not subject to civil liability for
25 the disclosure of information made in good faith to the department pursuant
26 to this section.

27 Sec. 93. Section 41-2501, Arizona Revised Statutes, is amended to
28 read:

29 41-2501. Applicability

30 A. This chapter applies only to procurements initiated after January
31 1, 1985 unless the parties agree to its application to procurements initiated
32 before that date.

33 B. This chapter applies to every expenditure of public monies,
34 including federal assistance monies except as otherwise specified in section
35 41-2637, by this state, acting through a state governmental unit as defined
36 in this chapter, under any contract, except that this chapter does not apply
37 to either grants as defined in this chapter, or contracts between this state
38 and its political subdivisions or other governments, except as provided in
39 chapter 24 of this title and in article 10 of this chapter. This chapter
40 also applies to the disposal of state materials. ~~Nothing in This chapter or~~
41 ~~in~~ AND rules adopted under this chapter shall DO NOT prevent any state
42 governmental unit or political subdivision from complying with the terms and
43 conditions of any grant, gift, bequest or cooperative agreement.

1 C. All political subdivisions and other local public agencies of this
2 state may adopt all or any part of this chapter and the rules adopted
3 pursuant to this chapter.

4 D. The Arizona board of regents, the legislative and judicial branches
5 of state government and the state compensation fund are not subject to the
6 provisions of this chapter except as prescribed in subsection E of this
7 section.

8 E. The Arizona board of regents and the judicial branch shall adopt
9 rules prescribing procurement policies and procedures for themselves and
10 institutions under their jurisdiction. The rules must be substantially
11 equivalent to the policies and procedures prescribed in this chapter.

12 F. The Arizona state lottery commission is exempt from the provisions
13 of this chapter for procurement relating to the design and operation of the
14 lottery or purchase of lottery equipment, tickets and related materials. The
15 executive director of the Arizona state lottery commission shall adopt rules
16 substantially equivalent to the policies and procedures in this chapter for
17 procurement relating to the design and operation of the lottery or purchase
18 of lottery equipment, tickets or related materials. All other procurement
19 shall be as prescribed by this chapter.

20 G. The Arizona health care cost containment system administration is
21 exempt from the provisions of this chapter for provider contracts pursuant
22 to section 36-2904, subsection A and contracts for goods and services
23 including program contractor contracts pursuant to title 36, chapter 29,
24 articles 2 and 3. All other procurement, including contracts for the
25 statewide administrator of the program pursuant to section 36-2903,
26 subsection ~~C~~ B, shall be as prescribed by this chapter.

27 H. Arizona industries for the blind is exempt from the provisions of
28 this chapter for purchases of finished goods from members of national
29 industries for the blind and for purchases of raw materials for use in the
30 manufacture of products for sale pursuant to section 41-1972. All other
31 procurement shall be as prescribed by this chapter.

32 I. Arizona correctional industries is exempt from the provisions of
33 this chapter for purchases of raw materials, components and supplies that are
34 used in the manufacture or production of goods or services for sale entered
35 into pursuant to section 41-1622. All other procurement shall be as
36 prescribed by this chapter.

37 J. The state transportation board and the director of the department
38 of transportation are exempt from the provisions of this chapter other than
39 section 41-2586 for the procurement of construction or reconstruction,
40 including engineering services, of transportation facilities or highway
41 facilities.

42 K. The Arizona highways magazine is exempt from the provisions of this
43 chapter for contracts for the production, promotion, distribution and sale
44 of the magazine and related products and for contracts for sole source

1 creative works entered into pursuant to section 28-7314, subsection A,
2 paragraph 5. All other procurement shall be as prescribed by this chapter.

3 L. The secretary of state is exempt from the provisions of this
4 chapter for contracts entered into pursuant to section 41-1012 to publish and
5 sell the administrative code. All other procurement shall be as prescribed
6 by this chapter.

7 M. The provisions of this chapter are not applicable to contracts for
8 professional witnesses if the purpose of such contracts is to provide for
9 professional services or testimony relating to an existing or probable
10 judicial proceeding in which this state is or may become a party or to
11 contract for special investigative services for law enforcement purposes.

12 N. The head of any state governmental unit, in relation to any
13 contract exempted by this section from the provisions of this chapter, has
14 the same authority to adopt rules, procedures or policies as is delegated to
15 the director pursuant to this chapter.

16 O. Agreements negotiated by legal counsel representing this state in
17 settlement of litigation or threatened litigation are exempt from the
18 provisions of this chapter.

19 P. The provisions of this chapter are not applicable to contracts
20 entered into by the department of economic security with a provider licensed
21 or certified by an agency of this state to provide child day care services
22 or with a provider of family foster care pursuant to section 8-503 or 36-554,
23 to contracts entered into with area agencies on aging created pursuant to the
24 older Americans act of 1965 (P.L. 89-73; 79 Stat. 218; 42 United States Code
25 section SECTIONS 3001 through 3058ee) or to contracts for services pursuant
26 to title 36, chapter 29, article 2.

27 Q. The department of health services may not require that persons with
28 whom it contracts follow the provisions of this chapter for the purposes of
29 subcontracts entered into for the provision of the following:

- 30 1. Mental health services pursuant to section 36-189, subsection B.
- 31 2. Services for the seriously mentally ill pursuant to title 36,
32 chapter 5, article 10.
- 33 3. Drug and alcohol services pursuant to section 36-141.
- 34 4. Domestic violence services pursuant to title 36, chapter 30,
35 article 1.

36 R. The department of health services is exempt from the provisions of
37 this chapter for contracts for services of physicians at the Arizona state
38 hospital.

39 S. Contracts for goods and services approved by the fund manager of
40 the public safety personnel retirement system are exempt from the provisions
41 of this chapter.

42 T. The Arizona department of agriculture is exempt from this chapter
43 with respect to contracts for private labor and equipment to effect cotton
44 or cotton stubble plow-up pursuant to rules adopted under title 3, chapter

1 2, article 1. On or before September 1 each year the director of the Arizona
2 department of agriculture shall establish and announce costs for each acre
3 of cotton or cotton stubble to be abated by private contractors.

4 U. The Arizona state parks board is exempt from the provisions of this
5 chapter for purchases of guest supplies and items for resale such as food,
6 linens, gift items, sundries, furniture, china, glassware and utensils for
7 the facilities located in the Tonto natural bridge state park.

8 V. The Arizona state parks board is exempt from the provisions of this
9 chapter for the purchase, production, promotion, distribution and sale of
10 publications, souvenirs and sundry items obtained and produced for resale.

11 W. The Arizona state schools for the deaf and the blind are exempt
12 from the provisions of this chapter when purchasing products through a
13 cooperative that is organized and operates in accordance with state law if
14 such products are not available on a statewide contract and are related to
15 the operation of the schools or are products for which special discounts are
16 offered for educational institutions.

17 X. Expenditures of monies in the morale, welfare and recreational fund
18 established by section 26-153 are exempt from the provisions of this chapter.

19 Y. The state department of corrections is exempt from the provisions
20 of this chapter for purchases of food commodities to be used in the
21 preparation of meals for inmates. All other procurement shall be as
22 prescribed by this chapter.

23 Z. Notwithstanding section 41-2534, the director of the state
24 department of corrections may contract with local medical providers in
25 counties with a population of less than four hundred thousand persons
26 according to the most recent United States decennial census for the following
27 purposes:

28 1. To acquire hospital and professional medical services for inmates
29 who are incarcerated in state department of corrections facilities that are
30 located in those counties.

31 2. To ensure the availability of emergency medical services to inmates
32 in all counties by contracting with the closest medical facility that offers
33 emergency treatment and stabilization.

34 AA. The department of environmental quality is exempt from the
35 provisions of this chapter for contracting for procurements relating to the
36 water quality assurance revolving fund program established pursuant to title
37 49, chapter 2, article 5. The department shall engage in a source selection
38 process that is similar to the procedures prescribed by this chapter. The
39 department may contract for remedial actions with a single selection process.
40 The exclusive remedy for disputes or claims relating to contracting pursuant
41 to this subsection is as prescribed by article 9 of this chapter and the
42 rules adopted pursuant to that article. All other procurement by the
43 department shall be as prescribed by this chapter.

1 BB. The motor vehicle division of the department of transportation is
2 exempt from the provisions of this chapter for third party authorizations
3 pursuant to title 28, chapter 13, only if all of the following conditions
4 exist:

5 1. The division does not pay any public monies to an authorized third
6 party.

7 2. Exclusivity is not granted to an authorized third party.

8 3. The director has complied with the requirements prescribed in title
9 28, chapter 13 in selecting an authorized third party.

10 CC. This section does not exempt third party authorizations pursuant
11 to title 28, chapter 13 from any other applicable law.

12 DD. The state forester is exempt from the provisions of this chapter
13 for purchases and contracts relating to wild land fire suppression and
14 pre-positioning equipment resources and for other activities related to
15 combating wild land fires and other unplanned risk activities, including
16 fire, flood, earthquake, wind and hazardous material responses. All other
17 procurement by the state forester shall be as prescribed by this chapter.

18 Sec. 94. Section 42-11101, Arizona Revised Statutes, is amended to
19 read:

20 42-11101. Definitions

21 In this article, unless the context otherwise requires:

22 1. "Afflicted" means persons who, because of a mental or physical
23 condition, illness or condition of distress, adversity or harassment, or
24 imminent risk of such condition, are unable to reasonably take care of
25 themselves or their families or to properly function in society without
26 periodic or continuous assistance.

27 2. "Indigent" means ~~persons or families that meet the criteria of~~
28 ~~section 11-297, subsection B or that are~~ A PERSON WHO IS without sufficient
29 means or ability to provide themselves with adequate food, shelter or social
30 necessities.

31 Sec. 95. Section 46-134, Arizona Revised Statutes, is amended to read:

32 46-134. Powers and duties; expenditure; limitation

33 A. The state department shall:

34 1. Administer all forms of public relief and assistance except those
35 which by law are administered by other departments, agencies or boards.

36 2. Administer child welfare activities, including:

37 (a) Importation of children.

38 (b) Licensing and supervising private and local public child caring
39 agencies and institutions.

40 (c) Providing the cost of care of:

41 (i) Children who are in temporary custody, are the subject of a
42 dependency petition or are adjudicated by the court as dependent and who are
43 in out-of-home placement, except state institutions.

1 (ii) Children who are voluntarily placed in foster family homes as
2 provided in section 8-806.

3 (iii) Children who are the subject of a dependency petition or are
4 adjudicated dependent and who are in the custody of the department and
5 ordered by the court pursuant to section 8-845 to reside in an independent
6 living program pursuant to section 8-521.

7 (d) Providing services for children placed in adoption.

8 (e) Providing the cost of care of unwed mothers who are under the age
9 of eighteen years during the period of their pregnancy and confinement in
10 foster family homes or institutions and when determined by the department to
11 be economically eligible. Costs of hospitalization and medical expenses
12 attendant to the care of the mother and child shall be excluded from any
13 payments made under this subdivision.

14 3. For the purposes of paragraph 2, subdivision (c), develop and
15 implement in conjunction with the department of education and the department
16 of juvenile corrections a uniform budget format to be submitted by licensed
17 child welfare agencies and approved private special education schools. The
18 budget format shall be developed in such a manner that, at a minimum,
19 residential and educational instructional costs are separate and distinct
20 budgetary items.

21 4. Develop a section of rehabilitation for the visually impaired which
22 shall include a sight conservation section, a vocational rehabilitation
23 section in accordance with the federal vocational rehabilitation act, a
24 vending stand section in accordance with the federal Randolph-Sheppard act
25 and an adjustment service section which shall include rehabilitation teaching
26 and other social services deemed necessary, and shall cooperate with similar
27 agencies already established. The administrative officer and staff of the
28 section for the blind and visually impaired shall be employed only in the
29 work of that section.

30 5. Assist other departments, agencies and institutions of the state
31 and federal governments, when requested, by performing services in conformity
32 with the purposes of this title.

33 6. Act as agent of the federal government in furtherance of any
34 functions of the state department.

35 7. Carry on research and compile statistics relating to the entire
36 public welfare program throughout this state, including all phases of
37 dependency and defectiveness.

38 8. Cooperate with the superior court in cases of delinquency and
39 related problems.

40 9. Develop plans in cooperation with other public and private agencies
41 for the prevention and treatment of conditions giving rise to public welfare
42 and social security problems.

43 10. Make necessary expenditures in connection with the duties specified
44 in paragraphs 7, 8, 9, 15, 16 and 17.

1 11. Have the power to apply for, accept, receive and expend public and
2 private gifts or grants of money or property upon such terms and conditions
3 as may be imposed by the donor and for any purpose provided for by this
4 chapter.

5 12. Make rules, and take action necessary or desirable to carry out the
6 provisions of this title, which are not inconsistent with this title.

7 13. Administer any additional welfare functions required by law.

8 14. Provide the cost of care and transitional independent living
9 services for a person under twenty-one years of age pursuant to section
10 8-521.01.

11 15. Petition, as necessary to implement the case plan established under
12 section 8-824 or 8-845, for the appointment of a guardian or a temporary
13 guardian under title 14, chapter 5 for children who are in custody of the
14 department pursuant to court order. Persons applying to be guardians or
15 temporary guardians under this section shall be fingerprinted. A foster
16 parent or certified adoptive parent already fingerprinted is not required to
17 be fingerprinted again if he is the person applying to be the guardian or
18 temporary guardian.

19 16. If a tribal government elects to operate a cash assistance program
20 in compliance with the requirements of the United States department of health
21 and human services, with the review of the joint legislative budget
22 committee, provide matching monies at a rate that is consistent with the
23 applicable fiscal year budget and that is not more than the state matching
24 rate for the aid to families with dependent children program as it existed
25 on July 1, 1994.

26 17. Furnish a federal, state or local law enforcement officer, at the
27 request of the officer, with the current address of any recipient if the
28 officer furnishes the agency with the name of the recipient and notifies the
29 agency that the recipient is a fugitive felon or a probation, parole or
30 community supervision violator or has information that is necessary for the
31 officer to conduct the official duties of the officer and the location or
32 apprehension of the recipient is within these official duties.

33 18. In conjunction with Indian tribal governments, request a federal
34 waiver from the United States department of agriculture that will allow
35 tribal governments that perform eligibility determinations for temporary
36 assistance for needy families programs to perform the food stamp eligibility
37 determinations for persons who apply for services pursuant to section
38 36-2901, paragraph 4- 6, subdivision (b) (a). If the waiver is approved, the
39 state shall provide the state matching monies for the administrative costs
40 associated with the food stamp eligibility based on federal guidelines. As
41 part of the waiver, the department shall recoup from a tribal government all
42 federal fiscal sanctions that result from inaccurate eligibility
43 determinations.

1 B. The total amount of state monies that may be spent in any fiscal
 2 year by the state department for foster care as provided in subsection A,
 3 paragraph 2, subdivision (c) of this section shall not exceed the amount
 4 appropriated or authorized by section 35-173 for that purpose. This section
 5 shall not be construed to impose a duty on an officer, agent or employee of
 6 this state to discharge a responsibility or to create any right in a person
 7 or group if the discharge or right would require an expenditure of state
 8 monies in excess of the expenditure authorized by legislative appropriation
 9 for that specific purpose.

10 C. Beginning on January 1, 2001, the department shall complete a
 11 written report on the distribution of the federal monies received pursuant
 12 to section 8-521.01. The joint legislative budget committee shall determine
 13 the data to be collected regarding how the monies will be spent and have been
 14 spent. The department shall submit this report annually to the governor, the
 15 president of the senate, the speaker of the house of representatives, the
 16 joint legislative budget committee and the joint legislative committee on
 17 children and family services and shall provide a copy of this report to the
 18 secretary of state and the director of the ~~department~~ of ARIZONA STATE
 19 library, archives and public records.

20 Sec. 96. Laws 1999, first special session, chapter 1, section 7 is
 21 amended to read:

22 Sec. 7. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

	<u>1999-00</u>	<u>2000-01</u>
23		
24	<u>Administration</u>	
25	FTE positions	2,407.5
26	Operating lump sum appropriation	\$ 58,443,800
27	DOA data center charges	4,978,600
28	Indian advisory council	212,400
29	DES eligibility	42,047,400
30	DES Title XIX pass-through	291,600
31	DHS Title XIX pass-through	1,374,400
32	Healthcare group administration	1,267,000
33	Office of administrative hearings	158,300
34	CHIP - administration	5,492,100
35	CHIP - services	54,921,000
36	Total expenditure authority -	
37	administration	\$169,186,600

38 Of the \$169,186,600 expenditure authority for administration in fiscal
 39 year 1999-2000, \$51,919,700 is appropriated from the state general fund,
 40 \$1,253,200 is appropriated from the donations fund and \$60,413,100 is
 41 appropriated from the children's health insurance program fund. Of the
 42 \$188,216,500 expenditure authority for administration in fiscal year
 43 2000-2001, \$52,064,800 is appropriated from the state general fund,

1 \$1,256,600 is appropriated from the donations fund and \$79,379,300 is
 2 appropriated from the children's health insurance fund.

3 It is the intent of the legislature that the appropriation for the
 4 department of administration data center charges be used only for the payment
 5 of charges incurred by the department for the use of computing services
 6 provided by the department of administration data center.

7 The amounts appropriated for the department of economic security
 8 special line item shall be used for intergovernmental agreements with the
 9 department of economic security for the purpose of eligibility determination
 10 and other functions. The general fund share may be used for eligibility
 11 determination for other programs administered by the division of benefits and
 12 medical eligibility based on the results of the Arizona random moment
 13 sampling survey.

14 The amounts appropriated for the department of health services special
 15 line item shall be used for intergovernmental agreements with the department
 16 of health services for the purpose of medicaid-related licensure,
 17 certification and registration, and other functions.

18	<u>Acute care</u>		
19	Capitation	\$ 860,502,400	\$ 902,781,000
20			\$ 889,375,400
21	Fee for service	215,377,400	225,133,800
22	Reinsurance	39,477,200	41,949,800
23	Medicare premiums	31,052,600	48,724,100
24	Disproportionate share payments	124,891,500	124,891,500
25			104,508,900
26	Graduate medical education	<u>18,289,800</u>	<u>18,289,800</u>
27	Total expenditure authority -		
28	acute care	\$1,289,590,900	\$1,361,770,000
29			\$1,327,981,800

30 Of the \$1,289,590,900 expenditure authority for acute care in fiscal
 31 year 1999-2000, \$421,314,100 is appropriated from the state general fund. Of
 32 the ~~\$1,361,770,000~~ \$1,327,981,800 expenditure authority for acute care in
 33 fiscal year 2000-2001, ~~\$440,861,800~~ \$420,479,200 is appropriated from the
 34 state general fund.

35 Of the appropriation for disproportionate share payments for fiscal
 36 years YEAR 1999-2000 and ~~2000-2001~~ made pursuant to section 36-2903.01,
 37 subsection R, Arizona Revised Statutes, the sum of \$83,894,300 is for
 38 qualifying county operated hospitals, \$23,831,900 is for deposit in the
 39 Arizona state hospital fund and \$15,150,000 is for other qualifying
 40 disproportionate share hospitals. OF THE APPROPRIATION FOR DISPROPORTIONATE
 41 SHARE PAYMENTS FOR FISCAL YEAR 2000-2001 MADE PURSUANT TO SECTION 36-2903.01,
 42 SUBSECTION R, ARIZONA REVISED STATUTES, THE SUM OF \$59,149,000 IS FOR
 43 QUALIFYING COUNTY OPERATED HOSPITALS, \$28,194,600 IS FOR DEPOSIT IN THE

1 ARIZONA STATE HOSPITAL FUND AND \$15,150,000 IS FOR OTHER QUALIFYING
 2 DISPROPORTIONATE SHARE HOSPITALS.

3 The remaining \$2,015,300 is for in lieu payments to counties having a
 4 population of five hundred thousand persons or less according to the most
 5 recent United States decennial census in an amount that is the difference
 6 between the disproportionate share payments made pursuant to section
 7 36-2903.01, subsection R, Arizona Revised Statutes, and \$201,700, if the
 8 disproportionate share payments are less than \$201,700. For each county that
 9 would receive less than \$100,900 from these in lieu payments, the Arizona
 10 health care cost containment system administration shall make an additional
 11 in lieu payment that will provide the county with a total payment of
 12 \$100,900.

13 The fiscal years YEAR 1999-2000 and ~~2000-2001~~ disproportionate share
 14 payment of \$124,891,500 AND FISCAL YEAR 2000-2001 PAYMENT OF \$104,508,900 is
 15 based on federal fiscal years 1999-2000 and 2000-2001 authorized expenditure
 16 level of \$81,000,000. If the final federal expenditure authorization is an
 17 amount different from the estimate, the governor shall direct the Arizona
 18 health care cost containment system administration, subject to the
 19 availability of monies and subject to the review of the joint legislative
 20 budget committee, to proportionately adjust authorization amounts among the
 21 identified recipients of disproportionate share hospital payment. Before the
 22 final payment, the governor shall provide notification to the president of
 23 the senate, the speaker of the house of representatives, the chairmen of the
 24 house and senate appropriations committees and the staff director of the
 25 joint legislative budget committee of the adjusted federal authorized
 26 expenditure level and the proposed distribution plan for these monies.

27 Before making capitation changes to current fee for service programs
 28 that may have a budgetary impact in fiscal year 1999-2000 or fiscal year
 29 2000-2001, the Arizona health care cost containment system administration
 30 shall report its plan to the joint legislative budget committee for review.

31 Long-term care

32	Program lump sum appropriation	\$516,834,600	\$568,039,100
33	Board of nursing	<u>209,700</u>	<u>209,700</u>
34	Total expenditure authority -		
35	long-term care	\$517,044,300	\$568,248,800

36 Any federal funds that the Arizona health care cost containment system
 37 administration passes through to the department of economic security for use
 38 in long-term administration care for the developmentally disabled shall not
 39 count against the long-term care expenditure authority above.

40 Pursuant to section 11-292, subsection B, Arizona Revised Statutes, the
 41 fiscal year 1999-2000 nonfederal portion of the costs of providing long-term
 42 care system services is \$174,985,800. The state contribution is \$20,397,800
 43 and the county contribution is \$154,588,000. The fiscal year 2000-2001
 44 nonfederal portion of the costs of providing long-term care services is

1 \$192,429,800. The state contribution is \$35,014,600 and the county
 2 contribution is \$157,415,200.

3	Total expenditure authority	\$ 1,975,821,800	\$ 2,118,235,300
4			\$ 2,084,447,100
5	Less tobacco tax medically needy		
6	account withdrawals	(30,328,400)	(31,947,300)
7	Less collections, other receipts		
8	and balances forward	<u>(1,390,195,500)</u>	<u>(1,477,710,900)</u>
9			<u>(1,464,305,300)</u>
10	Total appropriation - Arizona health care		
11	cost containment system	\$ 555,297,900	\$ 608,577,100
12			\$ 588,194,500
13	Fund sources:		
14	State general fund	\$ 493,631,600	\$ 527,941,200
15			\$ 507,558,600
16	Other appropriated funds	61,666,300	80,635,900

17 Sec. 97. Laws 1999, chapter 176, section 14 is amended to read:
 18 Sec. 14. Withholding state shared revenues; fiscal years
 19 1999-2000 and 2000-2001

20 A. Based on the distribution of disproportionate share funding to
 21 county operated hospitals made pursuant to section 36-2903.01, subsection R,
 22 Arizona Revised Statutes, for fiscal years 1999-2000 and 2000-2001, the staff
 23 director of the joint legislative budget committee shall compute amounts to
 24 be withheld from transaction privilege tax revenues for counties with a
 25 population of at least five hundred thousand persons according to the most
 26 recent United States decennial census in accordance with subsection B of this
 27 section.

28 B. Notwithstanding section 42-5029, subsection C, paragraph 2, Arizona
 29 Revised Statutes, beginning with the first monthly distribution of
 30 transaction privilege tax revenues and at the direction of the governor, the
 31 state treasurer shall withhold an amount totaling \$64,652,000 from state
 32 transaction privilege tax revenues otherwise distributable, after any amounts
 33 withheld for the county long-term care contribution for fiscal year
 34 1999-2000, and the state treasurer shall withhold an amount totaling
 35 ~~\$64,652,000~~ \$39,906,700 from state transaction privilege tax revenues
 36 otherwise distributable, after any amounts withheld for the county long-term
 37 care contribution for fiscal year 2000-2001 from counties with a population
 38 of at least five hundred thousand persons according to the most recent United
 39 States decennial census. Amounts withheld from individual counties under
 40 this subsection shall be determined pursuant to subsection A of this section.

41 C. In addition to the amount specified in subsection B of this
 42 section, the state treasurer may also withhold transaction privilege tax
 43 revenues in fiscal year 1999-2000 if amounts withheld pursuant to Laws 1998,

1 fourth special session, chapter 5, section 3, as amended by section 9 of this
2 act, for fiscal year 1998-1999 were insufficient.

3 D. In addition to the amount specified in subsection B of this
4 section, the state treasurer may also withhold in fiscal year 2000-2001
5 transaction privilege tax revenues if amounts withheld pursuant to subsection
6 B of this section for fiscal year 1999-2000 were insufficient.

7 E. IN ADDITION TO THE AMOUNT SPECIFIED IN SUBSECTION B OF THIS
8 SECTION, THE STATE TREASURER MAY ALSO WITHHOLD IN FISCAL YEAR 2001-2002
9 TRANSACTION PRIVILEGE TAX REVENUES IF AMOUNTS WITHHELD PURSUANT TO SUBSECTION
10 B OF THIS SECTION FOR FISCAL YEAR 2000-2001 WERE INSUFFICIENT.

11 Sec. 98. Laws 2001, chapter 236, section 7 is amended to read:

12 Sec. 7. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

	<u>2001-02</u>	<u>2002-03</u>
<u>Administration</u>		
FTE positions	2,478.8	2,491.8
Operating lump sum appropriation	\$ 67,419,300	\$ 68,430,700
DOA data center charges	5,534,100	5,717,500
Indian advisory council	222,900	222,900
DES eligibility	44,529,000	44,537,500
DES Title XIX pass-through	301,900	302,000
DHS Title XIX pass-through	1,681,000	1,662,400
Healthcare group administration	1,300,500	1,300,600
Office of administrative hearings	174,200	174,200
CHIP - administration	8,623,900	9,001,800
CHIP - services	62,131,200	78,292,200
Finger imaging	<u>950,000</u>	<u>950,000</u>
Total expenditure authority - administration	\$192,868,000	\$210,591,800
Performance measures:		
Cost avoidance from fraud and abuse prevention program	\$ 7,000,000	\$ 7,000,000
Per cent of enrollees filing a grievance	0.4	0.4
Per cent of eligibility accuracy as measured by quality control sample	97	97
Per cent of AHCCCS employee turnover	11.5	11.5
Administration as a per cent of total cost	4.4	4.4
Customer satisfaction rating for eligibility determination clients (Scale 1-8)	6.0	6.0

39 Of the \$192,868,000 expenditure authority for administration in fiscal
40 year 2001-2002, \$57,593,700 is appropriated from the state general fund,
41 \$1,300,500 is appropriated from the donations fund and \$70,755,100 is
42 appropriated from the children's health insurance program fund. Of the
43 \$210,591,800 expenditure authority for administration in fiscal year
44 2002-2003, \$57,636,000 is appropriated from the state general fund,

1 \$1,300,600 is appropriated from the donations fund and \$87,294,000 is
2 appropriated from the children's health insurance program fund.

3 It is the intent of the legislature that the appropriation for the
4 department of administration data center charges be used only for the payment
5 of charges incurred by the department for the use of computing services
6 provided by the department of administration data center.

7 The amounts appropriated for the department of economic security
8 eligibility special line item shall be used for intergovernmental agreements
9 with the department of economic security for the purpose of eligibility
10 determination and other functions. The general fund share may be used for
11 eligibility determination for other programs administered by the division of
12 benefits and medical eligibility based on the results of the Arizona random
13 moment sampling survey.

14 The amounts appropriated for the department of health services title
15 XIX pass-through special line item shall be used for intergovernmental
16 agreements with the department of health services for the purpose of
17 medicaid-related licensure, certification and registration, and other
18 functions.

19 The Arizona health care cost containment system administration shall
20 report by January 1 of each year on the agency's use of the cost savings that
21 results from entering into an agreement with another state as outlined in
22 Laws 1999, chapter 313, section 27. The report shall also include detail on
23 the source of all revenues and expenditure of monies from the
24 intergovernmental service fund.

25 Before the expenditure of any monies for the Arizona health care cost
26 containment system administration customer eligibility system, the Arizona
27 health care cost containment system administration shall submit a report to
28 the joint legislative budget committee for its review. The report shall
29 discuss how the automation improvements are compatible with the no wrong door
30 initiative.

31 If federal matching monies are received for the finger imaging
32 enrollment program, the Arizona health care cost containment system shall
33 revert the portion of the state general fund appropriation received equal to
34 the federal dollars received for this program in the year that the federal
35 monies are received.

36 The Arizona health care cost containment system shall report by
37 September 30 of each year to the joint legislative budget committee on the
38 services that receive reimbursement from the federal government under the
39 medicaid in public school initiative. The report shall include information
40 on the type of services, how those services meet the definition of medical
41 necessity, and the total amount of federal dollars that the schools have
42 received under the medicaid in public school initiative.

1	<u>Acute care</u>		
2	Capitation	\$1,077,731,200	\$1,175,442,800
3		\$ 930,767,900	\$1,023,969,500
4	Fee for service	311,501,600	342,685,100
5	Reinsurance	68,420,800	72,584,100
6		53,223,300	56,724,400
7	Medicare premiums	33,454,100	37,294,000
8	Graduate medical education	<u>21,683,200</u>	<u>22,528,100</u>
9	Total expenditure authority -		
10	acute care	\$1,652,962,700	\$1,790,705,900
11		\$1,350,630,100	\$1,483,201,100

12	Performance measures:		
13	Per cent of two year old children enrolled		
14	in AHCCCS who have received age		
15	appropriate immunizations	83	83
16	Per cent of well child visits in the first		
17	15 months of life (EPSDT)	75	75
18	Per cent of children's access to primary		
19	care provider	83	83
20	Per cent of women receiving annual cervical		
21	screening	46	46
22	Member satisfaction as measured by		
23	percentage of enrollees that choose		
24	to change health plans	4.0	4.0

25 Of the ~~\$1,652,962,700~~ \$1,350,630,100 expenditure authority for acute
 26 care in fiscal year 2001-2002, ~~\$522,694,700~~ \$296,505,100 is appropriated from
 27 the state general fund. Of the ~~\$1,790,705,900~~ \$1,483,201,100 expenditure
 28 authority for acute care in fiscal year 2002-2003, ~~\$564,813,200~~ \$330,995,700
 29 is appropriated from the state general fund.

30 Before making fee-for-service program or rate changes that pertain to
 31 hospital, nursing facility or home and community based services rates or for
 32 any of the other fee-for-service rate categories that have increases that,
 33 in the aggregate, are two per cent above and \$1,500,000 from the state
 34 general fund greater than budgeted medical inflation in fiscal year 2001-2002
 35 and fiscal year 2002-2003, the Arizona health care cost containment system
 36 administration shall report its plan to the joint legislative budget
 37 committee for review.

38 Before implementation of capitation rate changes that have a budgetary
 39 impact, the Arizona health care cost containment system administration shall
 40 report its plan to the joint legislative budget committee for review.

1	<u>Long-term care</u>		
2	Program lump sum appropriation	\$632,968,900	\$694,667,900
3	Board of nursing	<u>209,700</u>	<u>209,700</u>
4	Total expenditure authority -		
5	long-term care	\$633,178,600	\$694,877,600

6	Performance measures:		
7	Per cent of nursing facility residents that		
8	receive influenza immunization	85	85
9	Per cent of members utilizing home and		
10	community based services (HCBS)	49	49
11	Per cent of ALTCS applications processed on		
12	time (within 45 days)	90	90
13	Per cent of financial redeterminations		
14	processed on time (within 12 months)	90	90

15 Any federal funds that the Arizona health care cost containment system
16 administration passes through to the department of economic security for use
17 in long-term administration care for the developmentally disabled shall not
18 count against the long-term care expenditure authority above.

19 Pursuant to section 11-292, subsection B, Arizona Revised Statutes, the
20 fiscal year 2001-2002 nonfederal portion of the costs of providing long-term
21 care system services is \$217,077,800. The state contribution is \$48,318,100
22 and the county contribution is \$168,759,700. The fiscal year 2002-2003
23 nonfederal portion of the costs of providing long-term care services is
24 \$237,434,300. The state contribution is \$58,554,700 and the county
25 contribution is \$178,879,600.

26 Before making fee-for-service program or rate changes that pertain to
27 hospital, nursing facility or home and community based services rates or for
28 any of the other fee-for-service rate categories that have increases that,
29 in the aggregate, are two per cent above and \$1,500,000 from the state
30 general fund greater than budgeted medical inflation in fiscal year 2001-2002
31 and fiscal year 2002-2003, the Arizona health care cost containment system
32 administration shall report its plan to the joint legislative budget
33 committee for review.

34 Before implementation of capitation rate changes that have a budgetary
35 impact, the Arizona health care cost containment system administration shall
36 report its plan to the joint legislative budget committee for review.

37 The administration shall provide the joint legislative budget committee
38 staff an implementation plan for the provider rate adjustment by September
39 1, 2001.

40 It is the intent of the legislature that the agency distribute one
41 hundred per cent of the increase intended for providers to contracted
42 community treatment providers.

43 It is the intent of the legislature that the provider rate increase be
44 incorporated into contracted rates. Since this increase in the contracted

1 rate would not be competitively procured, the adjustment in this section is
 2 exempt from the provisions of Arizona Revised Statutes, title 41, chapter 23,
 3 related to procurement.

4 It is the intent of the legislature that the agency allocate funds in
 5 this section as a flat percentage increase across the total dollar value of
 6 all contracts in eligible categories.

7 It is the intent of the legislature that monies for the adjustment
 8 effective as of October 1, 2001 be allocated only to providers with contracts
 9 for eligible services in effect as of October 1, 2001.

10 It is the intent of the legislature that independent providers are
 11 eligible for these increases.

12 It is the intent of the legislature that community treatment providers
 13 allocate the adjustments for salary increases to direct care staff who
 14 provide direct care services for more than eighty per cent of their time
 15 weekly and who earn less than thirteen dollars per hour.

16 It is the intent of the legislature that these funds be spent for
 17 ongoing pay adjustments and salary-related employee related expenses such as
 18 workers' compensation, unemployment insurance, and FICA.

19 Each contract provider receiving a rate adjustment shall report to the
 20 agency by June 1, 2002 on how the adjustment was used. The Arizona health
 21 care cost containment system shall summarize this information and report it
 22 to the joint legislative budget committee by July 1, 2002.

23	Total expenditure authority	\$ 2,479,009,300	\$ 2,696,175,300
24		\$ 2,176,676,700	\$ 2,388,670,500
25	Less tobacco tax medically needy		
26	account withdrawals	(36,856,900)	(37,329,100)
27	Less collections, other receipts		
28	and balances forward	(1,741,490,300)	(1,889,247,700)
29		<u>(1,665,347,100)</u>	<u>(1,815,560,400)</u>
30	Total appropriation - Arizona health care		
31	cost containment system	\$ 700,662,100	\$ 769,598,500
32		\$ 474,472,400	\$ 535,781,000
33	Fund sources:		
34	State general fund	\$ 628,606,500	\$ 681,003,900
35		\$ 402,416,900	\$ 447,186,400
36	Other appropriated funds	72,055,600	88,594,600
37	Performance measures:		
38	Per cent of people under age 65 that are		
39	uninsured	24	24
40	Per cent of children (under 18 years)		
41	that are uninsured	22	22
42	AHCCCS enrollment	583,364	622,705

1	Children's health insurance program		
2	(CHIP) enrollment	45,627	54,558
3	Premium sharing enrollment	7,000	7,000
4	Sec. 99. <u>Repeal</u>		
5	Laws 2001, chapter 232, section 20 is repealed.		
6	Sec. 100. <u>County uncompensated care contribution</u>		
7	A. Notwithstanding any law to the contrary, in fiscal year 2001-2002,		
8	beginning with the second monthly distribution of transaction privilege tax		
9	revenues, the state treasurer shall withhold the following amounts from state		
10	transaction privilege revenues otherwise distributable, after any amounts		
11	withheld for the county long-term care contribution or the county		
12	administration contribution pursuant to section 11-292, subsection P, Arizona		
13	Revised Statutes for deposit in the Arizona health care cost containment		
14	system fund established by section 36-2913, Arizona Revised Statutes, and		
15	allocated to hospitals for uncompensated care:		
16	1. Apache, \$47,000.		
17	2. Cochise, \$87,700.		
18	3. Coconino, \$86,500.		
19	4. Gila, \$35,500.		
20	5. Graham, \$25,200.		
21	6. Greenlee, \$6,500.		
22	7. La Paz, \$13,400.		
23	8. Maricopa, \$2,076,400.		
24	9. Mohave, \$100,900.		
25	10. Navajo, \$66,100.		
26	11. Pima, \$601,200.		
27	12. Pinal, \$117,600.		
28	13. Santa Cruz, \$27,800.		
29	14. Yavapai, \$111,100.		
30	15. Yuma, \$99,100.		
31	B. Notwithstanding any law to the contrary, for fiscal year 2002-2003,		
32	beginning with the second monthly distribution of transaction privilege tax		
33	revenues, the state treasurer shall withhold the following amounts from state		
34	transaction privilege revenues otherwise distributable, after any amounts		
35	withheld for the county long-term care contribution or the county		
36	administration contribution pursuant to section 11-292, subsection P, Arizona		
37	Revised Statutes for deposit in the Arizona health care cost containment		
38	system fund established by section 36-2913, Arizona Revised Statutes, and		
39	allocated to hospitals for uncompensated care:		
40	1. Apache, \$87,300.		
41	2. Cochise, \$162,700.		
42	3. Coconino, \$160,500.		
43	4. Gila, \$65,900.		
44	5. Graham, \$46,800.		

- 1 6. Greenlee, \$12,000.
- 2 7. La Paz, \$24,900.
- 3 8. Maricopa, \$3,853,800.
- 4 9. Mohave, \$187,400.
- 5 10. Navajo, \$122,800.
- 6 11. Pima, \$1,115,900.
- 7 12. Pinal, \$218,300.
- 8 13. Santa Cruz, \$51,600.
- 9 14. Yavapai, \$206,200.
- 10 15. Yuma, \$183,900.

11 C. If a county does not provide funding as specified in subsection A
12 or B of this section, the state treasurer shall subtract the amount owed to
13 the Arizona health care cost containment system fund by the county from any
14 payments required to be made by the state treasurer to that county pursuant
15 to section 42-5029, subsection D, paragraph 2, Arizona Revised Statutes, plus
16 interest on that amount pursuant to section 44-1201, Arizona Revised
17 Statutes, retroactive to the first day the funding was due. If the monies
18 the state treasurer withholds are insufficient to meet that county's funding
19 requirement as specified in subsection A of this section, the state treasurer
20 shall withhold from any other monies payable to that county from whatever
21 state funding source is available an amount necessary to fulfill that
22 county's requirement. The state treasurer shall not withhold distributions
23 from the highway user revenue fund pursuant to title 28, chapter 18, article
24 2, Arizona Revised Statutes.

25 D. Payment of an amount equal to one-twelfth of the total monies
26 prescribed pursuant to subsection A or B of this section shall be made to the
27 state treasurer on or before the fifth day of each month. On request from
28 the director of the Arizona health care cost containment system
29 administration, the state treasurer shall require that up to three months'
30 payments be made in advance, if necessary.

31 E. The state treasurer shall deposit the monies paid pursuant to
32 subsection D of this section in the Arizona health care cost containment
33 system fund established by section 36-2913, Arizona Revised Statutes.

34 F. Subject to legislative appropriation, in fiscal years 2001-2002 and
35 2002-2003, the Arizona health care cost containment system administration
36 shall distribute the amounts withheld pursuant to subsection A or B of this
37 section to each private hospital based on the private hospital's relative
38 share of the total amount the administration paid for nonobstetric adult
39 hospital emergency care based on the most current year for which this
40 information is available.

41 Sec. 101. County contribution; expanded coverage

42 A. Notwithstanding any law to the contrary, in fiscal year 2001-2002,
43 the state treasurer shall withhold the amount of \$3,750,000 from the counties
44 beginning with the second monthly distribution of transaction privilege tax

1 revenues otherwise distributable after any amounts withheld for the county
2 long-term care contribution, for each county's contribution for
3 administration costs of implementing section 36-2901.01 and 36-2901.04,
4 Arizona Revised Statutes, based on the following percentages:

- 5 1. Apache, 1.342.
- 6 2. Cochise, 2.503.
- 7 3. Coconino, 2.469.
- 8 4. Gila, 1.014.
- 9 5. Graham, 0.721.
- 10 6. Greenlee, 0.185.
- 11 7. La Paz, 0.384.
- 12 8. Maricopa, 59.289.
- 13 9. Mohave, 2.882.
- 14 10. Navajo, 1.889.
- 15 11. Pima, 17.167.
- 16 12. Pinal, 3.359.
- 17 13. Santa Cruz, 0.794.
- 18 14. Yavapai, 3.173.
- 19 15. Yuma, 2.829.

20 B. Pursuant to sections 35-146 and 35-147, Arizona Revised Statutes,
21 the state treasurer shall deposit monies withheld pursuant to this section
22 in the budget neutrality compliance fund established by section 36-2928,
23 Arizona Revised Statutes.

24 Sec. 102. Claims for services before October 1, 2001

25 A claim by a hospital or a health care provider against a county for
26 hospitalization or medical care provided before October 1, 2001 is subject
27 to the provisions of title 11, chapter 2, Arizona Revised Statutes, and title
28 36, chapter 29, Arizona Revised Statutes, that were in effect at the date of
29 services

30 Sec. 103. Claims resolution process

31 A. Pursuant to the requirements of this section, a county board of
32 supervisors or its designee shall establish a claims resolution process for
33 use by hospitals and health care providers that receive a denial from a
34 county of all or any portion of a claim submitted. Except as provided
35 pursuant to subsection H of this section, the process shall comply with the
36 requirements of this section. A hospital or health care provider shall use
37 a claims resolution process established pursuant to this section as a
38 condition of seeking any other relief. A claims resolution process
39 established pursuant to this section requires a mutual obligation of a county
40 and hospital or health care provider to make available documents or
41 information and a good faith effort to resolve the disputed claim through the
42 claims resolution process.

43 B. A hospital or a health care provider may dispute a claim or any
44 portion of a claim that a county denies by transmitting a letter of dispute

1 and request for claim resolution to the county within ninety days after the
2 county denies the claim.

3 C. Notwithstanding any laws or requirements that relate to
4 confidentiality or privilege but that do not relate to attorney-client
5 privilege, not less than ninety days or more than one hundred eighty days
6 after the county receives the letter of dispute pursuant to subsection B of
7 this section, the county and the hospital or health care provider shall make
8 available relevant documents and attempt to resolve the dispute. Within
9 sixty days of a written request made within that period, the county, hospital
10 or health care provider shall make available relevant documents and
11 information concerning a disputed claim.

12 D. Within forty-five days after the period provided for the exchange
13 of documents and dispute resolution pursuant to subsection C of this section,
14 the county shall provide the hospital or health care provider written notice
15 of its decision with regard to each claim that is subject to the claims
16 resolution process. If the county agrees to issue a payment, the county
17 shall remit payment within forty-five days after it issues this written
18 notice.

19 E. Notwithstanding subsection C or D of this section, if after all
20 relevant documents are made available and the parties agree in writing that
21 the dispute cannot be resolved through the claims resolution process, the
22 county shall issue a written notice of its decision pursuant to subsection
23 D of this section within forty-five days after the parties make this
24 agreement.

25 F. The claims resolution process begins when the county receives the
26 letter of dispute and ends when the county provides notice pursuant to
27 subsection D, E or H of this section. During the claims resolution process,
28 a claim is not subject to a payment penalty pursuant to the provisions of
29 title 11, chapter 2, article 7, Arizona Revised Statutes, that were in effect
30 at the date of service, and interest shall not accrue pursuant to section
31 44-1201, Arizona Revised Statutes.

32 G. The claims resolution process is not subject to review pursuant to
33 title 12, chapter 7, article 6, Arizona Revised Statutes.

34 H. Notwithstanding subsection A of this section, a county board of
35 supervisors or its designee and a hospital or health care provider may
36 establish an alternative claims resolution process if the process establishes
37 a resolution completion date.

38 Sec. 104. Binding arbitration; county option

39 A. As the exclusive remedy for resolving claims of hospitals and
40 health care providers at or less than the amount established in subsection
41 B of this section, a county board of supervisors may adopt a system of
42 binding arbitration as provided in this section.

43 B. A disputed claim of not more than four thousand five hundred
44 dollars after deducting any payments computed at full bill charges is subject

1 to binding arbitration. The parties may agree to resolve claims of more
2 than this amount by binding arbitration.

3 C. A county board of supervisors that adopts binding arbitration shall
4 establish a roster of available arbitrators. The roster shall contain the
5 names of available arbitrators that are acceptable to both the county and an
6 association representing hospitals in this state. The entities shall not
7 unreasonably withhold agreement of proposed arbitrators.

8 D. Within ninety days after receiving notice of the county's decision
9 pursuant to former section 11-297.03, subsection D, E or H, Arizona Revised
10 Statutes, a hospital or health care provider may file with the county a
11 notice of intent to seek binding arbitration.

12 E. Within thirty days after the county receives the notice pursuant
13 to subsection D of this section, the county and the hospital or health care
14 provider shall agree on an arbitrator. If the parties cannot agree, each
15 party shall designate an arbitrator from the roster and these two arbitrators
16 shall designate a third arbitrator, who shall conduct the hearing not more
17 than one hundred twenty days after that arbitrator is selected.

18 F. The county and the hospital or the health care provider shall seek
19 any depositions pursuant to section 12-1507, subsection B, Arizona Revised
20 Statutes, within forty days after the arbitrator is selected. The arbitrator
21 shall direct that the parties produce documents and other information and
22 identify witnesses within forty days after the arbitrator is selected or
23 within a shorter time prescribed by the arbitrator. The parties shall
24 exchange all books, records, documents and other evidence and all witness
25 lists not less than five days before the hearing date.

26 G. Unless otherwise provided in this section, the procedures for the
27 conduct of a hearing, award, confirmation of award, fees and expenses of
28 arbitration and opposition to an award shall be as provided in title 12,
29 chapter 9, article 1, Arizona Revised Statutes. In the absence of a
30 governing statute, the rules of the American arbitration association for
31 commercial arbitration then in effect serve as a guideline on procedural
32 issues.

33 H. An arbitrator designated pursuant to this section and the parties
34 to the arbitration shall maintain the confidentiality of patient medical
35 records.

36 Sec. 105. Statute of limitation; time frames

37 A. Notwithstanding any other law, a hospital or health care provider
38 that is not required to use binding arbitration pursuant to former section
39 11-297.04, Arizona Revised Statutes, to resolve a disputed claim shall file
40 an action in court not more than ninety days after it receives written notice
41 pursuant to former section 11-297.03, subsection D, E or H, Arizona Revised
42 Statutes.

43 B. Notwithstanding any other law, for consecutive services provided
44 to a patient who is discharged or released beginning on October 1, 1999, a

1 hospital or health care provider shall seek reimbursement of claims only
2 pursuant to the provisions of title 11, chapter 2, Arizona Revised Statutes,
3 and title 36, chapter 29, Arizona Revised Statutes, in effect at the date of
4 service.

5 C. To settle a disputed claim for services that are provided to a
6 patient who is discharged or released before October 1, 1999, the county,
7 with the consent of the hospital or health care provider, may use the claims
8 resolution process prescribed by section 11-297.03, Arizona Revised Statutes.

9 Sec. 106. Joint legislative committee on the implementation of
10 proposition 204

11 A. The joint legislative committee on the implementation of
12 proposition 204 is established consisting of the following members:

13 1. Six members of the house of representatives appointed by the
14 speaker of the house of representatives, not more than three of whom are
15 members of the same political party. The speaker of the house of
16 representatives shall designate one of these members to cochair the
17 committee.

18 2. Six members of the senate appointed by the president of the senate,
19 not more than three of whom are members of the same political party. The
20 president of the senate shall designate one of these members to cochair the
21 committee.

22 B. The committee shall:

23 1. Develop a uniform process that will be used for data collection
24 required by this section and in a format determined by the committee.

25 2. Review the number of persons who are enrolled in the Arizona health
26 care cost containment system as a result of the expansion of eligibility.

27 3. Review the number, location and hours of operation of eligibility
28 offices operated by the county and by the department of economic security
29 before and after the transfer of county responsibility to the department of
30 economic security.

31 4. Review the average time it takes the Arizona health care cost
32 containment system administration and the department of economic security to
33 process applications as a result of the expansion of eligibility.

34 5. Review the number of persons who were denied eligibility by the
35 Arizona health care cost containment system and the department of economic
36 security and the most common reasons for the denial.

37 6. Review data provided by the Arizona health care cost containment
38 system administration that show the income received by each hospital based
39 on the expanded hospital population as a result of the expansion of
40 eligibility in the Arizona health care cost containment system.

41 7. Review data provided by hospitals that show the number of persons
42 who the hospital served and who would have been eligible for Arizona health
43 care cost containment system services if they would have submitted an

1 application and the dollar amount of the uncompensated care based on the
2 Arizona health care cost containment system fee schedule for those persons.

3 8. Consider the expenditures for the new eligibility groups and the
4 budget neutrality agreement with the federal health care financing
5 administration.

6 9. Identify the amount received by each private hospital from the
7 Arizona health care cost containment system administration for any
8 disproportionate share payment to each hospital.

9 10. Recommend whether the appropriations to counties required by this
10 act should continue after fiscal year 2002-2003.

11 11. Review the expenditures and the balance and projected future
12 deposits from tobacco settlement funds.

13 12. Consider the financial and operational status of county hospitals
14 and health systems and recommend measures to assure their continuing
15 operation.

16 13. Submit a report of its findings regarding county hospitals and
17 health care systems to the governor, president of the senate and speaker of
18 the house of representatives on or before December 15, 2001.

19 14. Submit a report of its findings to the governor, the president of
20 the senate and the speaker of the house of representatives on or before
21 August 15, 2002 and August 15, 2003. Each report shall be specific to the
22 year beginning April 1, 2001 and April 1, 2002. The report shall include any
23 recommendations for legislative or administrative changes and shall include
24 a recommendation as to whether the state shall continue to pay hospitals for
25 uncompensated care. The report shall also include a recommendation regarding
26 the continuation of payments to hospitals made by the uncompensated care pool
27 established by this act.

28 Sec. 107. Transfer of county responsibilities

29 A. The director of the department of economic security and a county
30 board of supervisors shall enter into an intergovernmental agreement for the
31 transfer to the department of the duties of a county department that
32 determines the eligibility of applicants for services provided pursuant to
33 title 36, chapter 29, article 1, Arizona Revised Statutes.

34 B. The agreement shall provide for the following:

35 1. The transfer of office equipment and furniture that the county and
36 the department agree to transfer for use in the eligibility process.

37 2. The employment of persons who are employed by the county in the
38 eligibility process and who agree to the transfer.

39 3. The effective date that will complete the transfer.

40 C. On the agreement's effective date, the department of economic
41 security assumes all of the powers, duties and responsibilities of the county
42 eligibility process.

43 D. After the date of transfer of county responsibilities pursuant to
44 this section, the department may enter into an intergovernmental agreement

1 with a county to perform administrative duties to assist with the eligibility
2 process.

3 E. The department of administration shall transfer into the state
4 service on a noncompetitive basis a permanent county employee who is affected
5 by the agreement authorized by this section and who agrees to be transferred
6 to state employment. If the employee has not successfully completed six
7 months' related experience, the employee shall serve a ninety day
8 probationary period in the state service.

9 F. When a county transfers its eligibility responsibilities pursuant
10 to this section, office equipment and furniture that the county and the
11 department of economic security agree to transfer and that are individually
12 valued at five thousand dollars or less transfer to the department of
13 economic security as a contribution to implement sections 36-2901.01 and
14 36-2901.04, Arizona Revised Statutes, the department or the state is not
15 obligated to pay for these transfers.

16 G. A county employee who is employed in the eligibility process and
17 who wishes to transfer pursuant to this section shall be offered state
18 employment at not less than the employee's county salary and within the same
19 geographic area as the employee's county employment. The state shall
20 integrate each transferred employee into state benefit programs effective on
21 the first day of employment. The state shall make an effort to train each
22 transferred employee within the same geographic area as that employee's
23 previous county employment.

24 Sec. 108. Eligibility determinations

25 Until October 1, 2002, the department of economic security may allow
26 a county pursuant to an intergovernmental agreement to perform eligibility
27 determinations for the Arizona health care cost containment system. The
28 agreement shall specify reimbursement levels for the eligibility
29 determinations and the amount of fiscal sanctions for erroneous
30 determinations.

31 Sec. 109. Hospital reimbursement study

32 A. The director of the Arizona health care cost containment system
33 administration in cooperation with at least two urban hospitals, one rural
34 hospital and a nonprofit trade association that represents hospitals shall
35 evaluate the inpatient hospital reimbursement system established pursuant to
36 title 36, chapter 29, article 1, Arizona Revised Statutes.

37 B. The evaluation shall include the following:

38 1. Development of a methodology that will enable the Arizona health
39 care cost containment system administration to compare reimbursement levels
40 paid by the Arizona health care cost containment system contractors with the
41 reimbursement levels of other categories of payers, including medicare and
42 insurers licensed pursuant to title 20, Arizona Revised Statutes.

43 2. Evaluate the relationship between the inpatient hospital
44 reimbursement rates and payments provided pursuant to title 36, chapter 29,

1 article 1, Arizona Revised Statutes, the actual costs hospitals incur in
2 treating patients who are enrolled in the Arizona health care cost
3 containment system and the adequacy of the rates and payments to cover those
4 costs.

5 3. A review of selected states and the reimbursement methodologies
6 used by these states for medicaid eligible persons.

7 4. A review of inflationary indicators that other states use to
8 increase hospital reimbursement.

9 5. A review of the federal requirements for title XIX reimbursement
10 of emergency services provided to nondocumented aliens, including any
11 services that do not meet the definition of an emergency service and that may
12 jeopardize title XIX funding.

13 6. A review of the impact of the inpatient hospital reimbursement
14 pilot program established by Laws 1996, chapter 288, section 20 on the
15 reimbursement levels and the number of contracts that were signed between the
16 Arizona health care cost containment system contractors and the hospitals
17 before, during and after the pilot program.

18 7. Recommendations that encourage contractual arrangements between the
19 Arizona health care cost containment system and the hospitals to reduce the
20 reliance on the fee-for-service schedule established by the system.

21 C. The director shall submit a written report of the evaluation to the
22 joint legislative committee on the implementation of proposition 204
23 established pursuant to section 106 of this act on or before November 15,
24 2002.

25 Sec. 110. Extension of existing health care contractor
26 contracts

27 Notwithstanding the requirements of section 36-2906, Arizona Revised
28 Statutes, until October 1, 2004, the Arizona health care cost containment
29 system administration may extend any contracts awarded to contractors before
30 the effective date of this act.

31 Sec. 111. Counties; hospitals; maintenance of effort

32 A. Notwithstanding any law to the contrary, until July 1, 2006, a
33 county that maintains or operates or has a contract for the operation of a
34 hospital must maintain the hospital, including emergency services,
35 commensurate with community need and good business practices unless before
36 that date the county enters into a lease, transfer or assignment to a
37 district or nonprofit corporation established by the county to operate a
38 hospital.

39 B. If a county plans to close a hospital it must give the Arizona
40 health care cost containment system administration at least twelve months'
41 notice of the planned date of closure.

1 Sec. 112. Conditional repeal

2 Section 111 of this act, relating to county hospital maintenance of
3 effort, is repealed on July 1, 2003 unless legislation is enacted before that
4 date that does both of the following:

5 1. Authorizes counties with a population of more than two million
6 persons to establish a special district or nonprofit corporation to operate
7 and maintain a health system as defined in section 11-1401, Arizona Revised
8 Statutes.

9 2. For a county that operates a hospital and receives an offset
10 payment pursuant to this act, appropriates the same amount of offset payment
11 to that county for fiscal years 2003-2004, 2004-2005 and 2005-2006 as the
12 amount appropriated to the county for an offset payment as prescribed by this
13 act. The amount of this appropriation shall be reduced to reflect any
14 reduction in that county's contribution to a pool for uncompensated care
15 provided by private hospitals.

16 Sec. 113. Exemption from rule making

17 A. The Arizona health care cost containment system administration and
18 the department of economic security are exempt from the rule making
19 requirements of title 41, chapter 6, Arizona Revised Statutes, for two years
20 from the effective date of this act to enact the requirements of this act.

21 B. Before adopting a proposed rule, the administration and the
22 department shall hold at least one public meeting in an urban county and one
23 public meeting in a rural county and shall present the proposed rules to the
24 joint legislative committee on the implementation of proposition 204.

25 Sec. 114. Exemption from the procurement code

26 The department of economic security is exempt from the procurement code
27 requirements of title 41, chapter 23, Arizona Revised Statutes, to implement
28 the eligibility determination process prescribed by this act.

29 Sec. 115. Conforming legislation

30 The legislative council staff shall prepare proposed legislation
31 conforming the Arizona Revised Statutes to the provisions of this act for
32 consideration in the forty-fifth legislature, second regular session.

33 Sec. 116. Delayed repeal

34 Sections 102, 103 and 104 of this act, relating to residual claims and
35 obligations, are repealed from and after November 15, 2004.

36 Sec. 117. Delayed repeal

37 Section 106 of this act, relating to the joint legislative committee
38 on the implementation of proposition 204, is repealed from and after November
39 15, 2003.

40 Sec. 118. Appropriation; purpose; exemption

41 A. The sum of \$5,432,500 is appropriated from the state general fund
42 in fiscal year 2001-2002 to the Arizona health care cost containment system
43 for distribution as follows to the following counties to offset a net loss

1 in revenue due to the implementation of sections 36-2901.01 and 36-2901.04,
2 Arizona Revised Statutes:

- 3 1. Cochise, \$5,500.
- 4 2. Graham, \$239,900.
- 5 3. Greenlee, \$247,300.
- 6 4. La Paz, \$188,600.
- 7 5. Maricopa, \$203,800.
- 8 6. Pima, \$4,178,100.
- 9 7. Santa Cruz, \$215,300.
- 10 8. Yavapai, \$154,000.

11 B. The appropriation made in subsection A of this section is exempt
12 from the provisions of section 35-190, Arizona Revised Statutes, relating to
13 lapsing of appropriations.

14 C. The appropriation made in subsection A of this section and any
15 savings realized by any of the counties as a result of the implementation of
16 proposition 204 shall be used for indigent health care costs.

17 Sec. 119. Appropriation; purpose; exemption

18 A. The sum of \$4,825,600 is appropriated from the state general fund
19 in fiscal year 2002-2003 to the Arizona health care cost containment system
20 for distribution as follows to the following counties to offset a net loss
21 in revenue due to the implementation of sections 36-2901.01 and 36-2901.04,
22 Arizona Revised Statutes:

- 23 1. Graham, \$234,200.
- 24 2. Greenlee, \$234,400.
- 25 3. La Paz, \$159,700.
- 26 4. Pima, \$3,817,800.
- 27 5. Santa Cruz, \$214,800.
- 28 6. Yavapai, \$164,700.

29 B. The appropriation made in subsection A of this section is exempt
30 from the provisions of section 35-190, Arizona Revised Statutes, relating to
31 lapsing of appropriations.

32 C. The appropriation made in subsection A of this section and any
33 savings realized by any of the counties as a result of the implementation of
34 proposition 204 shall be used for indigent health care costs.

35 Sec. 120. Appropriation; purpose; exemption

36 A. The sum of \$112,019,900 is appropriated from the state general fund
37 in fiscal year 2001-2002 to the Arizona health care cost containment system
38 administration for deposit in the budget neutrality compliance fund
39 established by section 36-2928, Arizona Revised Statutes.

40 B. The appropriation made in subsection A of this section is exempt
41 from the provisions of section 35-190, Arizona Revised Statutes, relating to
42 lapsing of appropriations.

1 Sec. 121. Appropriation; purpose; exemption

2 A. The sum of \$116,847,800 is appropriated from the state general fund
3 in fiscal year 2002-2003 to the Arizona health care cost containment system
4 administration for deposit in the budget neutrality compliance fund
5 established by section 36-2928, Arizona Revised Statutes.

6 B. The appropriation made in subsection A of this section is exempt
7 from the provisions of section 35-190, Arizona Revised Statutes, relating to
8 lapsing of appropriations.

9 Sec. 122. Appropriation; purpose; exemption

10 A. The sum of \$10,000,000 is appropriated from the following sources
11 in fiscal year 2001-2002 to the Arizona health care cost containment system
12 administration for the disproportionate share distributions to hospitals as
13 prescribed by this act:

14 1. \$6,498,000 from federal matching monies from the Arizona health
15 care cost containment system fund established by section 36-2913, Arizona
16 Revised Statutes.

17 2. \$3,502,000 from the county contribution prescribed in section 100,
18 subsection A of this act relating to county uncompensated care contributions.

19 B. The appropriation made in subsection A of this section is exempt
20 from the provisions of section 35-190, Arizona Revised Statutes, relating to
21 lapsing of appropriations.

22 Sec. 123. Appropriation; purpose; exemption

23 A. The sum of \$6,500,000 is appropriated from the county contribution
24 prescribed in section 100, subsection B of this act relating to county
25 uncompensated care contributions in fiscal year 2002-2003 to the Arizona
26 health care cost containment system administration for uncompensated care
27 payments to hospitals as prescribed by this act.

28 B. The appropriation made in subsection A of this section is exempt
29 from the provisions of section 35-190, Arizona Revised Statutes, relating to
30 lapsing of appropriations.

31 Sec. 124. Appropriation; purpose; exemption

32 A. The sum of \$3,500,000 is appropriated from the state general fund
33 in fiscal year 2002-2003 to the Arizona health care cost containment system
34 administration for uncompensated care payments to hospitals as prescribed by
35 this act.

36 B. The appropriation made in subsection A of this section is exempt
37 from the provisions of section 35-190, Arizona Revised Statutes, relating to
38 lapsing of appropriations.

39 Sec. 125. Appropriation; purpose

40 The sum of \$13,405,600 is appropriated from the state general fund in
41 fiscal year 2001-2002 to the medical services stabilization fund established
42 by section 36-2922, Arizona Revised Statutes, to repay the fund for fiscal
43 year 2000-2001 cost resulting from decreased revenue from the
44 disproportionate share hospitals program in fiscal year 2000-2001.

1 Sec. 126. Appropriation; purpose; adjustment

2 A. The sum of \$12,162,800 is appropriated from the state general fund
3 and \$35,532,600 is appropriated in total expenditure authority for fiscal
4 year 2001-2002 to the Arizona health care cost containment system for
5 disproportionate share hospitals payments.

6 B. The fiscal year 2001-2002 disproportionate share payment of
7 \$35,532,600 is based on the federal fiscal year 2001-2002 authorized
8 expenditure level of \$23,369,800. If the final federal expenditure
9 authorization is an amount different from the estimate, the governor shall
10 direct the Arizona health care cost containment system administration,
11 subject to the availability of monies and subject to review of the joint
12 legislative budget committee, to proportionately adjust authorization amounts
13 among the identified recipients of the disproportionate share hospital
14 payment. Before the final payment, the governor shall provide notification
15 to the president of the senate, the speaker of the house of representatives,
16 the chairmen of the house and senate appropriations committees and the staff
17 director of the joint legislative budget committee of the adjusted federal
18 authorized expenditure level and the proposed distribution plan for these
19 monies.

20 C. The appropriation for disproportionate share payments for fiscal
21 year 2001-2002 made pursuant to section 36-2903.01, subsection R, Arizona
22 Revised Statutes, includes \$15,150,000 for private qualifying
23 disproportionate share hospitals and \$20,382,600 for deposit in the Arizona
24 state hospital fund.

25 Sec. 127. Appropriation; purpose; adjustment

26 A. The sum of \$5,189,800 is appropriated from the state general fund
27 and \$15,150,000 is appropriated in total expenditure authority for fiscal
28 year 2002-2003 to the Arizona health care cost containment system for
29 disproportionate share hospital payments.

30 B. The fiscal year 2002-2003 disproportionate share payment of
31 \$15,150,000 is based on the federal fiscal year 2002-2003 authorized
32 expenditure level of \$9,964,200. If the final federal expenditure
33 authorization is an amount different from the estimate, the governor shall
34 direct the Arizona health care cost containment system administration,
35 subject to the availability of monies and subject to review of the joint
36 legislative budget committee, to proportionately adjust authorization amounts
37 among the identified recipients of the disproportionate share hospital
38 payment. Before the final payment, the governor shall provide notification
39 to the president of the senate, the speaker of the house of representatives,
40 the chairmen of the house and senate appropriations committees and the staff
41 director of the joint legislative budget committee of the adjusted federal
42 authorized expenditure level and the proposed distribution plan for these
43 monies.

1 C. The appropriation for disproportionate share payments for fiscal
2 year 2002-2003 made pursuant to section 36-2903.01, subsection R, Arizona
3 Revised Statutes, includes \$15,150,000 for private qualifying
4 disproportionate share hospitals.

5 ~~Sec. 128. Appropriation; purpose~~

6 ~~The sum of \$11,993,900 is appropriated from the state general fund in~~
7 ~~each of fiscal years 2001-2002 and 2002-2003 to the Arizona state hospital~~
8 ~~to replace decreased disproportionate share hospital payments:~~

9 ~~Sec. 129. Appropriation; purpose~~

10 ~~The sum of \$500,000 is appropriated from the Arizona state hospital~~
11 ~~fund in each of fiscal years 2001-2002 and 2002-2003 to the Arizona state~~
12 ~~hospital to reflect increased federal reimbursements for title XIX eligible~~
13 ~~clients:~~

14 Sec. 130. Conditional effective date

15 This act is effective from and after September 30, 2001, if:

16 1. Each county, and its successors and assignees, that is a party to
17 any action seeking recovery of funds received by this state pursuant to the
18 master settlement agreement entered into on November 23, 1998, between this
19 state and certain United States tobacco product manufacturers executes a
20 release that the court determines is sufficient to relinquish all rights,
21 title and interest to monies received pursuant to the master settlement
22 agreement and the consent decree in Maricopa county cause number CV96-14769
23 and any related action, including Maricopa county cause numbers CV99-20533
24 and CV2000-019545, that could result in an offset against the monies provided
25 to this state by the master settlement agreement.

26 2. Each county that is not a party to any action seeking recovery of
27 funds received by this state pursuant to the master settlement agreement
28 entered into on November 23, 1998, between this state and certain United
29 States tobacco product manufacturers executes a release that the attorney
30 general of this state determines is sufficient to relinquish all rights,
31 title and interest to make a future claim to monies received pursuant to the
32 master settlement agreement and the consent decree in Maricopa county cause
33 number CV96-14769 and any related action that could result in an offset
34 against the monies provided to this state by the master settlement agreement.

35 Sec. 131. Retroactivity

36 A. Sections 96, 97, 126 and 127 of this act are effective
37 retroactively to May 1, 2001.

38 B. Section 98 of this act is effective retroactively to July 1, 2001.

39 Sec. 132. Title

40 This act shall be known and may be cited as the "Senator Andrew Nichols
41 Comprehensive Health Insurance Coverage Act".

APPROVED BY THE GOVERNOR MAY 7, 2001.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 7, 2001.

Passed the House April 30, 2001,

by the following vote: 57 Ayes,

0 Nays, 3 Not Voting

Jake Flake
Speaker of the House
Spomen L. Moore
Chief Clerk of the House

Passed the Senate April 27, 2001,

by the following vote: 26 Ayes,

2 Nays, 2 Not Voting

Barbara Sant
President of the Senate
Norma Lowe
Asst. Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill was received by the Governor this

1 day of May, 2001,

at 10:54 o'clock A M.

Sandra Ramirez
Secretary to the Governor

Approved this 7th day of

May, 2001,

at 3:25 o'clock P M.

Jane Dee Hull
Governor of Arizona

S.B. 1577

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this 7 day of May, 2001,

at 4:55 o'clock P M.

Patricia Taylor
Secretary of State