

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

CHAPTER 84

SENATE BILL 1140

AN ACT

REPEALING SECTION 8-548.07, ARIZONA REVISED STATUTES; AMENDING SECTION 36-2903.01, ARIZONA REVISED STATUTES; 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. Repeal

3 Section 8-548.07, Arizona Revised Statutes, is repealed.

4 Sec. 2. Section 36-2903.01, Arizona Revised Statutes, is amended to
5 read:

6 36-2903.01. Additional powers and duties; violation;
7 classification

8 A. The director may adopt rules which provide that the system may
9 withhold or forfeit payments to be made to a nonprovider by the system if the
10 nonprovider fails to comply with the provisions of this article or rules
11 adopted pursuant to this article which relate to the specific services
12 rendered for which a claim for payment is made.

13 B. The director shall:

14 1. Prescribe uniform forms to be used by all providers and shall
15 prescribe and furnish uniform forms and procedures, including methods of
16 identification of members, to counties to be used for determining and
17 reporting eligibility of members. The rules may include requirements that
18 an applicant shall personally complete or assist in the completion of
19 eligibility application forms, except in situations in which the person is
20 disabled. The auditor general shall make recommendations to the director
21 regarding the format of forms in order to ensure that the system records are
22 readily available.

23 2. 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 under which the department of economic security or Arizona works agency
26 established by title 46, chapter 2, article 9 shall be required to determine
27 the eligibility of all persons defined pursuant to section 36-2901, paragraph
28 4, subdivision (b) and ensure that the eligibility process is designed to
29 maximize the enrollment of such persons with the county of residence. At the
30 administration's option, the interagency agreement may allow the
31 administration to determine the eligibility of certain persons including
32 those defined pursuant to section 36-2901, paragraph 4, subdivision (b). As
33 part of the agreement, the administration shall recoup from the department
34 of economic security or Arizona works agency all federal fiscal sanctions
35 that result from the department of economic security's or Arizona works
36 agency's inaccurate eligibility determinations for these persons.

37 3. Enter into an interagency agreement with the department of economic
38 security or Arizona works agency established by title 46, chapter 2, article
39 9 which shall require the department of economic security or Arizona works
40 agency established by title 46, chapter 2, article 9 to notify the
41 administration of persons determined eligible for the federal food stamp
42 program (P.L. 95-113; 91 Stat. 958-979) for the purpose of determining
43 eligibility for the system pursuant to section 36-2905.03.

44 4. By rule establish a procedure and time frames for the intake of
45 grievances and appeals, for the continuation of benefits and services during

1 the appeal process, for the informal resolution of grievances and appeals and
2 for a grievance process at the contractor level. With the exception of
3 grievances filed pursuant to section 36-2904, subsection H, a grievance shall
4 be filed in writing with and received by the administration not later than
5 sixty days after the date of the adverse action, decision or policy
6 implementation being grieved. A policy implementation may be subject to a
7 grievance procedure, but it may not be appealed for a hearing. The
8 administration is not required to participate in a mandatory settlement
9 conference if it is not a real party in interest. In any proceeding before
10 the administration, including a grievance or appeal tribunal, persons may
11 represent themselves or be represented by a duly authorized agent who is not
12 charging a fee. A legal entity may be represented by an officer, partner or
13 employee who is specifically authorized by the legal entity to represent it
14 in the particular proceeding.

15 5. Apply for and accept federal funds available under title XIX of the
16 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section
17 1396 (1980)) in support of the system. The application made by the director
18 pursuant to this paragraph shall be designed to qualify for federal funding
19 primarily on a prepaid capitated basis. Such funds may be used only for the
20 support of persons defined as eligible pursuant to title XIX of the social
21 security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396
22 (1980)).

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

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

33 D. The director shall adopt rules for use by the counties in
34 determining whether an applicant is a resident of this state and of the
35 county and is either a United States citizen, a qualified alien as prescribed
36 in section 36-2903.03 or eligible for state assisted emergency care under
37 section 36-2905.05. The rules shall require that state residency is not
38 established unless the requirements of paragraphs 1 and 2 of this subsection
39 are met or unless residency is proved pursuant to paragraph 3 of this
40 subsection:

41 1. The applicant produces one of the following:

42 (a) A recent Arizona rent or mortgage receipt or utility bill.

43 (b) A current Arizona motor vehicle driver license.

44 (c) A current Arizona motor vehicle registration.

45 (d) A document showing that the applicant is employed in this state.

1 (e) A document showing that the applicant has registered with a public
2 or private employment service in this state.

3 (f) Evidence that the applicant has enrolled the applicant's children
4 in a school in this state.

5 (g) Evidence that the applicant is receiving public assistance in this
6 state.

7 (h) Evidence of registration to vote in this state.

8 2. The applicant signs an affidavit attesting that all of the
9 following apply to the applicant:

10 (a) The applicant does not own or lease a residence outside this
11 state.

12 (b) The applicant does not own or lease a motor vehicle registered
13 outside this state.

14 (c) The applicant is not receiving public assistance outside this
15 state. As used in this subdivision, "public assistance" does not include
16 unemployment insurance benefits.

17 (d) The applicant is actively seeking employment in this state if he
18 is able to work and is not employed.

19 3. An applicant who does not meet the requirements of paragraph 1 or
20 2 of this subsection may apply to have residency determined by a special
21 eligibility officer who shall be appointed by the county board of
22 supervisors. The special eligibility officer shall receive any proof of
23 residency offered by the applicant and may inquire into any facts relevant
24 to the question of residency. A determination of residency shall not be
25 granted unless a preponderance of the credible evidence supports the
26 applicant's intent to remain indefinitely in this state. A denial of a
27 determination of residency may be appealed in the same manner as any other
28 denial of eligibility for the system.

29 4. An applicant who has relocated to this state from another state or
30 foreign country within six months before the date of application for the
31 purpose of obtaining state assisted medical care pursuant to this article
32 shall have the applicant's residency determined by a special eligibility
33 officer appointed pursuant to paragraph 3 of this subsection. The special
34 eligibility officer shall require, at a minimum, compliance with paragraphs
35 1 and 2 of this subsection. The special eligibility officer shall also
36 receive any additional proof of residency offered by the applicant and may
37 inquire into any facts relevant to the question of residency. A
38 determination of residency shall not be made unless a preponderance of the
39 credible evidence supports the applicant's intent to remain indefinitely in
40 this state. A denial of the determination of residency may be appealed in
41 the same manner as any other denial of eligibility for the system.

42 E. In accordance with constitutional standards and pursuant to
43 subsection D of this section, the director of the department of economic
44 security shall establish and maintain residency standards for those public

1 benefit programs related to eligibility in the system which are equivalent
2 to those residency standards established for the purposes of this article.

3 F. The director may adopt rules to do the following:

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

13 2. Defer liability, in whole or in part, of prepaid capitated contract
14 providers for care provided to members who are hospitalized on the date of
15 enrollment or under other circumstances. Payment shall be on a capped
16 fee-for-service basis for services other than hospital services and at the
17 rate established pursuant to subsection I or J of this section for hospital
18 services or at the rate paid by the health plan, whichever is less.

19 G. The director shall adopt rules which further specify the medical
20 care and hospital services which are covered by the system pursuant to
21 section 36-2907.

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

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

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

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

36 (b) The schedule of rates and charges for a hospital which became
37 effective after May 31, 1984 but prior to BEFORE July 2, 1984, if the
38 hospital's previous rate schedule became effective prior to BEFORE April 30,
39 1983.

40 (c) The schedule of rates and charges for a hospital which became
41 effective after May 31, 1984 but prior to BEFORE July 2, 1984, limited to
42 five per cent over the hospital's previous rate schedule, and if the
43 hospital's previous rate schedule became effective on or after April 30, 1983
44 but prior to BEFORE October 1, 1983. For the purposes of this paragraph
45 "constant" means equal to or lower than.

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

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

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

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

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

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

22 5. The director shall define by rule the method of determining when
23 a hospital bill will be considered received and when a hospital's billed
24 charges will be considered paid. Payment received by a hospital from the
25 administration pursuant to this subsection or from a provider either by
26 contract or pursuant to section 36-2904, subsection K shall be considered
27 payment of the hospital bill in full, except that a hospital may collect any
28 unpaid portion of its bill from other third party payors or in situations
29 covered by title 33, chapter 7, article 3.

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

33 1. For inpatient hospital stays, the administration shall use a
34 prospective tiered per diem methodology, using hospital peer groups if
35 analysis shows that cost differences can be attributed to independently
36 definable features that hospitals within a peer group share. In peer
37 grouping the administration may consider such factors as length of stay
38 differences and labor market variations. If there are no cost differences,
39 the administration shall implement a stop loss-stop gain or similar
40 mechanism. Any stop loss-stop gain or similar mechanism shall ensure that
41 the tiered per diem rates assigned to a hospital do not represent less than
42 ninety per cent of its 1990 base year costs or more than one hundred ten per
43 cent of its 1990 base year costs, adjusted by an audit factor, during the
44 period of March 1, 1993 through September 30, 1994. The tiered per diem
45 rates set for hospitals shall represent no less than eighty-seven and

1 one-half per cent or more than one hundred twelve and one-half per cent of
2 its 1990 base year costs, adjusted by an audit factor, from October 1, 1994
3 through September 30, 1995 and no less than eighty-five per cent or more than
4 one hundred fifteen per cent of its 1990 base year costs, adjusted by an
5 audit factor, from October 1, 1995 through September 30, 1996. For the
6 periods after September 30, 1996 no stop loss-stop gain or similar mechanisms
7 shall be in effect. An adjustment in the stop loss-stop gain percentage may
8 be made to ensure that total payments do not increase as a result of this
9 provision. If peer groups are used the administration shall establish
10 initial peer group designations for each hospital before implementation of
11 the per diem system. The administration may also use a negotiated rate
12 methodology. The tiered per diem methodology may include separate
13 consideration for specialty hospitals which limit their provision of services
14 to specific patient populations, such as rehabilitative patients or
15 children. The initial per diem rates shall be based upon ON hospital claims
16 and encounter data for dates of service November 1, 1990 through October 31,
17 1991 and processed through May of 1992.

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

24 3. For outpatient hospital services, the administration shall
25 reimburse a hospital by applying a hospital specific outpatient
26 cost-to-charge ratio to the covered charges.

27 4. Except if submitted under an electronic claims submission system,
28 a hospital bill is considered received for purposes of this paragraph upon
29 ON initial receipt of the legible, error-free claim form by the
30 administration if the claim includes the following error-free documentation
31 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 Payment received by a hospital from the administration pursuant to this
40 subsection or from a provider either by contract or pursuant to section
41 36-2904, subsection K is considered payment by the administration or the
42 provider of the administration's or provider's liability for the hospital
43 bill. A hospital may collect any unpaid portion of its bill from other third
44 party payors or in situations covered by title 33, chapter 7, article 3.

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

4 (a) Except for members who are eligible pursuant to section 36-2901,
5 paragraph 4, subdivisions (a), (c), (h) and (j), if the hospital's bill is
6 paid within thirty days of the date the bill was received, the administration
7 shall pay ninety-nine per cent of the rate.

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

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

16 6. In developing the reimbursement methodology, if a review of the
17 reports filed by a hospital pursuant to section 36-125.04 indicates that
18 further investigation is considered necessary to verify the accuracy of the
19 information in the reports, the administration may examine the hospital's
20 records and accounts related to the reporting requirements of section
21 36-125.04. The administration shall bear the cost incurred in connection
22 with this examination unless the administration finds that the records
23 examined are significantly deficient or incorrect, in which case the
24 administration may charge the cost of the investigation to the hospital
25 examined.

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

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

1 9. Beginning September 30, 1997, the administration shall establish
2 a separate graduate medical education program to reimburse hospitals that had
3 graduate medical education programs that were approved by the administration
4 as of October 1, 1999. The administration shall separately account for
5 monies for the graduate medical education program based on the total
6 reimbursement for graduate medical education reimbursed to hospitals by the
7 system in federal fiscal year 1995-1996 pursuant to the tiered per diem
8 methodology specified in this section. The graduate medical education
9 program reimbursement shall be adjusted annually by the increase or decrease
10 in the index published by the data resources incorporated hospital market
11 basket index for prospective hospital reimbursement. Subject to legislative
12 appropriation, on an annual basis, each qualified hospital shall receive a
13 single payment from the graduate medical education program that is equal to
14 the same percentage of graduate medical education reimbursement that was paid
15 by the system in federal fiscal year 1995-1996. Any reimbursement for
16 graduate medical education made by the administration shall not be subject
17 to future settlements or appeals by the hospitals to the administration.

18 10. The prospective tiered per diem payment methodology for inpatient
19 hospital services may include a mechanism for the payment of claims with
20 extraordinary operating costs per day. For tiered per diem rates effective
21 beginning on October 1, 1999, outlier cost thresholds are frozen at the
22 levels in effect on January 1, 1999 and adjusted annually by the
23 administration by the data resources incorporated market basket index for
24 prospective payment system hospitals.

25 K. The director may adopt rules which specify enrollment procedures
26 including notice to providers of enrollment. The rules may provide for
27 varying time limits for enrollment in different situations. The rules shall
28 provide for continuous enrollment of a pregnant woman who is determined
29 eligible pursuant to section 11-297 or 36-2905 and whose condition of
30 pregnancy is clinically verified in writing by a health care professional
31 licensed pursuant to title 32, chapter 13, 15, 17 or 25 or chapter 6, article
32 7 of this title until the last day of the month after the month of the
33 estimated date of delivery. The rules shall provide that as a condition of
34 continuous enrollment pursuant to this subsection the woman must notify her
35 county of residence and provide necessary verification of her pregnancy and
36 estimated date of delivery before the end of her certification period. The
37 rules shall specify the procedures by which the county shall notify the
38 administration that a pregnant woman qualifies for continuous enrollment and
39 shall specify procedures for the pregnant woman to notify the county of any
40 change in her financial or clinical status that might disqualify her from
41 continuous enrollment pursuant to this subsection. Pursuant to rules adopted
42 by the director, a child born to a woman under continuous enrollment shall
43 also be enrolled until the last day of the month after the month of the
44 estimated date of delivery. This subsection does not prevent a person from
45 qualifying for continued eligibility as otherwise provided in section 11-297

1 or this article. The administration shall specify in contract when a person
2 who has been determined eligible will be enrolled with that provider and the
3 date on which the provider will be financially responsible for health and
4 medical services to the person.

5 L. The administration may make direct payments to hospitals for
6 hospitalization and medical care provided to a member in accordance with the
7 provisions of this article and rules. The director may adopt rules which
8 shall establish the procedures by which the administration shall pay
9 hospitals pursuant to this subsection if a provider fails to make timely
10 payment to a hospital. Such payment shall be at a level determined pursuant
11 to section 36-2904, subsection J or K. The director may withhold payment due
12 to a provider in the amount of any payment made directly to a hospital by the
13 administration on behalf of a provider pursuant to this subsection.

14 M. The director shall establish a special unit within the
15 administration for the purpose of monitoring the third party payment
16 collections required by providers and nonproviders pursuant to section
17 36-2903, subsection C, paragraph 10 and subsection G and section 36-2915,
18 subsection E. The director shall 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 collected by a provider or
22 nonprovider which the provider or nonprovider may keep and the percentage of
23 such payments which the provider or nonprovider may be required to pay to the
24 administration. Both providers and nonproviders are required to pay to the
25 administration one hundred per cent of all third party payments collected
26 which duplicate administration fee-for-service payments. A provider that
27 contracts with the administration pursuant to section 36-2904, subsection A
28 may be entitled to retain a percentage of third party payments if the
29 payments collected and retained by a provider are reflected in reduced
30 capitation rates. A provider may be required to pay the administration a
31 percentage of third party payments collected by a provider that are not
32 reflected in reduced capitation rates.

33 N. Upon oral or written notice from the patient that the patient
34 believes the claims to be covered by the system, a provider or nonprovider
35 of health and medical services prescribed in section 36-2907 shall not do
36 either of the following unless the provider or nonprovider has verified
37 through the administration that the person has been determined ineligible,
38 has not yet been determined eligible or was not, at the time services were
39 rendered, eligible or enrolled:

40 1. Charge, submit a claim to or demand or otherwise collect payment
41 from a member or person who has been determined eligible unless specifically
42 authorized by this article or rules adopted pursuant to this article.

43 2. Refer or report a member or person who has been determined eligible
44 to a collection agency or credit reporting agency for the failure of the
45 member or person who has been determined eligible to pay charges for system

1 covered care or services unless specifically authorized by this article or
2 rules adopted pursuant to this article.

3 O. The administration may conduct postpayment review of all claims
4 paid by the administration and may recoup any monies erroneously paid. The
5 director may adopt rules that specify procedures for conducting postpayment
6 review. Prepaid capitated providers may conduct a postpayment review of all
7 claims paid by prepaid capitated providers and may recoup monies that are
8 erroneously paid.

9 P. The director or his THE DIRECTOR'S designees may employ and
10 supervise personnel necessary to assist the director in performing the
11 functions of the administration.

12 Q. The administration may contract with providers for obstetrical care
13 who are eligible to provide services under title XIX of the social security
14 act.

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

36 ~~S. Notwithstanding any law to the contrary, the administration may~~
37 ~~receive confidential adoption information for the purposes of identifying~~
38 ~~adoption related third party payors in order to recover the total costs for~~
39 ~~prenatal care and the delivery of the child, including capitation,~~
40 ~~reinsurance and any fee-for-service costs incurred by the administration on~~
41 ~~behalf of an eligible person who the administration has reason to believe had~~
42 ~~an arrangement to have the eligible person's newborn adopted. Except for the~~
43 ~~sole purpose of identifying adoption related third party payors, the~~
44 ~~administration shall not further disclose any information obtained pursuant~~
45 ~~to this subsection and shall develop and implement safeguards to protect the~~

1 ~~confidentiality of this information including limiting access to the~~
2 ~~information to only those administration personnel whose official duties~~
3 ~~require it. At no time shall the administration release to the adoptive~~
4 ~~parents' or birth parents' insurance carrier personally identifying~~
5 ~~information regarding the other party. A person who knowingly violates the~~
6 ~~requirements of this subsection pertaining to confidentiality is guilty of~~
7 ~~a class 6 felony.~~

8 S. NOTWITHSTANDING ANY LAW TO THE CONTRARY, THE ADMINISTRATION MAY
9 RECEIVE CONFIDENTIAL ADOPTION INFORMATION TO DETERMINE WHETHER AN ADOPTED
10 CHILD SHOULD BE TERMINATED FROM THE SYSTEM.

11 T. The adoption agency or the adoption attorney shall notify the
12 administration within thirty days after an eligible person receiving services
13 has placed that person's child for adoption.

14 ~~U. The administration shall not seek maternity expenditure cost~~
15 ~~recovery from a third party payor on arrangements involving the placement of~~
16 ~~a newborn with special needs as defined in section 8-141, children in the~~
17 ~~custody of the state or children placed with relatives.~~

18 V. U. If the administration implements an electronic claims
19 submission system it may adopt procedures pursuant to subsection J of this
20 section requiring documentation different than prescribed under subsection
21 J, paragraph 4 of this section.

APPROVED BY THE GOVERNOR APRIL 9, 2001.
FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 9, 2001.

Passed the House April 02, 2001,

by the following vote: 57 Ayes,

0 Nays, 3 Not Voting

[Signature]
Speaker of the House

[Signature]
Chief Clerk of the House

Passed the Senate February 14, 2001,

by the following vote: 30 Ayes,

0 Nays, 0 Not Voting

[Signature]
President of the Senate

[Signature]
Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill was received by the Governor this
_____ day of _____, 20____,

at _____ o'clock _____ M.

Secretary to the Governor

Approved this _____ day of
_____, 20____,

at _____ o'clock _____ M.

Governor of Arizona

S.B. 1140

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State
this _____ day of _____, 20____,

at _____ o'clock _____ M.

Secretary of State

SENATE CONCURS IN HOUSE
AMENDMENTS AND FINAL PASSAGE

Passed the Senate April 5, 2001,

by the following vote: 29 Ayes,

0 Nays, 1 Not Voting

Ronald A. Smith
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

5 day of April, 2001,

at 1:07 o'clock P M.

Sandra Gamble
Secretary to the Governor

APPROVED THIS 9th day of

April, 2001,

at 11:55 o'clock A M.

Janice K. Hull
Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this 9 day of April, 2001,

at 4:33 o'clock P M.

Robert Boyler
Secretary of State

S.B. 1140