

State of Arizona  
House of Representatives  
Forty-sixth Legislature  
First Regular Session  
2003

CHAPTER 265

## HOUSE BILL 2535

### AN ACT

AMENDING SECTIONS 8-142.01 AND 8-512, ARIZONA REVISED STATUTES; AMENDING TITLE 8, CHAPTER 5, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 8-514.05; AMENDING SECTIONS 36-342.01, 36-545.08, 36-559 AND 36-562, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 5.1, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-568.02; AMENDING SECTIONS 36-2005, 36-2174, 36-2218, 36-2219.01 AND 36-2901.03, ARIZONA REVISED STATUTES; REPEALING SECTION 36-2901.06, ARIZONA REVISED STATUTES; AMENDING SECTIONS 36-2903, 36-2903.01, 36-2903.03 AND 36-2904, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-2905.01; AMENDING SECTIONS 36-2906, 36-2907, 36-2907.04, 36-2907.10 AND 36-2907.11, ARIZONA REVISED STATUTES; AMENDING SECTION 36-2907.07, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 1999, CHAPTER 262, SECTION 15; AMENDING SECTION 36-2907.07, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2001, CHAPTER 313, SECTION 2; AMENDING SECTIONS 36-2907.08, 36-2909 AND 36-2913, ARIZONA REVISED STATUTES; REPEALING SECTION 36-2921, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2002, CHAPTER 329, SECTION 7; REPEALING SECTION 36-2921, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2001, CHAPTER 313, SECTION 3; REPEALING SECTION 36-2921, ARIZONA REVISED STATUTES, AS ADDED BY LAWS 2001, CHAPTER 374, SECTION 3; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING A NEW SECTION 36-2921; REPEALING SECTIONS 36-2923, 36-2923.01, 36-2923.02 AND 36-2923.03, ARIZONA REVISED STATUTES; AMENDING SECTION 36-2928, ARIZONA REVISED STATUTES; AMENDING SECTION 36-2939, ARIZONA REVISED STATUTES; AMENDING SECTIONS 36-2983, 36-2986, 36-2987, 36-2995, 36-3411, 41-3203 AND 46-231, ARIZONA REVISED STATUTES; REPEALING LAWS 2001, CHAPTER 344, SECTION 100, AS AMENDED BY LAWS 2002, CHAPTER 321, SECTION 6; PROVIDING FOR DELAYED REPEAL OF SECTION 36-2981.01, ARIZONA REVISED STATUTES; MAKING AN APPROPRIATION; RELATING TO HEALTH AND WELFARE BUDGET RECONCILIATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Section 8-142.01, Arizona Revised Statutes, is amended to  
3 read:

4 8-142.01. Adoption subsidy program; hospital reimbursement

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

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

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

- 20 1. An admission face sheet.
- 21 2. An itemized statement.
- 22 3. An admission history and physical.
- 23 4. A discharge summary or an interim summary if the claim is split.
- 24 5. An emergency record, if admission was through the emergency room.
- 25 6. Operative reports, if applicable.
- 26 7. A labor and delivery room report, if applicable.

27 D. The department shall require that the hospital pursue other third  
28 party payors before submitting a claim to the department. Payment received  
29 by a hospital from the department pursuant to this section is considered  
30 payment by the department of the department's liability for the hospital  
31 bill. A hospital may collect any unpaid portion of its bill from other third  
32 party payors or in situations covered by title 33, chapter 7, article 3.

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

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

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

43 3. If the hospital's bill is paid any time after sixty days of the  
44 date the bill was received, the department shall pay one hundred per cent of  
45 the rate plus a fee of one per cent per month for each month or portion of

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

3 F. For medical services other than those for which a rate has been  
4 established pursuant to section 36-2903.01, subsection H, the department  
5 shall pay according to the Arizona health care cost containment system capped  
6 fee-for-service schedule adopted pursuant to section 36-2904,  
7 subsection L-K.

8 G. For any hospital or medical claims not covered under subsection A  
9 or F of this section, the department shall establish and adopt a schedule  
10 setting out maximum allowable fees that the department deems reasonable for  
11 such services after appropriate study and analysis of usual and customary  
12 fees charged by providers.

13 Sec. 2. Section 8-512, Arizona Revised Statutes, is amended to read:

14 8-512. Comprehensive medical and dental care; guidelines

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

- 17 1. Placed in a foster home.
- 18 2. In the custody of the department and placed with a relative.
- 19 3. In the custody of the department and placed in a certified adoptive  
20 home before the entry of the final order of adoption.
- 21 4. In the custody of the department and in an independent living  
22 program as provided in section 8-521.
- 23 5. In the custody of a probation department and placed in foster  
24 care. The department shall not provide this care if the cost exceeds funds  
25 currently appropriated and available for that purpose.

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

- 27 1. A program of regular health examinations and immunizations  
28 including as minimums:
  - 29 (a) Vaccinations to prevent mumps, rubella, smallpox and polio.
  - 30 (b) Tests for anemia, coccidioidomycosis and tuberculosis.
  - 31 (c) Urinalysis, blood count and hemoglobin tests.
  - 32 (d) Regular examinations for general health, hearing and vision,  
33 including providing corrective devices when needed.
- 34 2. Inpatient and outpatient hospital care.
- 35 3. Necessary services of physicians, surgeons, psychologists and  
36 psychiatrists.
- 37 4. Dental care consisting of at least oral examinations including  
38 diagnostic radiographs, oral prophylaxis and topical fluoride applications,  
39 restoration of permanent and primary teeth, pulp therapy, extraction when  
40 necessary, fixed space maintainers where needed and other services for relief  
41 of pain and infection.
- 42 5. Drug prescription service.

43 C. The facilities of any hospital or other institution within the  
44 state, public or private, may be employed by the foster parent, relative,

1 certified adoptive parent, agency or division having responsibility for the  
2 care of the child.

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

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

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

- 15 1. An admission face sheet.
- 16 2. An itemized statement.
- 17 3. An admission history and physical.
- 18 4. A discharge summary or an interim summary if the claim is split.
- 19 5. An emergency record, if admission was through the emergency room.
- 20 6. Operative reports, if applicable.
- 21 7. A labor and delivery room report, if applicable.

22 G. The department shall require that the hospital pursue other third  
23 party payors before submitting a claim to the department. Payment received  
24 by a hospital from the department is considered payment by the department of  
25 the department's liability for the hospital bill. A hospital may collect any  
26 unpaid portion of its bill from other third party payors or in situations  
27 covered by title 33, chapter 7, article 3.

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

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

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

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

41 I. For medical services other than those for which a rate has been  
42 established pursuant to section 36-2903.01, subsection H, the department  
43 shall pay according to the Arizona health care cost containment system capped  
44 fee-for-service schedule adopted pursuant to section 36-2904,  
45 subsection L K.

1 J. For any hospital or medical claims not covered under subsection D  
2 or I of this section, the department shall establish and adopt a schedule  
3 setting out maximum allowable fees that the department deems reasonable for  
4 such services after appropriate study and analysis of usual and customary  
5 fees charged by providers. The department shall not pay to any plan or  
6 intermediary that portion of the cost of any service provided that exceeds  
7 allowable charges prescribed by the department pursuant to this subsection.

8 K. The department shall not pay claims for services pursuant to this  
9 section that are submitted more than one hundred eighty days after the date  
10 of the service for which the payment is claimed.

11 L. The department may provide for payment through an insurance plan,  
12 hospital service plan, medical service plan, or any other health service plan  
13 authorized to do business in this state, fiscal intermediary or a combination  
14 of such plans or methods. The state shall not be liable for and the  
15 department shall not pay to any plan or intermediary any portion of the cost  
16 of comprehensive medical and dental care in excess of funds appropriated and  
17 available for such purpose at the time the plan or intermediary incurs the  
18 expense for such care.

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

27 Sec. 3. Title 8, chapter 5, article 1, Arizona Revised Statutes, is  
28 amended by adding section 8-514.05, to read:

29 8-514.05. Foster care provider access to child health  
30 information; consent to treatment

31 A. IF A HEALTH PLAN, A HEALTH CARE PROVIDER LICENSED OR CERTIFIED  
32 PURSUANT TO TITLE 32 OR TITLE XIX OF THE SOCIAL SECURITY ACT OR A HEALTH CARE  
33 INSTITUTION LICENSED PURSUANT TO TITLE 36, CHAPTER 4 HAS PROVIDED OR IS  
34 PROVIDING SERVICES TO A CHILD PLACED IN OUT-OF-HOME PLACEMENT AND HAS CUSTODY  
35 OR CONTROL OF THAT CHILD'S MEDICAL OR BEHAVIORAL HEALTH RECORDS, THE PLAN,  
36 PROVIDER OR INSTITUTION MUST PROVIDE THE FOLLOWING TO THE CHILD'S FOSTER  
37 PARENT, GROUP HOME STAFF, FOSTER HOME STAFF, RELATIVE OR OTHER PERSON OR  
38 AGENCY IN WHOSE CARE THE CHILD IS CURRENTLY PLACED PURSUANT TO THIS ARTICLE  
39 OR ARTICLE 4 OF THIS CHAPTER:

- 40 1. MEDICAL RECORDS.
- 41 2. BEHAVIORAL HEALTH RECORDS.
- 42 3. INFORMATION RELATING TO THE CHILD'S CONDITION AND TREATMENT.
- 43 4. THE CHILD'S PRESCRIPTION AND NONPRESCRIPTION DRUGS, MEDICATIONS,
- 44 DURABLE MEDICAL EQUIPMENT, DEVICES AND RELATED INFORMATION.

1 B. IF A HEALTH PLAN, A HEALTH CARE PROVIDER LICENSED OR CERTIFIED  
2 PURSUANT TO TITLE 32 OR TITLE XIX OF THE SOCIAL SECURITY ACT OR A HEALTH CARE  
3 INSTITUTION LICENSED PURSUANT TO TITLE 36, CHAPTER 4 HAS PROVIDED OR IS  
4 PROVIDING SERVICES TO A CHILD FOR WHOM THE DEPARTMENT IS THE LEGAL GUARDIAN  
5 OR IS PROVIDING FOSTER CARE OR SUBSTANCE ABUSE SERVICES AND HAS CUSTODY OR  
6 CONTROL OF THAT CHILD'S MEDICAL OR BEHAVIORAL HEALTH RECORDS, THE PLAN,  
7 PROVIDER OR INSTITUTION MUST PROVIDE THE FOLLOWING TO THE DEPARTMENT'S  
8 EMPLOYEES WHO ARE INVOLVED IN THE CHILD'S CASE MANAGEMENT:

- 9 1. MEDICAL RECORDS.
- 10 2. BEHAVIORAL HEALTH RECORDS.
- 11 3. INFORMATION RELATING TO THE CHILD'S CONDITION AND TREATMENT.
- 12 4. THE CHILD'S PRESCRIPTION AND NONPRESCRIPTION DRUGS, MEDICATIONS,  
13 DURABLE MEDICAL EQUIPMENT, DEVICES AND RELATED INFORMATION.

14 C. THE FOSTER PARENT, GROUP HOME STAFF, FOSTER HOME STAFF, RELATIVE  
15 OR OTHER PERSON OR AGENCY IN WHOSE CARE THE CHILD IS CURRENTLY PLACED  
16 PURSUANT TO THIS ARTICLE OR ARTICLE 4 OF THIS CHAPTER:

- 17 1. MAY GIVE CONSENT FOR THE FOLLOWING:
  - 18 (a) EVALUATION AND TREATMENT FOR EMERGENCY CONDITIONS THAT ARE NOT  
19 LIFE THREATENING.
  - 20 (b) ROUTINE MEDICAL AND DENTAL TREATMENT AND PROCEDURES, INCLUDING  
21 EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT SERVICES, AND SERVICES BY  
22 HEALTH CARE PROVIDERS TO RELIEVE PAIN OR TREAT SYMPTOMS OF COMMON CHILDHOOD  
23 ILLNESSES OR CONDITIONS.
  - 24 2. SHALL NOT CONSENT TO:
    - 25 (a) GENERAL ANESTHESIA.
    - 26 (b) SURGERY.
    - 27 (c) TESTING FOR THE PRESENCE OF THE HUMAN IMMUNODEFICIENCY VIRUS.
    - 28 (d) BLOOD TRANSFUSIONS.
    - 29 (e) ABORTIONS.

30 ~~Sec. 4. Section 36-342.01, Arizona Revised Statutes, is amended to~~  
31 read:

32 36-342.01. Vital records electronic systems fund; purpose;  
33 nonlapsing; expenditure plan; review

34 A. The vital records electronic systems fund is established consisting  
35 of monies deposited pursuant to section 36-342. The department shall  
36 administer the fund. The department shall use fund monies for costs  
37 associated with the vital records automation system AND FOR OPERATING COSTS  
38 OF THE DEPARTMENT.

39 B. Fund monies:

- 40 1. Do not revert to the state general fund.
- 41 2. Are exempt from the provisions of section 35-190 relating to  
42 lapsing of appropriations.
- 43 ~~3. Are continuously appropriated.~~

~~1 C. On notice from the director, the state treasurer shall invest and  
2 divest monies in the fund as provided by section 35-313, and monies earned  
3 from investment shall be credited to the fund.~~

~~4 D. Before the department spends fund monies for the purchase of new  
5 information technology, it must submit a detailed expenditure plan to the  
6 joint legislative budget committee for its review. The department shall  
7 submit this plan after it receives approval for the purchase from the  
8 government information technology agency pursuant to section 41-2513, but not  
9 later than February 1, 2004.~~

**VETO**

10 Sec. 5. Section 36-545.08, Arizona Revised Statutes, is amended to  
11 read:

12 36-545.08. Arizona state hospital fund; purpose

13 A. The Arizona state hospital fund is established for the purposes  
14 prescribed in section 36-545.01, subsection I. The department of health  
15 services shall administer the fund. The fund consists of the following:

16 1. Monies appropriated by the legislature and matching federal monies  
17 paid to the department for disproportionate share payments to the state  
18 hospital.

19 2. Monies reimbursed by the federal government under title XIX of the  
20 social security act for services provided at the state hospital.

21 3. Monies collected pursuant to section 36-3410 for services to  
22 clients at the state hospital.

23 4. MONIES COLLECTED FROM COUNTIES FOR THE COST OF A DEFENDANT'S  
24 INPATIENT COMPETENCY RESTORATION TREATMENT.

25 B. The department shall deposit monies collected pursuant to  
26 subsection A of this section into three separate accounts.

27 C. Monies in the fund deposited under subsection A, paragraphs 1, and  
28 2 AND 4 of this section are subject to legislative appropriation and are  
29 designated for state hospital operations. Monies in the fund deposited under  
30 subsection A, paragraph 3 of this section are a continuing appropriation and  
31 are exempt from the provisions of section 35-190 relating to lapsing of  
32 appropriations. Monies in the fund deposited under subsection A, paragraph  
33 PARAGRAPHS 1 AND 4 of this section remaining unexpended and unencumbered at  
34 the end of the fiscal year revert to the state general fund. Monies in the  
35 fund deposited under subsection A, paragraph 2 of this section are exempt  
36 from the provisions of section 35-190 relating to lapsing of appropriations

37 Sec. 6. Section 36-559, Arizona Revised Statutes, is amended to read:

38 36-559. Eligibility for developmental disabilities programs,  
39 services and facilities

40 A. Except as provided in subsection B of this section, a  
41 developmentally disabled person WITH A DEVELOPMENTAL DISABILITY is eligible  
42 to apply for developmental disabilities programs, services and facilities  
43 operated by, licensed and supervised by, or supported by the department if  
44 such person:

45 1. Is a bona fide resident of the state of Arizona.



1 ~~periods of temporary absence, such as for home visits, vacations or other~~  
2 ~~purposes.~~

3 B. The financial contribution by the parent of a developmentally  
4 disabled minor WITH A DEVELOPMENTAL DISABILITY shall terminate upon the  
5 eighteenth birthday of such person. The financial contribution by parents  
6 on behalf of two or more developmentally disabled persons WITH DEVELOPMENTAL  
7 DISABILITIES receiving developmental disabilities programs or services shall  
8 not exceed the maximum amount such parents would be required to pay if only  
9 one of such children were receiving the programs or services.

10 C. The department shall by rule prescribe a fee schedule for  
11 developmental disability residential programs provided directly or indirectly  
12 by the department. The amount of annual liability of a developmentally  
13 disabled person or his estate WITH A DEVELOPMENTAL DISABILITY or parent for  
14 residential programs AND SERVICES provided shall be based on the percentage  
15 of gross income of the developmentally disabled person, his estate WITH A  
16 DEVELOPMENTAL DISABILITY or parent, as defined by section 61 of the United  
17 States internal revenue code, except that part of the gross income of a  
18 self-employed person which results from the operation of his business shall  
19 be adjusted by the deductions allowed in the internal revenue code relating  
20 to such income in computing adjusted gross income.

21 D. FOR A PERSON WITH A DEVELOPMENTAL DISABILITY OR A PARENT OF A MINOR  
22 WITH A DEVELOPMENTAL DISABILITY WITH AN ESTATE, TRUST OR ANNUITY, THE AMOUNT  
23 OF ANNUAL LIABILITY FOR RESIDENTIAL PROGRAMS AND SERVICES SHALL BE BASED ON  
24 THE ACTUAL COST OF SERVICES UNTIL THE INDIVIDUAL MEETS THE FINANCIAL  
25 ELIGIBILITY REQUIREMENTS FOR FEDERAL SOCIAL SECURITY SUPPLEMENTAL INCOME  
26 BENEFITS OR THE FINANCIAL ELIGIBILITY REQUIREMENTS FOR THE ARIZONA LONG-TERM  
27 CARE SYSTEM. IN BILLING A TRUST, THE DEPARTMENT IS NOT LIMITED TO TRUST  
28 INCOME, BUT SHALL ALSO BILL THE TRUST CORPUS.

29 ~~D.~~ E. The director shall review his order for payment for residential  
30 care AND SERVICES at least annually, and shall require the responsible person  
31 to update the financial information provided annually or at any time upon  
32 request by the county board of supervisors or by the parent, guardian, or  
33 other person making such payments. The provisions of section 36-563 shall  
34 apply to any order or change in order for payment.

35 ~~E.~~ F. The responsible person shall furnish current financial  
36 information to the director and to the appropriate county board of  
37 supervisors at the times and on the forms and in the manner prescribed by the  
38 director, provided that such information shall be held by the director and  
39 the county board of supervisors to be strictly confidential, and it shall not  
40 be divulged except in the instance where it is necessary in connection with  
41 legal action.

42 ~~F.~~ G. A financial contribution which shall not exceed the actual cost  
43 of the programs and services provided may be required from the client or the  
44 parent, spouse or estate of a developmental disability person WITH A  
45 DEVELOPMENTAL DISABILITY for the cost of any nonresidential developmental

1 disability program or service operated by or supported by the  
2 department. The department shall by rule adopt a fee schedule for financial  
3 contributions. The amount of liability of a client or the parent, spouse or  
4 estate of a client for nonresidential services and programs or any  
5 combination of residential and nonresidential services and programs shall not  
6 exceed the amount of the fee prescribed for residential services in  
7 subsection C of this section. Counties are not required to contribute to the  
8 cost of nonresidential services or programs provided to clients.

9 ~~G.~~ H. The amount payable by the ~~developmentally disabled~~ person WITH  
10 A DEVELOPMENTAL DISABILITY or his THE PERSON'S parent or estate for  
11 residential services shall be fixed by the director in accordance with the  
12 fee schedule prescribed in this section.

13 ~~H.~~ I. Money paid by a client, parent or guardian shall be paid to the  
14 director and deposited, pursuant to sections 35-146 and 35-147, in the state  
15 general fund.

16 ~~I.~~ J. The department shall provide monthly, OR MORE FREQUENT,  
17 billings, AS REQUIRED, to all persons responsible for paying for  
18 developmentally disabled residential or nonresidential services and programs  
19 provided directly or indirectly by the department. The department shall  
20 require all purchase of care providers to provide current lists of all  
21 persons receiving residential or nonresidential services and programs in  
22 facilities operated by such providers. The department shall forward reports  
23 of delinquent billings for residential and nonresidential services and  
24 programs provided by the department or by contractors to the attorney general  
25 for collection.

26 ~~J.~~ K. The department shall notify each client and the parent or  
27 guardian of such client for whom it has determined that contributions are  
28 required for the cost of residential or nonresidential services and programs  
29 that it reserves the right to terminate developmental disability residential  
30 or nonresidential services and programs to a client for nonpayment of fees  
31 required to be paid pursuant to this section.

32 ~~K.~~ L. Any person affected by an order of the director for payment of  
33 costs of care may contest such order and request an administrative hearing  
34 pursuant to section 36-563. Any person liable for the costs of care of a  
35 client may appeal to the director, pursuant to section 36-563, for a  
36 reduction in the amount of payment for such costs of care on the basis of  
37 hardship.

38 ~~L.~~ M. The provisions of subsections C and ~~G.~~ H of this section  
39 notwithstanding, the department may require clients who are receiving  
40 residential programs and who receive income or benefits to contribute to the  
41 cost of their support and maintenance, subject to the provisions of federal  
42 laws and regulations. Such contributions shall not be subject to the  
43 provisions of subsections A and ~~H.~~ I of this section. The department shall  
44 adopt rules which determine the amount and means of payment of such  
45 contributions, except that in no event shall the combined contribution made

1 on behalf of a client by a client or the client's parent or estate exceed the  
2 actual cost of the residential programs provided. A minimum of thirty per  
3 cent of the client's income or benefits shall be retained for the client's  
4 personal use.

5 Sec. 8. Title 36, chapter 5.1, article 1, Arizona Revised Statutes,  
6 is amended by adding section 36-568.02, to read:

7 36-568.02. Confidentiality of health information

8 A. IF A HEALTH PLAN, A HEALTH CARE PROVIDER LICENSED OR CERTIFIED  
9 PURSUANT TO TITLE 32 OR TITLE XIX OF THE SOCIAL SECURITY ACT OR A HEALTH CARE  
10 INSTITUTION LICENSED PURSUANT TO CHAPTER 4 OF THIS TITLE HAS PROVIDED OR IS  
11 PROVIDING SERVICES TO A PERSON AND HAS CUSTODY OR CONTROL OF THAT PERSON'S  
12 MEDICAL OR BEHAVIORAL HEALTH RECORDS, THE PLAN, PROVIDER OR INSTITUTION MUST  
13 PROVIDE THE FOLLOWING TO THAT PERSON'S SERVICE PROVIDER, RELATIVE OR OTHER  
14 PERSON OR AGENCY IN WHOSE CARE THE PERSON RECEIVING SERVICES IS CURRENTLY  
15 PLACED AND TO THE DEPARTMENT'S EMPLOYEES WHO ARE INVOLVED IN THAT PERSON'S  
16 CASE MANAGEMENT:

- 17 1. MEDICAL RECORDS.
- 18 2. BEHAVIORAL HEALTH RECORDS.
- 19 3. INFORMATION RELATING TO THE PERSON'S CONDITION AND TREATMENT.
- 20 4. THE PERSON'S PRESCRIPTION AND NONPRESCRIPTION DRUGS, MEDICATIONS,  
21 DURABLE MEDICAL EQUIPMENT, DEVICES AND RELATED INFORMATION.

22 B. NOTWITHSTANDING SUBSECTION A, A COMPETENT ADULT OR EMANCIPATED  
23 MINOR MAY RESTRICT THE RELEASE OF THE ADULT'S OR THE MINOR'S MEDICAL OR  
24 BEHAVIORAL HEALTH RECORDS, OR BOTH, AND INFORMATION THAT IS OTHERWISE  
25 ALLOWABLE UNDER STATE AND FEDERAL LAW.

~~26 Sec. 9. Section 36-2005, Arizona Revised Statutes, is amended to read:  
27 36-2005. Substance abuse services fund; purpose; administration~~

~~28 A. The substance abuse services fund is established. The fund shall  
29 consist of monies collected pursuant to section 12-116.02 and distributed  
30 pursuant to section 36-2219.01 BEFORE THE EFFECTIVE DATE OF THIS AMENDMENT  
31 TO THIS SECTION.~~

~~32 B. Subject to legislative appropriation, the director of the  
33 department shall administer the fund and may expend monies in the fund for  
34 administration of the fund and for alcohol and other drug screening,  
35 education or treatment for persons who have been ordered by the court to  
36 attend pursuant to sections 5-95.01, 8-249, 28-1381, 28-1382 and 28-1383 and  
37 who do not have sufficient financial ability to pay. Monies deposited  
38 pursuant to section 36-2219.01, paragraph 4 are subject to legislative  
39 appropriation and shall be accounted for separately for use in administering  
40 the provisions of section 36-141.~~

~~41 C. Monies in the substance abuse services fund are exempt from the  
42 provisions of section 35-190 relating to lapsing appropriations.~~

1           Sec. 10. Section 36-2174, Arizona Revised Statutes, is amended to  
2 read:

3           36-2174. Rural private primary care provider loan repayment  
4                                   program; private practice

5           A. SUBJECT TO THE AVAILABILITY OF MONIES, the department of health  
6 services shall establish a rural private primary care provider loan repayment  
7 program for physicians, dentists and mid-level providers with current or  
8 prospective rural primary care practices located in medically underserved  
9 areas in this state, as prescribed in section 36-2352. To be eligible to  
10 participate in the program an applicant shall agree to provide organized,  
11 discounted, sliding fee scale services for medically uninsured individuals  
12 from families with annual incomes below two hundred per cent of the federal  
13 poverty guidelines as established annually by the United States department  
14 of health and human services. The department shall approve the sliding fee  
15 scale used by the provider. The provider shall assure notice to consumers  
16 of the availability of these services. The department shall give preference  
17 to applicants who agree to serve in rural areas. For the purposes of this  
18 subsection, "rural" means either of the following:

19           1. A county with a population of less than four hundred thousand  
20 persons according to the most recent United States decennial census.

21           2. A census county division with less than fifty thousand persons in  
22 a county with a population of four hundred thousand or more persons according  
23 to the most recent United States decennial census.

24           B. Except as provided in section 36-2172, subsection B, paragraph 2,  
25 the program established pursuant to this section and loan repayment contracts  
26 made pursuant to this section shall comply with the requirements of section  
27 36-2172.

28           C. The department of health services may apply for and receive private  
29 donations and grant monies to implement the rural private primary care  
30 provider loan repayment program established pursuant to this section.

~~31           Sec. 11. Section 36-2218, Arizona Revised Statutes, is amended to  
32 read:~~

~~33           36-2218. Emergency medical services operating fund~~

~~34           A. An emergency medical services operating fund is established. The  
35 director shall administer the fund. The emergency medical services operating  
36 fund shall consist of monies collected pursuant to sections 12-116.02 and  
37 36-3251 and distributed pursuant to section 36-2219.01, subsection B,  
38 paragraph 2-1.~~

~~39           B. The director of the department of health services with advice from  
40 the council shall expend monies in the fund for funding local and state  
41 emergency medical services systems. Monies in the fund are subject to annual  
42 legislative appropriation.~~

~~1 Sec. 12. Section 36-2219.01, Arizona Revised Statutes, is amended to~~  
2 read:

3 36-2219.01. Medical services enhancement fund

4 A. A medical services enhancement fund is established consisting of  
5 monies collected pursuant to section 12-116.02. The state treasurer shall  
6 administer the fund.

7 B. On the first day of each month, the state treasurer shall  
8 distribute or deposit:

9 ~~1. Fourteen and two-tenths per cent in the substance abuse services~~  
10 ~~fund established pursuant to section 36-2005.~~

11 ~~2. 1. Forty-eight and nine-tenths per cent in the emergency medical~~  
12 ~~services operating fund established pursuant to section 36-2218 of which at~~  
13 ~~least eight per cent shall be used for personnel expenses, education,~~  
14 ~~training and equipment purchases in cities or towns with a population of less~~  
15 ~~than ninety thousand persons according to the most recent United States~~  
16 ~~decennial census.~~

17 ~~3. 2. Twenty-two per cent in the spinal and head injuries trust fund~~  
18 ~~established pursuant to section 41-3203.~~

19 ~~4. Nine and four-tenths per cent in a separate account of the~~  
20 ~~substance abuse services fund established by section 36-2005 for use in~~  
21 ~~administering the provisions of section 36-141.~~

22 ~~5. 3. Five and five-tenths TWENTY-NINE AND ONE-TENTH per cent in the~~  
23 ~~state general fund.~~

24 C. Monies distributed pursuant to subsection B of this section  
25 ~~constitute a continuing appropriation.~~

26 Sec. 13. Section 36-2901.03, Arizona Revised Statutes, is amended to  
27 read:

28 36-2901.03. Federal poverty program; eligibility

29 A. The administration shall adopt rules for a streamlined eligibility  
30 determination process for any person who applies to be an eligible person as  
31 defined in section 36-2901, paragraph 6, subdivision (a), item (jv). The  
32 administration shall adopt these rules in accordance with state and federal  
33 requirements and the section 1115 waiver.

34 B. The administration must base eligibility on an adjusted gross  
35 income that does not exceed one hundred per cent of the federal poverty  
36 guidelines.

37 C. For persons who the administration ADMINISTRATION determines are  
38 eligible pursuant to this section, the date of eligibility is the first day  
39 of the month of application.

40 D. The administration shall determine an eligible person's continued  
41 eligibility ~~on an annual basis~~ EVERY SIX MONTHS.

42 ~~Sec. 14. Repeal~~

43 ~~Section 36-2901.06, Arizona Revised Statutes, is repealed.~~

VET

1           Sec. 15. 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 contractors for the provision of hospitalization  
9 and medical care coverage to members. Except as specifically required by  
10 federal law and by section 36-2909, the system is only responsible for  
11 providing care on or after the date that the person has been determined  
12 eligible for the system, and is only responsible for reimbursing the cost of  
13 care rendered on or after the date that the person was determined eligible  
14 for the system.

15           B. An agreement may be entered into with an independent contractor,  
16 subject to title 41, chapter 23, to serve as the statewide administrator of  
17 the system. The administrator has full operational responsibility, subject  
18 to supervision by the director, for the system, which may include any or all  
19 of the following:

20           1. Development of county-by-county implementation and operation plans  
21 for the system that include reasonable access to hospitalization and medical  
22 care services for members.

23           2. Contract administration, certification and oversight of  
24 contractors.

25           3. Provision of technical assistance services to contractors and  
26 potential contractors.

27           4. Development of a complete system of accounts and controls for the  
28 system including provisions designed to ensure that covered health and  
29 medical services provided through the system are not used unnecessarily or  
30 unreasonably including but not limited to inpatient behavioral health  
31 services provided in a hospital. Periodically the administrator shall  
32 compare the scope, utilization rates, utilization control methods and unit  
33 prices of major health and medical services provided in this state in  
34 comparison with other states' health care services to identify any  
35 unnecessary or unreasonable utilization within the system. The administrator  
36 shall periodically assess the cost effectiveness and health implications of  
37 alternate approaches to the provision of covered health and medical services  
38 through the system in order to reduce unnecessary or unreasonable  
39 utilization.

40           5. Establishment of peer review and utilization review functions for  
41 all contractors.

42           6. Assistance in the formation of medical care consortiums to provide  
43 covered health and medical services under the system for a county.

44           7. Development and management of a contractor payment system.

1           8. Establishment and management of a comprehensive system for assuring  
2 the quality of care delivered by the system.

3           9. Establishment and management of a system to prevent fraud by  
4 members, subcontracted providers of care, contractors and noncontracting  
5 providers.

6           10. Coordination of benefits provided under this article to any member.  
7 The administrator may require that contractors and noncontracting providers  
8 are responsible for the coordination of benefits for services provided under  
9 this article. Requirements for coordination of benefits by noncontracting  
10 providers under this section are limited to coordination with standard health  
11 insurance and disability insurance policies and similar programs for health  
12 coverage.

13           11. Development of a health education and information program.

14           12. Development and management of an enrollment system.

15           13. Establishment and maintenance of a claims resolution procedure to  
16 ensure that ninety per cent of the clean claims shall be paid within thirty  
17 days of receipt and ninety-nine per cent of the remaining clean claims shall  
18 be paid within ninety days of receipt. For the purpose of this paragraph,  
19 "clean claims" has the same meaning as prescribed in section 36-2904,  
20 subsection H- G.

21           14. Establishment of standards for the coordination of medical care and  
22 patient transfers pursuant to section 36-2909, subsection B.

23           15. Establishment of a system to implement medical child support  
24 requirements, as required by federal law. The administration may enter into  
25 an intergovernmental agreement with the department of economic security to  
26 implement the provisions of this paragraph.

27           16. Establishment of an employee recognition fund.

28           C. If an agreement is not entered into with an independent contractor  
29 to serve as statewide administrator of the system pursuant to subsection B  
30 of this section, the director shall ensure that the operational  
31 responsibilities set forth in subsection B of this section are fulfilled by  
32 the administration and other contractors as necessary.

33           D. If the director determines that the administrator will fulfill some  
34 but not all of the responsibilities set forth in subsection B of this  
35 section, the director shall ensure that the remaining responsibilities are  
36 fulfilled by the administration and other contractors as necessary.

37           E. The administrator or any direct or indirect subsidiary of the  
38 administrator is not eligible to serve as a contractor.

39           F. Except for reinsurance obtained by contractors, the administrator  
40 shall coordinate benefits provided under this article to any eligible person  
41 who is covered by workers' compensation, disability insurance, a hospital and  
42 medical service corporation, a health care services organization, an  
43 accountable health plan or any other health or medical or disability  
44 insurance plan including coverage made available to persons defined as  
45 eligible by section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e),

1 or who receives payments for accident-related injuries, so that any costs for  
2 hospitalization and medical care paid by the system are recovered from any  
3 other available third party payors. The administrator may require that  
4 contractors and noncontracting providers are responsible for the coordination  
5 of benefits for services provided under this article. Requirements for  
6 coordination of benefits by noncontracting providers under this section are  
7 limited to coordination with standard health insurance and disability  
8 insurance policies and similar programs for health coverage. The system  
9 shall act as payor of last resort for persons eligible pursuant to section  
10 36-2901, paragraph 6, subdivision (a), section 36-2974 or section 36-2981,  
11 paragraph 6 unless specifically prohibited by federal law. By operation of  
12 law, eligible persons assign to the system and a county rights to all types  
13 of medical benefits to which the person is entitled, including first party  
14 medical benefits under automobile insurance policies based on the order of  
15 priorities established pursuant to section 36-2915. The state has a right  
16 to subrogation against any other person or firm to enforce the assignment of  
17 medical benefits. The provisions of this subsection are controlling over the  
18 provisions of any insurance policy that provides benefits to an eligible  
19 person if the policy is inconsistent with the provisions of this subsection.

20 G. Notwithstanding subsection E of this section, the administrator may  
21 subcontract distinct administrative functions to one or more persons who may  
22 be contractors within the system.

23 H. The director shall require as a condition of a contract with any  
24 contractor that all records relating to contract compliance are available for  
25 inspection by the administrator and the director subject to subsection I of  
26 this section and that such records be maintained by the contractor for five  
27 years. The director shall also require that these records be made available  
28 by a contractor on request of the secretary of the United States department  
29 of health and human services, or its successor agency.

30 I. Subject to existing law relating to privilege and protection, the  
31 director shall prescribe by rule the types of information that are  
32 confidential and circumstances under which such information may be used or  
33 released, including requirements for physician-patient confidentiality.  
34 Notwithstanding any other provision of law, such rules shall be designed to  
35 provide for the exchange of necessary information among the counties, the  
36 administration and the department of economic security for the purposes of  
37 eligibility determination under this article. Notwithstanding any law to the  
38 contrary, a member's medical record shall be released without the member's  
39 consent in situations or suspected cases of fraud or abuse relating to the  
40 system to an officer of the state's certified Arizona health care cost  
41 containment system fraud control unit who has submitted a written request for  
42 the medical record.

43 J. The director shall prescribe rules that specify methods for:

44 1. The transition of members between system contractors and  
45 noncontracting providers.

1           2. The transfer of members and persons who have been determined  
2 eligible from hospitals that do not have contracts to care for such persons.

3           K. The director shall adopt rules that set forth procedures and  
4 standards for use by the system in requesting county long-term care for  
5 members or persons determined eligible.

6           L. To the extent that services are furnished pursuant to this article,  
7 and unless otherwise required pursuant to this chapter, a contractor is not  
8 subject to the provisions of title 20.

9           M. As a condition of the contract with any contractor, the director  
10 shall require contract terms as necessary in the judgment of the director to  
11 ensure adequate performance and compliance with all applicable federal laws  
12 by the contractor of the provisions of each contract executed pursuant to  
13 this chapter. Contract provisions required by the director shall include at  
14 a minimum the maintenance of deposits, performance bonds, financial reserves  
15 or other financial security. The director may waive requirements for the  
16 posting of bonds or security for contractors that have posted other security,  
17 equal to or greater than that required by the system, with a state agency for  
18 the performance of health service contracts if funds would be available from  
19 such security for the system on default by the contractor. The director may  
20 also adopt rules for the withholding or forfeiture of payments to be made to  
21 a contractor by the system for the failure of the contractor to comply with  
22 a provision of the contractor's contract with the system or with the adopted  
23 rules. The director may also require contract terms allowing the  
24 administration to operate a contractor directly under circumstances specified  
25 in the contract. The administration shall operate the contractor only as  
26 long as it is necessary to assure delivery of uninterrupted care to members  
27 enrolled with the contractor and accomplish the orderly transition of those  
28 members to other system contractors, or until the contractor reorganizes or  
29 otherwise corrects the contract performance failure. The administration  
30 shall not operate a contractor unless, before that action, the administration  
31 delivers notice to the contractor and provides an opportunity for a hearing  
32 in accordance with procedures established by the director. Notwithstanding  
33 the provisions of a contract, if the administration finds that the public  
34 health, safety or welfare requires emergency action, it may operate as the  
35 contractor on notice to the contractor and pending an administrative hearing,  
36 which it shall promptly institute.

37           N. The administration for the sole purpose of matters concerning and  
38 directly related to the Arizona health care cost containment system and the  
39 Arizona long-term care system is exempt from section 41-192.

40           O. Notwithstanding subsection F of this section, if the administration  
41 determines that according to federal guidelines it is more cost-effective for  
42 a person defined as eligible under section 36-2901, paragraph 6, subdivision  
43 (a) to be enrolled in a group health insurance plan in which the person is  
44 entitled to be enrolled, the administration may pay all of that person's  
45 premiums, deductibles, coinsurance and other cost sharing obligations for

1 services covered under section 36-2907. The person shall apply for  
2 enrollment in the group health insurance plan as a condition of eligibility  
3 under section 36-2901, paragraph 6, subdivision (a).

4 P. The total amount of state monies that may be spent in any fiscal  
5 year by the administration for health care shall not exceed the amount  
6 appropriated or authorized by section 35-173 for all health care purposes.  
7 This article does not impose a duty on an officer, agent or employee of this  
8 state to discharge a responsibility or to create any right in a person or  
9 group if the discharge or right would require an expenditure of state monies  
10 in excess of the expenditure authorized by legislative appropriation for that  
11 specific purpose.

12 Q. Notwithstanding section 36-470, a contractor or program contractor  
13 may receive laboratory tests from a laboratory or hospital-based laboratory  
14 for a system member enrolled with the contractor or program contractor  
15 subject to all of the following requirements:

16 1. The contractor or program contractor shall provide a written  
17 request to the laboratory in a format mutually agreed to by the laboratory  
18 and the requesting health plan or program contractor. The request shall  
19 include the member's name, the member's plan identification number, the  
20 specific test results that are being requested and the time periods and the  
21 quality improvement activity that prompted the request.

22 2. The laboratory data may be provided in written or electronic format  
23 based on the agreement between the laboratory and the contractor or program  
24 contractor. If there is no contract between the laboratory and the  
25 contractor or program contractor, the laboratory shall provide the requested  
26 data in a format agreed to by the noncontracted laboratory.

27 3. The laboratory test results provided to the member's contractor or  
28 program contractor shall only be used for quality improvement activities  
29 authorized by the administration and health care outcome studies required by  
30 the administration. The contractors and program contractors shall maintain  
31 strict confidentiality about the test results and identity of the member as  
32 specified in contractual arrangements with the administration and pursuant  
33 to state and federal law.

34 4. The administration, after collaboration with the department of  
35 health services regarding quality improvement activities, may prohibit the  
36 contractors and program contractors from receiving certain test results if  
37 the administration determines that a serious potential exists that the  
38 results may be used for purposes other than those intended for the quality  
39 improvement activities. The department of health services shall consult with  
40 the clinical laboratory licensure advisory committee established by section  
41 36-465 before providing recommendations to the administration on certain test  
42 results and quality improvement activities.

43 5. The administration shall provide contracted laboratories and the  
44 department of health services with an annual report listing the quality  
45 improvement activities that will require laboratory data. The report shall

1 be updated and distributed to the contracting laboratories and the department  
2 of health services when laboratory data is needed for new quality improvement  
3 activities.

4 6. A laboratory that complies with a request from the contractor or  
5 program contractor for laboratory results pursuant to this section is not  
6 subject to civil liability for providing the data to the contractor or  
7 program contractor. The administration, the contractor or a program  
8 contractor that uses data for reasons other than quality improvement  
9 activities is subject to civil liability for this improper use.

10 R. For the purpose of this section, "quality improvement activities"  
11 means those requirements, including health care outcome studies specified in  
12 federal law or required by the ~~health care financing administration~~ CENTERS  
13 FOR MEDICARE AND MEDICAID SERVICES or the administration, to improve health  
14 care outcomes.

15 Sec. 16. Section 36-2903.01, Arizona Revised Statutes, is amended to  
16 read:

17 36-2903.01. Additional powers and duties

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

24 B. The director shall:

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

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

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

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

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

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

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

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

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

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

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

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

1           5. Apply for and accept federal funds available under title XIX of the  
2 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section  
3 1396 (1980)) in support of the system. The application made by the director  
4 pursuant to this paragraph shall be designed to qualify for federal funding  
5 primarily on a prepaid capitated basis. Such funds may be used only for the  
6 support of persons defined as eligible pursuant to title XIX of the social  
7 security act or the approved section 1115 waiver.

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

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

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

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

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

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

38           4. NOTWITHSTANDING ANY OTHER LAW, REQUIRE PERSONS ELIGIBLE PURSUANT  
39 TO SECTION 36-2901, PARAGRAPH 6, SUBDIVISION (a), SECTION 36-2931, PARAGRAPH  
40 5 AND SECTION 36-2981, PARAGRAPH 6, AND BEFORE JULY 1, 2004, PURSUANT TO  
41 SECTION 36-2981.01 TO BE FINANCIALLY RESPONSIBLE FOR ANY COST SHARING  
42 REQUIREMENTS ESTABLISHED IN A STATE PLAN OR A SECTION 1115 WAIVER AND  
43 APPROVED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES. COST SHARING  
44 REQUIREMENTS MAY INCLUDE COPAYMENTS, COINSURANCE, DEDUCTIBLES, ENROLLMENT

1 FEES AND MONTHLY PREMIUMS FOR ENROLLED MEMBERS, INCLUDING HOUSEHOLDS WITH  
2 CHILDREN ENROLLED IN THE ARIZONA LONG-TERM CARE SYSTEM.

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

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

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

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

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

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

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

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

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

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

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

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

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

7 5. The director shall define by rule the method of determining when  
8 a hospital bill will be considered received and when a hospital's billed  
9 charges will be considered paid. Payment received by a hospital from the  
10 administration pursuant to this subsection or from a contractor either by  
11 contract or pursuant to section 36-2904, subsection ~~1~~ shall be considered  
12 payment of the hospital bill in full, except that a hospital may collect any  
13 unpaid portion of its bill from other third party payors or in situations  
14 covered by title 33, chapter 7, article 3.

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

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

1 data for dates of service November 1, 1990 through October 31, 1991 and  
2 processed through May of 1992.

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

9 3. For outpatient hospital services, the administration shall  
10 reimburse a hospital by applying a hospital specific outpatient  
11 cost-to-charge ratio to the covered charges.

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

- 16 (a) An admission face sheet.  
17 (b) An itemized statement.  
18 (c) An admission history and physical.  
19 (d) A discharge summary or an interim summary if the claim is split.  
20 (e) An emergency record, if admission was through the emergency room.  
21 (f) Operative reports, if applicable.  
22 (g) A labor and delivery room report, if applicable.

23 Payment received by a hospital from the administration pursuant to this  
24 subsection or from a contractor either by contract or pursuant to section  
25 36-2904, subsection J is considered payment by the administration or the  
26 contractor of the administration's or contractor's liability for the hospital  
27 bill. A hospital may collect any unpaid portion of its bill from other third  
28 party payors or in situations covered by title 33, chapter 7, article 3.

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

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

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

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

43 6. In developing the reimbursement methodology, if a review of the  
44 reports filed by a hospital pursuant to section 36-125.04 indicates that  
45 further investigation is considered necessary to verify the accuracy of the

1 information in the reports, the administration may examine the hospital's  
2 records and accounts related to the reporting requirements of section  
3 36-125.04. The administration shall bear the cost incurred in connection  
4 with this examination unless the administration finds that the records  
5 examined are significantly deficient or incorrect, in which case the  
6 administration may charge the cost of the investigation to the hospital  
7 examined.

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

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

28 9. Beginning September 30, 1997, the administration shall establish  
29 a separate graduate medical education program to reimburse hospitals that had  
30 graduate medical education programs that were approved by the administration  
31 as of October 1, 1999. The administration shall separately account for  
32 monies for the graduate medical education program based on the total  
33 reimbursement for graduate medical education reimbursed to hospitals by the  
34 system in federal fiscal year 1995-1996 pursuant to the tiered per diem  
35 methodology specified in this section. The graduate medical education  
36 program reimbursement shall be adjusted annually by the increase or decrease  
37 in the index published by the data resources incorporated hospital market  
38 basket index for prospective hospital reimbursement. Subject to legislative  
39 appropriation, on an annual basis, each qualified hospital shall receive a  
40 single payment from the graduate medical education program that is equal to  
41 the same percentage of graduate medical education reimbursement that was paid  
42 by the system in federal fiscal year 1995-1996. Any reimbursement for  
43 graduate medical education made by the administration shall not be subject  
44 to future settlements or appeals by the hospitals to the administration.

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

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

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

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

27           K. The director shall establish a special unit within the  
28 administration for the purpose of monitoring the third party payment  
29 collections required by contractors and noncontracting providers pursuant to  
30 section 36-2903, subsection B, paragraph 10 and subsection F and section  
31 36-2915, subsection E. The director shall determine by rule:

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

34           2. The percentage of third party payments that is collected by a  
35 contractor or noncontracting provider and that the contractor or  
36 noncontracting provider may keep and the percentage of such payments that the  
37 contractor or noncontracting provider may be required to pay to the  
38 administration. Contractors and noncontracting providers must pay to the  
39 administration one hundred per cent of all third party payments that are  
40 collected and that duplicate administration fee-for-service payments. A  
41 contractor that contracts with the administration pursuant to section  
42 36-2904, subsection A may be entitled to retain a percentage of third party  
43 payments if the payments collected and retained by a contractor are reflected  
44 in reduced capitation rates. A contractor may be required to pay the

1 administration a percentage of third party payments that are collected by a  
2 contractor and that are not reflected in reduced capitation rates.

3 L. On oral or written notice from the patient that the patient  
4 believes the claims to be covered by the system, a contractor or  
5 noncontracting provider of health and medical services prescribed in section  
6 36-2907 shall not do either of the following unless the contractor or  
7 noncontracting provider has verified through the administration that the  
8 person has been determined ineligible, has not yet been determined eligible  
9 or was not, at the time services were rendered, eligible or enrolled:

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

13 2. Refer or report a member or person who has been determined eligible  
14 to a collection agency or credit reporting agency for the failure of the  
15 member or person who has been determined eligible to pay charges for system  
16 covered care or services unless specifically authorized by this article or  
17 rules adopted pursuant to this article.

18 M. The administration may conduct postpayment review of all claims  
19 paid by the administration and may recoup any monies erroneously paid. The  
20 director may adopt rules that specify procedures for conducting postpayment  
21 review. A contractor may conduct a postpayment review of all claims paid by  
22 the contractor and may recoup monies that are erroneously paid.

23 N. The director or the director's designee may employ and supervise  
24 personnel necessary to assist the director in performing the functions of the  
25 administration.

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

29 P. Notwithstanding any law to the contrary, on federal approval the  
30 administration may make disproportionate share payments to private hospitals,  
31 county operated hospitals and state operated institutions for mental disease  
32 beginning October 1, 1991 in accordance with federal law and subject to  
33 legislative appropriation. If at any time the administration receives  
34 written notification from federal authorities of any change or difference in  
35 the actual or estimated amount of federal funds available for  
36 disproportionate share payments from the amount reflected in the legislative  
37 appropriation for such purposes, the administration shall provide written  
38 notification of such change or difference to the president and the minority  
39 leader of the senate, the speaker and the minority leader of the house of  
40 representatives, the director of the joint legislative budget committee, the  
41 legislative committee of reference and any hospital trade association within  
42 this state, within three working days not including weekends after receipt  
43 of the notice of the change or difference. In calculating disproportionate  
44 share payments as prescribed in this section, the administration may use  
45 either a methodology based on claims and encounter data that is submitted to

1 the administration from contractors or a methodology based on data that is  
2 reported to the administration by private hospitals and state operated  
3 institutions for mental disease. The selected methodology applies to all  
4 private hospitals and state operated institutions for mental disease  
5 qualifying for disproportionate share payments.

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

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

12 S. If the administration implements an electronic claims submission  
13 system it may adopt procedures pursuant to subsection H of this section  
14 requiring documentation different than prescribed under subsection H,  
15 paragraph 4 of this section.

16 Sec. 17. Section 36-2903.03, Arizona Revised Statutes, is amended to  
17 read:

18 36-2903.03. United States citizenship and qualified alien  
19 requirements for eligibility; definition

20 A. A person who is applying for eligibility under this chapter shall  
21 provide verification of United States citizenship or documented verification  
22 of qualified alien status.

23 B. A qualified alien may apply for eligibility pursuant to section  
24 36-2901, paragraph 6, subdivision (a) and, if otherwise eligible for title  
25 XIX, may receive all services pursuant to section 36-2907 if the qualified  
26 alien meets at least one of the following requirements:

27 1. Is designated as one of the exception groups under 8 United States  
28 Code section 1613(b).

29 2. Has been a qualified alien for at least five years.

30 3. Has been continuously present in the United States since August 21,  
31 1996.

32 C. Notwithstanding any other law, persons who were residing in the  
33 United States under color of law on or before August 21, 1996, and who were  
34 receiving services under this article based on eligibility criteria  
35 established under the supplemental security income program, may apply for  
36 state funded services and, if otherwise eligible for supplemental security  
37 income-medical assistance only coverage except for United States citizenship  
38 or qualified alien requirements, may be enrolled with the system and receive  
39 all services pursuant to section 36-2907.

40 D. A person who is a qualified alien who does not meet the  
41 requirements of subsection B of this section or who is a noncitizen who does  
42 not claim and provide verification of qualified alien status may apply for  
43 title XIX eligibility under section 36-2901, paragraph 6, subdivision (a)  
44 and, if otherwise eligible for title XIX, may receive only emergency services

1 pursuant to section 1903(v) of the social security act or state funded  
2 ~~emergency services pursuant to section 36-2901.06.~~  
3 E. In determining the eligibility for all qualified aliens pursuant  
4 to this chapter, the income and resources of any person who executed an  
5 affidavit of support pursuant to section 213A of the immigration and  
6 nationality act on behalf of the qualified alien and the income and resources  
7 of the spouse, if any, of the sponsoring individual shall be counted at the  
8 time of application and for the redetermination of eligibility for the  
9 duration of the attribution period as specified in federal law.  
10 F. A person who is a qualified alien or a noncitizen and who is not  
11 eligible for title XIX may apply for the state emergency services program as  
12 prescribed in section 36-2901.06 and, if eligible, may receive only emergency  
13 services.  
14 G. For purposes of this section, "qualified alien" means an individual  
15 who is one of the following:  
16 1. Defined as a qualified alien under 8 United States Code section  
17 1641.  
18 2. Defined as a qualified alien by the attorney general of the United  
19 States under the authority of Public Law 104-208, section 501.  
20 3. An Indian described in 8 United States Code section 1612(b)(2)(e).  
21 Sec. 18. Section 36-2904, Arizona Revised Statutes, is amended to  
22 read:  
23 36-2904. Prepaid capitation coverage; requirements; long-term  
24 care; dispute resolution; award of contracts;  
25 notification; report  
26 A. The administration may expend public funds appropriated for the  
27 purposes of this article and shall execute prepaid capitated health services  
28 contracts, pursuant to section 36-2906, with group disability insurers,  
29 hospital and medical service corporations, health care services organizations  
30 and any other appropriate public or private persons, including county-owned  
31 and operated facilities, for health and medical services to be provided under  
32 contract with contractors. The administration may assign liability for  
33 eligible persons and members through contractual agreements with contractors.  
34 If there is an insufficient number of qualified bids for prepaid capitated  
35 health services contracts for the provision of hospitalization and medical  
36 care within a county, the director may:  
37 1. Execute discount advance payment contracts, pursuant to section  
38 36-2906 and subject to section 36-2903.01, for hospital services.  
39 2. Execute capped fee-for-service contracts for health and medical  
40 services, other than hospital services. Any capped fee-for-service contract  
41 shall provide for reimbursement at a level of not to exceed a capped  
42 fee-for-service schedule adopted by the administration.  
43 B. During any period in which services are needed and no contract  
44 exists, the director may do either of the following:

1 Pay noncontracting providers for health and medical services, other  
2 than hospital services, on a capped fee-for-service basis for members and  
3 persons who are determined eligible. However, the state shall not pay any  
4 amount for services that exceeds a maximum amount set forth in a capped  
5 fee-for-service schedule adopted by the administration.  
6 2. Pay a hospital subject to the reimbursement level limitation  
7 prescribed in section 36-2903.01.  
8 If health and medical services are provided in the absence of a contract, the  
9 director shall continue to attempt to procure by the bid process as provided  
10 in section 36-2906 contracts for such services as specified in this  
11 subsection.  
12 C. Payments to contractors shall be made monthly or quarterly and may  
13 be subject to contract provisions requiring the retention of a specified  
14 percentage of the payment by the director, a reserve fund or other contract  
15 provisions by which adjustments to the payments are made based on utilization  
16 efficiency, including incentives for maintaining quality care and minimizing  
17 unnecessary inpatient services. Reserve funds withheld from contractors  
18 shall be distributed to contractors who meet performance standards  
19 established by the director. Any reserve fund established pursuant to this  
20 subsection shall be established as a separate account within the Arizona  
21 health care cost containment system fund.  
22 ~~D. The administration shall adopt rules for the payment of nominal~~  
23 ~~copayments by members to the contractors except for services provided in~~  
24 ~~emergencies. These rules shall provide for the waiver of copayments in~~  
25 ~~appropriate circumstances for members.~~  
26 F. D. Except as prescribed in subsection F E of this section, a  
27 member defined as eligible pursuant to section 36-2901, paragraph 6,  
28 subsection (a) may select, to the extent practicable as determined by the  
29 administration, from among the available contractors of hospitalization and  
30 medical care and may select a primary care physician or primary care  
31 practitioner from among the primary care physicians and primary care  
32 practitioners participating in the contract in which the member is enrolled.  
33 The administration shall provide reimbursement only to entities that have a  
34 provider agreement with the administration and that have agreed to the  
35 contractual requirements of that agreement. Except as provided in sections  
36 36-2908 and 36-2909, the system shall only provide reimbursement for any  
37 health or medical services or costs of related services provided by or under  
38 referral from the primary care physician or primary care practitioner  
39 participating in the contract in which the member is enrolled. The director  
40 shall establish requirements as to the minimum time period that a member is  
41 assigned to specific contractors in the system.  
42 F. E. For a member defined as eligible pursuant to section 36-2901,  
43 paragraph 6, subsection (a), item (v) the director shall enroll the member  
44 with an available contractor located in the geographic area of the member's  
45 residence. The member may select a primary care physician or primary care

1 pursuant to section 1903(v) of the social security act or ~~state funded~~  
2 ~~emergency services pursuant to section 36-2901.06.~~

3 E. In determining the eligibility for all qualified aliens pursuant  
4 to this chapter, the income and resources of any person who executed an  
5 affidavit of support pursuant to section 213A of the immigration and  
6 nationality act on behalf of the qualified alien and the income and resources  
7 of the spouse, if any, of the sponsoring individual shall be counted at the  
8 time of application and for the redetermination of eligibility for the  
9 duration of the attribution period as specified in federal law.

10 F. A person who is a qualified alien or a noncitizen and who is not  
11 eligible for title XIX ~~may apply for the state emergency services program as~~  
12 ~~prescribed in section 36-2901.06 and, if eligible, may receive only emergency~~  
13 ~~services.~~

14 G. For purposes of this section, "qualified alien" means an individual  
15 who is one of the following:

16 1. Defined as a qualified alien under 8 United States Code section  
17 1641.

18 2. Defined as a qualified alien by the attorney general of the United  
19 States under the authority of Public Law 104-208, section 501.

20 3. An Indian described in 8 United States Code section 1612(b)(2)(e).

21 Sec. 18. Section 36-2904, Arizona Revised Statutes, is amended to  
22 read:

23 36-2904. Prepaid capitation coverage; requirements; long-term  
24 care; dispute resolution; award of contracts;  
25 notification; report

26 A. The administration may expend public funds appropriated for the  
27 purposes of this article and shall execute prepaid capitated health services  
28 contracts, pursuant to section 36-2906, with group disability insurers,  
29 hospital and medical service corporations, health care services organizations  
30 and any other appropriate public or private persons, including county-owned  
31 and operated facilities, for health and medical services to be provided under  
32 contract with contractors. The administration may assign liability for  
33 eligible persons and members through contractual agreements with contractors.  
34 If there is an insufficient number of qualified bids for prepaid capitated  
35 health services contracts for the provision of hospitalization and medical  
36 care within a county, the director may:

37 1. Execute discount advance payment contracts, pursuant to section  
38 36-2906 and subject to section 36-2903.01, for hospital services.

39 2. Execute capped fee-for-service contracts for health and medical  
40 services, other than hospital services. Any capped fee-for-service contract  
41 shall provide for reimbursement at a level of not to exceed a capped  
42 fee-for-service schedule adopted by the administration.

43 B. During any period in which services are needed and no contract  
44 exists, the director may do either of the following:

1           1. Pay noncontracting providers for health and medical services, other  
2 than hospital services, on a capped fee-for-service basis for members and  
3 persons who are determined eligible. However, the state shall not pay any  
4 amount for services that exceeds a maximum amount set forth in a capped  
5 fee-for-service schedule adopted by the administration.

6           2. Pay a hospital subject to the reimbursement level limitation  
7 prescribed in section 36-2903.01.

8 If health and medical services are provided in the absence of a contract, the  
9 director shall continue to attempt to procure by the bid process as provided  
10 in section 36-2906 contracts for such services as specified in this  
11 subsection.

12           C. Payments to contractors shall be made monthly or quarterly and may  
13 be subject to contract provisions requiring the retention of a specified  
14 percentage of the payment by the director, a reserve fund or other contract  
15 provisions by which adjustments to the payments are made based on utilization  
16 efficiency, including incentives for maintaining quality care and minimizing  
17 unnecessary inpatient services. Reserve funds withheld from contractors  
18 shall be distributed to contractors who meet performance standards  
19 established by the director. Any reserve fund established pursuant to this  
20 subsection shall be established as a separate account within the Arizona  
21 health care cost containment system fund.

22           ~~D. The administration shall adopt rules for the payment of nominal~~  
23 ~~copayments by members to the contractors except for services provided in~~  
24 ~~emergencies. These rules shall provide for the waiver of copayments in~~  
25 ~~appropriate circumstances for members.~~

26           ~~E. D.~~ Except as prescribed in subsection ~~F~~ E of this section, a  
27 member defined as eligible pursuant to section 36-2901, paragraph 6,  
28 subdivision (a) may select, to the extent practicable as determined by the  
29 administration, from among the available contractors of hospitalization and  
30 medical care and may select a primary care physician or primary care  
31 practitioner from among the primary care physicians and primary care  
32 practitioners participating in the contract in which the member is enrolled.  
33 The administration shall provide reimbursement only to entities that have a  
34 provider agreement with the administration and that have agreed to the  
35 contractual requirements of that agreement. Except as provided in sections  
36 36-2908 and 36-2909, the system shall only provide reimbursement for any  
37 health or medical services or costs of related services provided by or under  
38 referral from the primary care physician or primary care practitioner  
39 participating in the contract in which the member is enrolled. The director  
40 shall establish requirements as to the minimum time period that a member is  
41 assigned to specific contractors in the system.

42           ~~F.~~ E. For a member defined as eligible pursuant to section 36-2901,  
43 paragraph 6, subdivision (a), item (v) the director shall enroll the member  
44 with an available contractor located in the geographic area of the member's  
45 residence. The member may select a primary care physician or primary care

1 practitioner from among the primary care physicians or primary care  
2 practitioners participating in the contract in which the member is enrolled.  
3 The system shall only provide reimbursement for health or medical services  
4 or costs of related services provided by or under referral from a primary  
5 care physician or primary care practitioner participating in the contract in  
6 which the member is enrolled. The director shall establish requirements as  
7 to the minimum time period that a member is assigned to specific contractors  
8 in the system.

9 ~~G.~~ F. If a person who has been determined eligible but who has not  
10 yet enrolled in the system receives emergency services, the director shall  
11 provide by rule for the enrollment of the person on a priority basis. If a  
12 person requires system covered services on or after the date the person is  
13 determined eligible for the system but before the date of enrollment, the  
14 person is entitled to receive these services in accordance with rules adopted  
15 by the director, and the administration shall pay for the services pursuant  
16 to section 36-2903.01 or, as specified in contract, with the contractor  
17 pursuant to the subcontracted rate or this section.

18 ~~H.~~ G. The administration shall not pay claims for system covered  
19 services that are initially submitted more than six months after the date of  
20 the service for which payment is claimed or after the date that eligibility  
21 is posted, whichever date is later, or that are submitted as clean claims  
22 more than twelve months after the date of service for which payment is  
23 claimed or after the date that eligibility is posted, whichever date is  
24 later, except for claims submitted for reinsurance pursuant to section  
25 36-2906, subsection C, paragraph 6. The administration shall not pay claims  
26 for system covered services that are submitted by contractors for reinsurance  
27 after the time period specified in the contract. The director may adopt  
28 rules or require contractual provisions that prescribe requirements and time  
29 limits for submittal of and payment for those claims. Notwithstanding any  
30 other provision of this article, if a claim that gives rise to a contractor's  
31 claim for reinsurance or deferred liability is the subject of an  
32 administrative grievance or appeal proceeding or other legal action, the  
33 contractor shall have at least sixty days after an ultimate decision is  
34 rendered to submit a claim for reinsurance or deferred  
35 liability. Contractors that contract with the administration pursuant to  
36 subsection A of this section shall not pay claims for system covered services  
37 that are initially submitted more than six months after the date of the  
38 service for which payment is claimed or after the date that eligibility is  
39 posted, whichever date is later, or that are submitted as clean claims more  
40 than twelve months after the date of the service for which payment is claimed  
41 or after the date that eligibility is posted, whichever date is later. For  
42 THE purposes of this subsection:

43 1. "Clean claims" means claims that may be processed without obtaining  
44 additional information from the subcontracted provider of care, from a  
45 noncontracting provider or from a third party but does not include claims

1 under investigation for fraud or abuse or claims under review for medical  
2 necessity.

3 2. "Date of service" for a hospital inpatient means the date of  
4 discharge of the patient.

5 3. "Submitted" means the date the claim is received by the  
6 administration or the prepaid capitated provider, whichever is applicable,  
7 as established by the date stamp on the face of the document or other record  
8 of receipt.

9 ~~F.~~ H. In any county having a population of five hundred thousand or  
10 fewer persons, a hospital that executes a subcontract other than a capitation  
11 contract with a contractor for the provision of hospital and medical services  
12 pursuant to this article shall offer a subcontract to any other contractor  
13 providing services to that portion of the county and to any other person that  
14 plans to become a contractor in that portion of the county. If such a  
15 hospital executes a subcontract other than a capitation contract with a  
16 contractor for the provision of hospital and medical services pursuant to  
17 this article, the hospital shall adopt uniform criteria to govern the  
18 reimbursement levels paid by all contractors with whom the hospital executes  
19 such a subcontract. Reimbursement levels offered by hospitals to contractors  
20 pursuant to this subsection may vary among contractors only as a result of  
21 the number of bed days purchased by the contractors, the amount of financial  
22 deposit required by the hospital, if any, or the schedule of performance  
23 discounts offered by the hospital to the contractor for timely payment of  
24 claims.

25 ~~F.~~ I. This subsection applies to inpatient hospital admissions and  
26 to outpatient hospital services on and after March 1, 1993. The director may  
27 negotiate at any time with a hospital on behalf of a contractor for services  
28 provided pursuant to this article. If a contractor negotiates with a  
29 hospital for services provided pursuant to this article, the following  
30 procedures apply:

31 1. The director shall require any contractor to reimburse hospitals  
32 for services provided under this article based on reimbursement levels that  
33 do not in the aggregate exceed those established pursuant to section  
34 36-2903.01 and under terms on which the contractor and the hospital agree.  
35 However, a hospital and a contractor may agree on a different payment  
36 methodology than the methodology prescribed by the director pursuant to  
37 section 36-2903.01. The director by rule shall prescribe:

38 (a) The time limits for any negotiation between the contractor and the  
39 hospital.

40 (b) The ability of the director to review and approve or disapprove  
41 the reimbursement levels and terms agreed on by the contractor and the  
42 hospital.

43 (c) That if a contractor and a hospital do not agree on reimbursement  
44 levels and terms as required by this subsection, the reimbursement levels  
45 established pursuant to section 36-2903.01 apply.

1 (d) That, except if submitted under an electronic claims submission  
2 system, a hospital bill is considered received for purposes of subdivision  
3 (f) of ~~this paragraph~~ on initial receipt of the legible, error-free claim  
4 form by the contractor if the claim includes the following error-free  
5 documentation in legible form:

6 (i) An admission face sheet.

7 (ii) An itemized statement.

8 (iii) An admission history and physical.

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

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

11 (vi) Operative reports, if applicable.

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

13 (e) That payment received by a hospital from a contractor is  
14 considered payment by the contractor of the contractor's liability for the  
15 hospital bill. A hospital may collect any unpaid portion of its bill from  
16 other third party payors or in situations covered by title 33, chapter 7,  
17 article 3.

18 (f) That a contractor shall pay for services rendered on and after  
19 October 1, 1997 under any reimbursement level according to paragraph 1 of  
20 this subsection subject to the following:

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

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

26 (iii) If the hospital's bill is paid any time after sixty days of the  
27 date the bill was received, the contractor shall pay one hundred per cent of  
28 the rate plus a fee of one per cent per month for each month or portion of  
29 a month following the sixtieth day of receipt of the bill until the date of  
30 payment.

31 2. In any county having a population of five hundred thousand or fewer  
32 persons, a hospital that executes a subcontract other than a capitation  
33 contract with a provider for the provision of hospital and medical services  
34 pursuant to this article shall offer a subcontract to any other provider  
35 providing services to that portion of the county and to any other person that  
36 plans to become a provider in that portion of the county. If a hospital  
37 executes a subcontract other than a capitation contract with a provider for  
38 the provision of hospital and medical services pursuant to this article, the  
39 hospital shall adopt uniform criteria to govern the reimbursement levels paid  
40 by all providers with whom the hospital executes a subcontract.

41 K. J. If there is an insufficient number of, or an inadequate member  
42 capacity in, contracts awarded to contractors, the director, in order to  
43 deliver covered services to members enrolled or expected to be enrolled in  
44 the system within a county, may negotiate and award, without bid, a contract  
45 with a health care services organization holding a certificate of authority

1 pursuant to title 20, chapter 4, article 9. The director shall require a  
2 health care services organization contracting under this subsection to comply  
3 with section 36-2906.01. The term of the contract shall not extend beyond  
4 the next bid and contract award process as provided in section 36-2906 and  
5 shall be no greater than capitation rates paid to contractors in the same  
6 county or counties pursuant to section 36-2906. Contracts awarded pursuant  
7 to this subsection are exempt from the requirements of title 41, chapter 23.

8 ~~T.~~ K. A contractor may require that a subcontracting or  
9 noncontracting provider shall be paid for covered services, other than  
10 hospital services, according to the capped fee-for-service schedule adopted  
11 by the director pursuant to subsection A, paragraph 2 of this section or  
12 subsection B, paragraph 1 of this section or at lower rates as may be  
13 negotiated by the contractor.

14 ~~M.~~ L. The director shall require any contractor to have a plan to  
15 notify members of reproductive age either directly or through the parent or  
16 legal guardian, whichever is most appropriate, of the specific covered family  
17 planning services available to them and a plan to deliver those services to  
18 members who request them. The director shall ensure that these plans include  
19 provisions for written notification, other than the member handbook, and  
20 verbal notification during a member's visit with the member's primary care  
21 physician or primary care practitioner.

22 ~~N.~~ M. The director shall adopt a plan to notify members of  
23 reproductive age who receive care from a contractor who elects not to provide  
24 family planning services of the specific covered family planning services  
25 available to them and to provide for the delivery of those services to  
26 members who request them. Notification may be directly to the member, or  
27 through the parent or legal guardian, whichever is most appropriate. The  
28 director shall ensure that the plan includes provisions for written  
29 notification, other than the member handbook, and verbal notification during  
30 a member's visit with the member's primary care physician or primary care  
31 practitioner.

32 ~~O.~~ N. The director shall annually prepare a report that represents  
33 a statistically valid sample and that indicates the number of children ages  
34 two and under by contractor who received the immunizations recommended by the  
35 national centers for disease control and prevention while enrolled as  
36 members. The report shall indicate each type of immunization and the number  
37 and percentage of enrolled children ages two and under who received each type  
38 of immunization. The report shall be done by contract year and shall be  
39 delivered to the governor, the president of the senate and the speaker of the  
40 house of representatives no later than April 1 of each year.

41 ~~P.~~ O. If the administration implements an electronic claims  
42 submission system it may adopt procedures pursuant to subsection ~~J~~ I,  
43 paragraph 1 of this section requiring documentation different than prescribed  
44 under subsection ~~J~~ I, paragraph 1, subdivision (d) of this section.

1           Sec. 19. Title 36, chapter 29, article 1, Arizona Revised Statutes,  
2 is amended by adding section 36-2905.01, to read:

3           36-2905.01. Inpatient hospital reimbursement program; large  
4                                   counties

5           A. NOTWITHSTANDING ANY OTHER LAW, BEGINNING ON OCTOBER 1, 2003, THE  
6 ADMINISTRATION SHALL ESTABLISH AND OPERATE A PROGRAM FOR INPATIENT HOSPITAL  
7 REIMBURSEMENT IN EACH COUNTY WITH A POPULATION OF MORE THAN FIVE HUNDRED  
8 THOUSAND PERSONS PURSUANT TO THIS CHAPTER.

9           B. BEGINNING ON OCTOBER 1, 2003, THE DIRECTOR SHALL REQUIRE  
10 CONTRACTORS TO ENTER INTO CONTRACTS WITH ONE OR MORE HOSPITALS IN THESE  
11 COUNTIES AND TO REIMBURSE THOSE HOSPITALS FOR SERVICES PROVIDED PURSUANT TO  
12 THIS CHAPTER BASED ON THE REIMBURSEMENT LEVELS NEGOTIATED WITH EACH HOSPITAL  
13 AND SPECIFIED IN THE CONTRACT AND UNDER THE TERMS ON WHICH THE CONTRACTOR AND  
14 THE HOSPITAL AGREE AND UNDER ALL OF THE FOLLOWING CONDITIONS:

15           1. THE DIRECTOR MAY REVIEW AND APPROVE OR DISAPPROVE THE REIMBURSEMENT  
16 LEVELS AND THE TERMS AGREED ON BY THE CONTRACTOR AND THE HOSPITAL.

17           2. IF THE CONTRACTOR IMPLEMENTS AN ELECTRONIC CLAIMS SUBMISSION SYSTEM  
18 IT MAY ADOPT PROCEDURES REQUIRING DOCUMENTATION OF THE SYSTEM.

19           3. PAYMENT RECEIVED BY A HOSPITAL FROM A CONTRACTOR IS CONSIDERED  
20 PAYMENT IN FULL BY THE CONTRACTOR. A HOSPITAL MAY COLLECT ANY UNPAID PORTION  
21 OF ITS BILL FROM OTHER THIRD PARTY PAYORS OR IN SITUATIONS COVERED BY TITLE  
22 33, CHAPTER 7, ARTICLE 3.

23           C. IF A CONTRACTOR AND A HOSPITAL DO NOT ENTER INTO A CONTRACT  
24 PURSUANT TO SUBSECTION B OF THIS SECTION, THE REIMBURSEMENT LEVEL FOR  
25 INPATIENT SERVICES PROVIDED ON DATES OF ADMISSION ON OR AFTER OCTOBER 1, 2003  
26 FOR THAT HOSPITAL IS THE REIMBURSEMENT LEVEL PRESCRIBED IN SECTION 36-2903.01  
27 MULTIPLIED BY NINETY-FIVE PER CENT.

28           D. FOR OUTPATIENT HOSPITAL SERVICES PROVIDED UNDER THE PROGRAM  
29 PRESCRIBED IN THIS SECTION, A CONTRACTOR MAY REIMBURSE A HOSPITAL EITHER  
30 PURSUANT TO RATES AND TERMS NEGOTIATED IN A CONTRACT BETWEEN THE CONTRACTOR  
31 AND THE HOSPITAL OR PURSUANT TO SECTION 36-2903.01, SUBSECTION H,  
32 PARAGRAPH 3.

33           E. CONTRACTS ESTABLISHED PURSUANT TO THIS SECTION SHALL SPECIFY THAT  
34 ARBITRATION MAY BE USED IN LIEU OF THE GRIEVANCE AND APPEAL PROCEDURE  
35 PRESCRIBED IN SECTION 36-2903.01, SUBSECTION B, PARAGRAPH 4 TO RESOLVE ANY  
36 DISPUTES ARISING UNDER THE CONTRACT.

37           Sec. 20. Section 36-2906, Arizona Revised Statutes, is amended to  
38 read:

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

41           A. The administration shall:

42           1. Supervise the administrator.

43           2. Review the proposals.

44           3. Award contracts.

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

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

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

13           (a) Inpatient hospital services.

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

16           (c) Pharmacy services.

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

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

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

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

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

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

44           7. For the awarding of contracts to contractors with qualified  
45 proposals determined to be the most advantageous to the state for each of the

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

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

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

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

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

35 F. Contracts shall be awarded as otherwise provided by law, except  
36 that in no event may a contract be awarded to any respondent that will cause  
37 the system to lose any federal monies to which it is 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 Sec. 21. Section 36-2907, Arizona Revised Statutes, is amended to~~  
2 read:

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

5 A. Unless modified pursuant to this section, contractors shall provide  
6 the following medically necessary health and medical services:

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

13 2. Outpatient health services that are ordinarily provided in  
14 hospitals, clinics, offices and other health care facilities by licensed  
15 health care providers. Outpatient health services include services provided  
16 by or under the direction of a physician or a primary care practitioner but  
17 do not include occupational therapy, or speech therapy for eligible persons  
18 who are twenty-one years of age or older.

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

21 4. Medications that are ordered on prescription by a physician or a  
22 dentist licensed pursuant to title 32, chapter 11.

23 ~~5. Emergency dental care and extractions for persons who are at least~~  
24 ~~twenty-one years of age.~~

25 ~~6.~~ 5. Medical supplies, equipment and prosthetic devices, not  
26 including hearing aids, ordered by a physician or a primary care practitioner  
27 or dentures ordered by a dentist licensed pursuant to title 32, chapter 11.  
28 Suppliers of durable medical equipment shall provide the administration with  
29 complete information about the identity of each person who has an ownership  
30 or controlling interest in their business and shall comply with federal  
31 bonding requirements in a manner prescribed by the administration.

32 ~~7.~~ 6. For persons who are at least twenty-one years of age, treatment  
33 of medical conditions of the eye excluding eye examinations for prescriptive  
34 lenses and the provision of prescriptive lenses.

35 ~~8.~~ 7. Early and periodic health screening and diagnostic services as  
36 required by section 1905(r) of title XIX of the social security act for  
37 members who are under twenty-one years of age.

38 ~~9.~~ 8. Family planning services that do not include abortion or  
39 abortion counseling. If a contractor elects not to provide family planning  
40 services, this election does not disqualify the contractor from delivering  
41 all other covered health and medical services under this chapter. In that  
42 event, the administration may contract directly with another contractor,  
43 including an outpatient surgical center or a noncontracting provider, to  
44 deliver family planning services to a member who is enrolled with the  
45 ~~contractor that elects not to provide family planning services.~~

~~1 10. 9. Podiatry services performed by a podiatrist licensed pursuant  
2 to title 32, chapter 7 and ordered by a primary care physician or primary  
3 care practitioner.~~

4 ~~11. 10. Nonexperimental transplants approved for title XIX  
5 reimbursement. TRANSPLANT SERVICES INCLUDE ALL TITLE XIX MEDICALLY NECESSARY  
6 SERVICES, INCLUDING DENTAL SERVICES, THAT ARE DIRECTLY RELATED TO A  
7 TRANSPLANT EVALUATION AND TREATMENT PLAN FOR AN INDIVIDUAL WHO HAS BEEN  
8 APPROVED FOR A TRANSPLANT PURSUANT TO THIS PARAGRAPH.~~

9 ~~12. 11. Ambulance and nonambulance transportation.~~

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

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

15 D. The director shall adopt rules necessary to limit, to the extent  
16 possible, the scope, duration and amount of services, including maximum  
17 limitations for inpatient services that are consistent with federal  
18 regulations under title XIX of the social security act (P.L. 89-97; 79 Stat.  
19 344; 42 United States Code section 1396 (1980)). To the extent possible and  
20 practicable, these rules shall provide for the prior approval of medically  
21 necessary services provided pursuant to this chapter.

22 E. The director shall make available home health services in lieu of  
23 hospitalization pursuant to contracts awarded under this article. For the  
24 purposes of this subsection, "home health services" means the provision of  
25 nursing services, home health aide services or medical supplies, equipment  
26 and appliances, which are provided on a part-time or intermittent basis by  
27 a licensed home health agency within a member's residence based on the orders  
28 of a physician or a primary care practitioner. Home health agencies shall  
29 comply with the federal bonding requirements in a manner prescribed by the  
30 administration.

31 F. The director shall adopt rules for the coverage of behavioral  
32 health services for persons who are eligible under section 36-2901, paragraph  
33 6, subdivision (a). The administration shall contract with the department  
34 of health services for the delivery of all medically necessary behavioral  
35 health services to persons who are eligible under rules adopted pursuant to  
36 this subsection. The division of behavioral health in the department of  
37 health services shall establish a diagnostic and evaluation program to which  
38 other state agencies shall refer children who are not already enrolled  
39 pursuant to this chapter and who may be in need of behavioral health  
40 services. In addition to an evaluation, the division of behavioral health  
41 shall also identify children who may be eligible under section 36-2901,  
42 paragraph 6, subdivision (a) or section 36-2931, paragraph 5 and shall refer  
43 the children to the appropriate agency responsible for making the final  
44 eligibility determination.

~~1 G. The director shall adopt rules for the provision of transportation  
2 services and rules providing for copayment by members for transportation for  
3 other than emergency purposes. Prior authorization is not required for  
4 medically necessary ambulance transportation services rendered to members or  
5 eligible persons initiated by dialing telephone number 911 or other  
6 designated emergency response systems.~~

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

12 I. If the director does not receive bids within the amounts budgeted  
13 or if at any time the amount remaining in the Arizona health care cost  
14 containment system fund is insufficient to pay for full contract services for  
15 the remainder of the contract term, the administration, on notification to  
16 system contractors at least thirty days in advance, may modify the list of  
17 services required under subsection A of this section for persons defined as  
18 eligible other than those persons defined pursuant to section 36-2901,  
19 paragraph 6, subdivision (a). The director may also suspend services or may  
20 limit categories of expense for services defined as optional pursuant to  
21 title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United  
22 States Code section 1396 (1970)) for persons defined pursuant to section  
23 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not  
24 apply to the continuity of care for persons already receiving these services.

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

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

31 1. Emergency services and specialty services provided pursuant to  
32 section 36-2908.

33 2. That the director may permit the delivery of health and medical  
34 services in other than the geographic service area in this state or in an  
35 adjoining state if the director determines that medical practice patterns  
36 justify the delivery of services or a net reduction in transportation costs  
37 can reasonably be expected. Notwithstanding the definition of physician as  
38 prescribed in section 36-2901, if services are procured from a physician or  
39 primary care practitioner in an adjoining state, the physician or primary  
40 care practitioner shall be licensed to practice in that state pursuant to  
41 licensing statutes in that state similar to title 32, chapter 13, 15, 17 or  
42 25 and shall complete a provider agreement for this state.

43 L. Covered outpatient services shall be subcontracted by a primary  
44 care physician or primary care practitioner to other licensed health care  
45 ~~providers to the extent practicable for purposes including, but not limited~~

~~1 to, making health care services available to underserved areas, reducing  
2 costs of providing medical care and reducing transportation costs.~~

~~3 M. The director shall adopt rules that prescribe the coordination of  
4 medical care for persons who are eligible for system services. The rules  
5 shall include provisions for the transfer of patients, the transfer of  
6 medical records and the initiation of medical care.~~

~~7 Sec. 22. Section 36-2907.04, Arizona Revised Statutes, is amended to  
8 read:~~

~~9 36-2907.04. Family planning services~~

~~10 A woman whose eligibility under section 36-2901, paragraph 6,  
11 subdivision (a), item (ii) ended no earlier than March 1, 1995 and who is not  
12 otherwise enrolled in the system is eligible to receive voluntary family  
13 planning services for two years if approval of the waiver requesting family  
14 planning services pursuant to this section is approved by the United States  
15 department of health and human services. This two year period begins on the  
16 first day following the end of that woman's sixty day federal eligibility  
17 period that begins on the last day of her pregnancy. Family planning  
18 services under this section are limited to those available pursuant to  
19 section 36-2907, subsection A, paragraph 9-8.~~

~~20 Sec. 23. Section 36-2907.07, Arizona Revised Statutes, as amended by  
21 Laws 1999, chapter 262, section 15, is amended to read:~~

~~22 36-2907.07. Tobacco tax program evaluations~~

~~23 A. SUBJECT TO THE AVAILABILITY OF MONIES, the administration shall MAY  
24 enter into an intergovernmental agreement pursuant to title 11, chapter 7,  
25 article 3 to contract with the department of health services to conduct  
26 annual program evaluations of each program receiving any tobacco tax monies  
27 pursuant to section 36-774.~~

~~28 B. IF THE ADMINISTRATION CONTRACTS FOR THE ANNUAL PROGRAM EVALUATIONS:~~

~~29 1. The annual program evaluations shall examine the effectiveness of  
30 the programs, the organizational structure of the programs and the efficiency  
31 of the programs.~~

~~32 C. 2. The evaluations shall include but are not limited to the  
33 following utilization information:~~

~~34 1. (a) The level and scope of services being offered.~~

~~35 2. (b) The type of services being used.~~

~~36 3. (c) The frequency of services being used.~~

~~37 4. (d) The personal characteristics of the program participants who  
38 receive services.~~

~~39 5. (e) The demographic characteristics of the program participants  
40 who receive services.~~

~~41 D. 3. The annual program evaluations shall include but are not  
42 limited to:~~

~~43 1. (a) Information on the number of the program participants.~~

~~44 2. (b) Information on program contractors and program service  
45 providers.~~

1           ~~3.~~ (c) Information on program revenues and expenditures.  
2           ~~4.~~ (d) Information on the average cost for each program participant  
3 receiving services and information on the average cost of providing each  
4 service.

5           ~~5.~~ (e) Information on the administrative costs to operate each  
6 program.

7           ~~6.~~ (f) An evaluation of the methods used by the department of health  
8 services for selecting eligible contractors.

9           ~~7.~~ (g) An estimate of the benefits and effects of providing health  
10 care services to persons who cannot afford those services or for whom there  
11 would otherwise be no coverage.

12           ~~E.~~ 4. The department of health services shall submit an annual report  
13 to the director of the joint legislative budget committee no later than  
14 November 1 of each year REGARDING THE EVALUATIONS.

15           ~~F. The administration shall annually withdraw monies from the~~  
16 ~~medically needy account established pursuant to section 36-774 in the amount~~  
17 ~~necessary to reimburse the department of health services for the evaluations~~  
18 ~~conducted pursuant to this section.~~

19           Sec. 24. Section 36-2907.07, Arizona Revised Statutes, as amended by  
20 Laws 2001, chapter 313, section 2, is amended to read:

21           36-2907.07. Tobacco tax program evaluations

22           A. SUBJECT TO THE AVAILABILITY OF MONIES, the administration shall MAY  
23 enter into an intergovernmental agreement pursuant to title 11, chapter 7,  
24 article 3 to contract with the auditor general to conduct or cause to conduct  
25 program evaluations of programs that both receive tobacco tax monies pursuant  
26 to section 36-774 and are administered by the department of health services.

27           B. IF THE ADMINISTRATION CONTRACTS FOR THE ANNUAL PROGRAM EVALUATIONS:

28           1. The auditor general shall establish a schedule for periodic reviews  
29 of the programs. The auditor general shall notify the joint legislative  
30 audit committee of the schedule for the periodic reviews of the  
31 programs. The joint legislative audit committee shall review the schedule  
32 and may approve or modify it.

33           ~~B.~~ 2. The ~~annual~~ program evaluations shall examine the effectiveness  
34 of the programs, the organizational structure of the programs and the  
35 efficiency of the programs.

36           ~~C.~~ 3. The evaluations shall include but are not limited to the  
37 following utilization information:

38           ~~1.~~ (a) The level and scope of services being offered.

39           ~~2.~~ (b) The type of services being used.

40           ~~3.~~ (c) The frequency of services being used.

41           ~~4.~~ (d) The personal characteristics of the program participants who  
42 receive services.

43           ~~5.~~ (e) The demographic characteristics of the program participants  
44 who receive services.

1           ~~D.~~ 4. The annual program evaluations shall include but are not  
2 limited to:

3           ~~1.~~ (a) Information on the number of the program participants.

4           ~~2.~~ (b) Information on program contractors and program service  
5 providers.

6           ~~3.~~ (c) Information on program revenues and expenditures.

7           ~~4.~~ (d) Information on the average cost for each program participant  
8 receiving services and information on the average cost of providing each  
9 service.

10          ~~5.~~ (e) Information on the administrative costs to operate each  
11 program.

12          ~~6.~~ (f) An evaluation of the methods used by the department of health  
13 services for selecting eligible contractors.

14          ~~7.~~ (g) An estimate of the benefits and effects of providing health  
15 care services to persons who cannot afford those services or for whom there  
16 would otherwise be no coverage.

17          ~~E.~~ 5. The department of health services shall provide data necessary  
18 to complete the evaluations required by this section.

19          ~~F.~~ 6. The auditor general shall submit an annual report to the  
20 director of the joint legislative budget committee REGARDING THE EVALUATIONS  
21 no later than November 1 of each year.

22          ~~G.~~ The administration shall annually withdraw monies from the  
23 medically needy account established pursuant to section 36-774 in the amount  
24 of three hundred thousand dollars to reimburse the auditor general for the  
25 evaluations conducted pursuant to this section.

26          ~~Sec. 25. Section 36-2907.08, Arizona Revised Statutes, is amended to~~  
27 read:

28           36-2907.08. Basic children's medical services program;  
29   definition

30           A. Beginning on October 1, 1996, the basic children's medical services  
31 program is established to provide grants to hospitals that exclusively serve  
32 the medical needs of children or that operate programs designed primarily for  
33 children. The director of the department of health services, pursuant to an  
34 intergovernmental agreement with the director of the Arizona health care cost  
35 containment system and subject to the availability of monies, shall implement  
36 and operate this program only to the extent that funding is available and has  
37 been specifically dedicated for the program.

38           B. To receive a grant under this section, a hospital shall submit an  
39 application as prescribed by the director of the department of health  
40 services in a request for proposal that indicates to the director's  
41 satisfaction that the applicant agrees to:

42           1. Use grant program monies to enhance the applicant's provision of  
43 additional medical services to children and to improve the applicant's  
44 ~~ability to deliver inpatient, outpatient and specialized clinical services.~~

1 ~~to indigent, uninsured or underinsured children who are not eligible to~~  
2 receive services under this article.

3 2. Establish and enforce a sliding fee scale for children who are  
4 provided services with grant monies.

5 3. Account for monies collected pursuant to paragraph 2 of this  
6 subsection separately from all other income it receives and to report this  
7 income on a quarterly basis to the administration.

8 4. Use the grant to supplement monies already available to the  
9 applicant.

10 5. Match the grant as prescribed by the director by rule with private  
11 monies the applicant has pledged from private sources. The director shall  
12 waive this requirement if the applicant is seeking the grant to qualify for  
13 a private or public grant for the delivery of inpatient, outpatient or  
14 specialized clinical care of indigent, uninsured or underinsured children who  
15 are not eligible to receive services under this article.

16 6. Provide a mechanism to ensure that grant program monies are not  
17 used for children who are eligible for services under this article.

18 7. Not use grant monies to fund the provision of emergency room  
19 services.

20 C. By contract, the director of the department of health services  
21 shall require a grantee to:

22 1. Annually account for all expenditures it makes with grant program  
23 monies during the previous year.

24 2. Agree to cooperate with any audits or reviews conducted by this  
25 state.

26 3. Agree to the requirements of this section and other conditions the  
27 director determines to be necessary for the effective use of grant program  
28 monies.

29 D. The director of the department of health services may limit either  
30 or both the grant amount per contract or the number of contracts awarded. In  
31 awarding contracts to qualified applicants the director shall consider:

32 1. The amount of monies available for the grant program.

33 2. The need for grant monies in the area served by the applicant as  
34 stated by the applicant in the response to the request for proposals and as  
35 researched by the administration.

36 3. The number of children estimated to be served by the applicant with  
37 grant program monies.

38 4. The services that will be provided or made available with grant  
39 program monies.

40 5. The percentages of grant monies that the applicant indicates will  
41 be reserved for administrative expenditures, direct service expenditures and  
42 medical care personnel costs.

43 6. The financial and programmatic ability of the applicant to meet the  
44 ~~contract's requirements.~~

1 ~~E. If the department of health services determines that a hospital has~~  
2 used grant monies in violation of this section it shall prohibit that  
3 hospital from receiving additional grant program monies until the hospital  
4 reimburses the department. The department shall impose an interest penalty  
5 as prescribed by the director of the department of health services by  
6 rule. The director shall deposit, pursuant to sections 35-146 and 35-147,  
7 penalties collected under this section in the medically needy account of the  
8 tobacco tax and health care fund.

9 F. The director of the department of health services may expend monies  
10 APPROPRIATED from the medically needy account of the tobacco tax and health  
11 care fund transferred pursuant to section 36-2921, subsection A, paragraph 6  
12 for the purpose of funding evaluations of the grant program established by  
13 this section. The director shall ensure that any evaluation is structured to  
14 meet at least the base requirements prescribed in section 36-2907.07.

15 G. The director of the department of health services may expend monies  
16 APPROPRIATED from the medically needy account of the tobacco tax and health  
17 care fund transferred pursuant to section 36-2921, subsection A, paragraph 6  
18 for administrative costs associated with the establishment or the operation  
19 of the grant program. The amount withdrawn annually for grant program  
20 administrative costs shall not exceed two per cent of the sum of any  
21 transfers of monies made pursuant to section 36-2921 and any appropriation  
22 of monies for the specified purpose of supporting the nonentitlement basic  
23 children's medical services program established in this section.

24 H. The department of health services shall directly administer the  
25 grant program and all contracts established pursuant to this section. The  
26 director of the department of health services shall publish rules pursuant  
27 to title 41, chapter 6 for the grant program before the issuance of the  
28 initial grant program request for proposals. The director of the department  
29 of health services and the contractor shall sign a contract before the  
30 transmission of any tobacco tax and health care fund monies to the  
31 contractor.

32 I. In administering the basic children's medical services program and  
33 awarding contracts established pursuant to this section, the director of the  
34 department of health services shall seek to efficiently and effectively  
35 coordinate the delivery of services provided through the program with  
36 services provided through other programs, including those established  
37 pursuant to chapter 2, article 3 of this title and sections 36-2907.05 and  
38 36-2907.06. The director shall seek to ensure that this coordination results  
39 in providing for either or both the coverage of additional children or the  
40 provision of additional medically necessary services to children instead of  
41 supplanting existing service opportunities or duplicating existing programs  
42 with no attendant increase in coverage.

43 J. For the purposes of this section, "grant program" refers to MEANS  
44 ~~the basic children's medical services program.~~

1 ~~Sec. 26. 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 10 is determined ineligible for  
8 coverage pursuant to section 36-2901.04 due to excess income or ineligible  
9 for coverage pursuant to section 36-2901, paragraph 6, subdivision (a) item  
10 (i), (ii) or (iii) and that person has not yet received the transplant, the  
11 person may extend the person's eligibility based on the total spend down  
12 requirement for the household divided by the number of persons in the  
13 household.

14 B. In order to extend eligibility the person shall enter into a  
15 contractual agreement with a hospital to pay the amount of excess income  
16 determined pursuant to this section. The hospital shall only be reimbursed  
17 by the administration at the contracted rate of the transplantation surgery,  
18 including up to one hundred days of posttransplantation care. The  
19 administration shall deduct the amount of excess income that the person  
20 agrees to pay the hospital before payment is made to the hospital for  
21 transplant services authorized by this section. The amount of excess income  
22 shall not be changed once the extended period of eligibility begins. The  
23 administration is not responsible to pay any of the spend down amount if the  
24 person does not pay the hospital. The contracting hospital shall submit a  
25 copy of the person's contractual agreement with the hospital to the  
26 administration.

27 C. The administration shall authorize extended eligibility services  
28 only for transplant candidates.

29 D. Extended eligibility pursuant to this section is for one  
30 twelve-month continuous period of time and is funded only pursuant to section  
31 36-2907.12.

32 E. This section does not prohibit a person from applying for  
33 eligibility pursuant to any other applicable law.

34 F. If the administration and a hospital that performed a transplant  
35 surgery on a person who is eligible pursuant to this section do not have a  
36 contracted rate, the administration shall not reimburse the hospital more  
37 than the contracted rate established by the administration.

38 G. A person who has extended eligibility pursuant to section  
39 36-2907.11 is not eligible for services pursuant to this section.

40 H. The extended eligibility of a person who is determined to be no  
41 longer medically eligible for a transplant terminates at the end of the month  
42 in which it is determined the person is not medically eligible for the  
43 transplant unless the person is otherwise eligible for services pursuant to  
44 ~~section 36-2901, paragraph 6, subdivision (a).~~

1 ~~Sec. 27, Section 36-2907.11, Arizona Revised Statutes, is amended to~~  
2 read:

3 36-2907.11. Retaining transplant status

4 A. If during a redetermination process for eligibility pursuant to  
5 this article a person who is eligible for a medically necessary and  
6 appropriate transplant as determined by the administration pursuant to  
7 section 36-2907, subsection A, paragraph ~~11~~ 10 is determined ineligible for  
8 coverage pursuant to section 36-2901.04 due to excess income or ineligible  
9 for coverage pursuant to section 36-2901, paragraph 6, subdivision (a), item  
10 (i), (ii) or (iii) and that person has not yet received the transplant, the  
11 person may enter into a contract with a hospital to pay the amount of excess  
12 income. For purposes of this section, the administration shall compute  
13 excess income based on the total spend down requirement for the household  
14 divided by the number of persons in the household. The administration shall  
15 recompute excess income pursuant to this section at the time the transplant  
16 becomes available.

17 B. If the hospital enters into the contractual agreement with the  
18 person, the hospital shall allow the person to retain the person's transplant  
19 candidacy status as long as the person is medically eligible but the person  
20 is not eligible for services pursuant to this article unless that person is  
21 determined eligible pursuant to subsection D of this section.

22 C. A person who has extended eligibility pursuant to section  
23 36-2907.10 is not eligible for services pursuant to this section.

24 D. Once a transplant is scheduled or performed the person shall  
25 reapply for eligibility pursuant to section 36-2901, paragraph 6, subdivision  
26 (a) and, if a spend down of excess income is necessary in order to be  
27 eligible for services pursuant to this article, the administration shall  
28 compute this income pursuant to the process specified in subsection A of this  
29 section. If the transplant is performed within thirty days before the date  
30 of the eligibility determination, the administration shall pay the hospital  
31 on a retroactive basis at the contracted rate for costs of the transplant  
32 surgery, including up to one hundred days of posttransplantation care. The  
33 administration shall deduct the amount of excess income that the person has  
34 agreed to pay the hospital before payment is made to the hospital for  
35 transplant services pursuant to this section. The amount of excess income  
36 shall not be recomputed after the date the person becomes eligible pursuant  
37 to this section. The administration is not responsible for paying any spend  
38 down amount if the person does not pay the hospital. The contracting  
39 hospital shall submit a copy of the person's contractual agreement with the  
40 hospital to the administration.

41 E. Eligibility pursuant to this section shall be funded only pursuant  
42 to section 36-2907.12.

43 F. This section does not prohibit a person from applying for  
44 ~~eligibility pursuant to any other applicable law.~~

~~1 G. If the administration and a hospital that performed a transplant  
2 surgery on a person eligible pursuant to this section do not have a  
3 contracted rate, the administration shall not reimburse the hospital more  
4 than the contracted rate established by the administration.~~

5 Sec. 28. Section 36-2909, Arizona Revised Statutes, is amended to  
6 read:

7 36-2909. Emergency hospital services; retroactive coverage;  
8 costs

9 A. If a member receives emergency hospitalization and medical care on  
10 or after the date of eligibility determination or the eligibility effective  
11 date from a hospital that does not have a contract to care for the person,  
12 the administration or the contractor is liable only for the costs of  
13 emergency hospitalization and medical care up to the time the person is  
14 discharged or until the time the person can be transferred. The  
15 administration or the prepaid capitated provider is also liable for further  
16 care in the following circumstances:

17 1. If the attending physician reasonably determines that the condition  
18 of the person receiving emergency hospitalization and medical care is such  
19 that it is medically inadvisable to transfer the person.

20 2. If the administration or the contractor does not transport the  
21 person from the hospital providing care after it has been determined that the  
22 person can be transferred.

23 B. Except for charges for services subject to section 36-2908,  
24 subsection B, all charges incurred by an eligible person who has not yet  
25 enrolled for hospitalization and medical care under subsection A of this  
26 section are payable by the administration pursuant to section 36-2903.01,  
27 subsection G or H or as specified in contract by the contractor pursuant to  
28 the subcontracted rate or section 36-2904, subsection I- H or J- I.

29 C. As a condition to receiving reimbursement pursuant to subsection  
30 B of this section, a hospital that is not a contractor or subcontractor under  
31 the system must designate a primary care physician or primary care  
32 practitioner to act as a coordinator of the services provided to persons who  
33 have been determined eligible but have not yet enrolled, before the persons'  
34 enrollment, discharge or transfer.

35 D. Emergency hospitalization and medical care provided pursuant to  
36 this section shall be in accordance with rules adopted pursuant to section  
37 36-2903.01, subsection E in order to qualify for reimbursement.

38 E. The director shall adopt rules that provide that members who have  
39 been determined eligible shall be enrolled with contractors as soon as  
40 practicable.

41 F. This section does not prevent the director or the contractor from  
42 denying payment for hospitalization or medical care that is not authorized  
43 or deemed medically necessary in accordance with rules adopted by the  
44 director.

1           Sec. 29. 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 paid by each county resolving to participate in the system  
19 equal to the actual cost, as limited by the board of supervisors, together  
20 with employee contributions of providing hospitalization and medical care  
21 under the system to full-time officers and employees of the county and its  
22 departments and agencies.

23           3. Monies paid by this state equal to the actual cost, as limited by  
24 section 38-651, together with employee contributions of providing  
25 hospitalization and medical care under the system to full-time officers and  
26 employees of this state, of its departments and agencies and of cities, towns  
27 and school districts of this state.

28           4. Monies drawn against appropriations made by this state for the  
29 costs of operating the Arizona health care cost containment system or the  
30 long-term care system. Monies shall be drawn against appropriations and  
31 transferred from the fund from which they were appropriated on an as needed  
32 basis only.

33           5. Gifts, donations and grants from any source.

34           6. Federal monies made available to this state for the operation of  
35 the Arizona health care cost containment system or the long-term care system.

36           7. Interest paid on monies deposited in the fund.

37           8. Monies paid by the owners of eligible businesses in this state,  
38 including employee contributions, for the actual cost of providing  
39 hospitalization and medical care under the system to their full-time  
40 employees together with interest paid on monies deposited in the fund.  
41 Administrative costs of the system to operate the eligible businesses program  
42 are subject to legislative appropriation.

43           9. Reimbursements for data collection.

44           D. The third party liability fund is comprised of monies paid by third  
45 party payors and lien and estate recoveries.

1 E. All monies in the funds other than monies appropriated by the state  
2 shall not lapse.

3 F. All monies drawn against appropriations made by this state  
4 remaining in the funds at the end of the fiscal year shall revert to the fund  
5 from which they were appropriated and drawn, and the appropriation shall  
6 lapse in accordance with section 35-190. Notwithstanding the provisions of  
7 section 35-191, subsection B, the period for administrative adjustments shall  
8 extend for only six months for appropriations made for system covered  
9 services.

10 G. Notwithstanding sections 35-190 and 35-191, all approved claims for  
11 system covered services presented after the close of the fiscal year in which  
12 they were incurred shall be paid either in accordance with subsection F of  
13 this section or in the current fiscal year with the monies available in the  
14 funds established by this section.

15 H. Claims for system covered services that are determined valid by the  
16 director pursuant to section 36-2904, subsection H- G and the department's  
17 grievance and appeal procedure shall be paid from the funds established by  
18 this section.

19 I. For purposes of this section, system covered services exclude  
20 administrative charges for operating expenses.

21 J. All payments for claims from the funds established by this section  
22 shall be accounted for by the administration by the fiscal year in which the  
23 claims were incurred, regardless of the fiscal year in which the payments  
24 were made.

25 K. Notwithstanding any other law, county owned or contracted providers  
26 are subject to all claims processing and payment requirements or limitations  
27 of this chapter that are applicable to noncounty providers.

28 Sec. 30. Repeal

29 The following are repealed:

30 1. Section 36-2921, Arizona Revised Statutes, as amended by Laws 2002,  
31 chapter 329, section 7.

32 2. Section 36-2921, Arizona Revised Statutes, as amended by Laws 2001,  
33 chapter 313, section 3.

34 3. Section 36-2921, Arizona Revised Statutes, as added by Laws 2001,  
35 chapter 374, section 3.

36 ~~Sec. 31. Title 36, chapter 29, article 1, Arizona Revised Statutes,~~  
37 ~~is amended by adding a new section 36-2921, to read:~~

38 ~~36-2921. Tobacco tax allocations; medically needy account;~~  
39 ~~general appropriations; report~~

40 ~~A. THE MONIES IN THE MEDICALLY NEEDY ACCOUNT ESTABLISHED PURSUANT TO~~  
41 ~~SECTION 36-774 SHALL BE SPENT FOR HEALTH CARE SERVICES IN THE ARIZONA HEALTH~~  
42 ~~CARE COST CONTAINMENT SYSTEM AND THE DEPARTMENT OF HEALTH SERVICES AS~~  
43 ~~AUTHORIZED IN THE GENERAL APPROPRIATION ACT.~~

44 ~~B. ON OR BEFORE NOVEMBER 1, THE ADMINISTRATION SHALL ANNUALLY REPORT~~  
45 ~~TO THE DIRECTOR OF THE JOINT LEGISLATIVE BUDGET COMMITTEE THE ANNUAL REVENUES~~

~~1 DEPOSITED IN THE MEDICALLY NEEDY ACCOUNT. THE ADMINISTRATION SHALL  
2 IMMEDIATELY REPORT TO THE DIRECTOR OF THE JOINT LEGISLATIVE BUDGET COMMITTEE  
3 IF AT ANY TIME THE ADMINISTRATION ESTIMATES THAT THE AMOUNT AVAILABLE IN THE  
4 MEDICALLY NEEDY ACCOUNT WILL NOT BE SUFFICIENT TO FUND THE MAXIMUM  
5 ALLOCATIONS ESTABLISHED IN THE GENERAL APPROPRIATION ACT.~~

6 Sec. 32. Repeal

7 Sections 36-2923, 36-2923.01, 36-2923.02 and 36-2923.03, Arizona  
8 Revised Statutes, are repealed.

~~9 Sec. 33. Section 36-2928, Arizona Revised Statutes, is amended to~~

10 read:

11 36-2928. Budget neutrality compliance fund; nonlapsing

12 A. The budget neutrality compliance fund is established consisting of  
13 third party liability recoveries pursuant to section 36-2913, county  
14 contributions deposited pursuant to section 11-292, subsection P and section  
15 11-300, subsection ~~D~~ E and appropriations. The administration shall  
16 administer the fund. Monies in the fund are continuously appropriated and  
17 do not revert to the state general fund SUBJECT TO LEGISLATIVE APPROPRIATION.

18 B. On notice from the administration, the state treasurer shall invest  
19 and divest monies in the fund as provided by section 35-313, and monies  
20 earned from investment shall be credited to the Arizona tobacco litigation  
21 settlement fund established by section 36-2901.02.

22 C. The administration shall use any remaining fund monies to pay for  
23 expenditures made pursuant to section 36-2901.02, subsection B, paragraph 1  
24 if sufficient monies are not available in the Arizona tobacco litigation  
25 settlement fund established by section 36-2901.02, except that the  
26 administration shall use fund monies deposited pursuant to section 11-292,  
27 subsection Q for any direct and indirect eligibility costs associated with  
28 the expansion of program services.

29 D. On or before June 30 of each year, the administration shall  
30 transfer from the Arizona tobacco litigation settlement fund established by  
31 section 36-2901.02 an amount necessary to reimburse the fund established  
32 pursuant to this section for its expenditures made to cover costs associated  
33 with the expanded definition of eligibility pursuant to section 36-2901.01,  
34 36-2901.04 or 36-2903.03.

35 E. Notwithstanding subsection C of this section, in fiscal year  
36 2001-2002, the administration shall use forty-six million seven hundred  
37 thirty-six thousand dollars of fund monies for maintenance of effort for the  
38 state match for persons who are determined eligible pursuant to section  
39 36-2901.01, 36-2901.04 or 36-2903.03. Beginning in fiscal year 2002-2003 and  
40 each fiscal year thereafter, the administration shall adjust this amount for  
41 ~~inflation based on the GDP price deflator as defined in section 41-563.~~

1           Sec. 34. Section 36-2939, Arizona Revised Statutes, is amended to  
2 read:

3           36-2939. Long-term care system services

4           A. The following services shall be provided by the program contractors  
5 to members determined to need institutional services pursuant to this  
6 article:

7           1. Nursing facility services other than services in an institution for  
8 tuberculosis or mental disease.

9           2. Notwithstanding any other law, behavioral health services if these  
10 services are not duplicative of long-term care services provided as of  
11 January 30, 1993 under this subsection and are authorized by the program  
12 contractor through the long-term care case management system. If the  
13 administration is the program contractor, the administration may authorize  
14 these services.

15           3. Hospice services. For the purposes of this paragraph, "hospice"  
16 means a program of palliative and supportive care for terminally ill members  
17 and their families or caregivers.

18           4. Case management services as provided in section 36-2938.

19           5. Health and medical services as provided in section 36-2907.

20           B. In addition to the services prescribed in subsection A of this  
21 section, the department, as a program contractor, shall provide the following  
22 services if appropriate to members who are defined as developmentally  
23 disabled pursuant to section 36-551 and are determined to need institutional  
24 services pursuant to this article:

25           1. Intermediate care facility for mental retardation services for a  
26 member who has a developmental disability as defined in section 36-551. For  
27 purposes of this article, such facility shall meet all federally approved  
28 standards and may only include the Arizona training program facilities, a  
29 state owned and operated service center, state owned or operated community  
30 residential settings or existing licensed facilities operated by this state  
31 or under contract with the department on or before July 1, 1988.

32           2. Home and community based services which may be provided in a  
33 member's home or an alternative residential setting as prescribed in section  
34 36-591 or other behavioral health alternative residential facilities licensed  
35 by the department of health services and approved by the director of the  
36 Arizona health care cost containment system administration and which may  
37 include:

38           (a) Home health, which means the provision of nursing services or home  
39 health aide services or medical supplies, equipment and appliances, which are  
40 provided on a part-time or intermittent basis by a licensed home health  
41 agency within a member's residence based on a physician's orders and in  
42 accordance with federal law. Physical therapy, occupational therapy, or  
43 speech and audiology services provided by a home health agency may be  
44 provided in accordance with federal law. Beginning on July 1, 1998, home

1 health agencies shall comply with federal bonding requirements in a manner  
2 prescribed by the administration.

3 (b) Home health aide, which means a service that provides intermittent  
4 health maintenance, continued treatment or monitoring of a health condition  
5 and supportive care for activities of daily living provided within a member's  
6 residence.

7 (c) Homemaker, which means a service that provides assistance in the  
8 performance of activities related to household maintenance within a member's  
9 residence.

10 (d) Personal care, which means a service that provides assistance to  
11 meet essential physical needs within a member's residence.

12 (e) Developmentally disabled day care, which means a service that  
13 provides planned care supervision and activities, personal care, activities  
14 of daily living skills training and habilitation services in a group setting  
15 during a portion of a continuous twenty-four hour period.

16 (f) Habilitation, which means the provision of physical therapy,  
17 occupational therapy, speech or audiology services or training in independent  
18 living, special developmental skills, sensory-motor development, behavior  
19 intervention, and orientation and mobility in accordance with federal law.

20 (g) Respite care, which means a service that provides short-term care  
21 and supervision available on a twenty-four hour basis.

22 (h) Transportation, which means a service that provides or assists in  
23 obtaining transportation for the member.

24 (i) Other services or licensed or certified settings approved by the  
25 director.

26 C. In addition to services prescribed in subsection A of this section,  
27 home and community based services may be provided in a member's home, in an  
28 adult foster care home as prescribed in section 36-401, in an assisted living  
29 home or a residential unit as defined in section 36-401 or in a level one  
30 or level two behavioral health alternative residential facility approved by  
31 the director by program contractors to all members who are not defined as  
32 developmentally disabled pursuant to section 36-551 and are determined to  
33 need institutional services pursuant to this article. The director may also  
34 approve other licensed residential facilities as appropriate on a case by  
35 case basis for traumatic brain injured members. Home and community based  
36 services may include the following:

37 1. Home health, which means the provision of nursing services or home  
38 health aide services or medical supplies, equipment and appliances, which are  
39 provided on a part-time or intermittent basis by a licensed home health  
40 agency within a member's residence based on a physician's orders and in  
41 accordance with federal law. Physical therapy, occupational therapy, or  
42 speech and audiology services provided by a home health agency may be  
43 provided in accordance with federal law. Beginning on July 1, 1998, home  
44 health agencies shall comply with federal bonding requirements in a manner  
45 prescribed by the administration.

1           2. Home health aide, which means a service that provides intermittent  
2 health maintenance, continued treatment or monitoring of a health condition  
3 and supportive care for activities of daily living provided within a member's  
4 residence.

5           3. Homemaker, which means a service that provides assistance in the  
6 performance of activities related to household maintenance within a member's  
7 residence.

8           4. Personal care, which means a service that provides assistance to  
9 meet essential physical needs within a member's residence.

10          5. Adult day health, which means a service that provides planned care  
11 supervision and activities, personal care, personal living skills training,  
12 meals and health monitoring in a group setting during a portion of a  
13 continuous twenty-four hour period. Adult day health may also include  
14 preventive, therapeutic and restorative health related services that do not  
15 include behavioral health services.

16          6. Habilitation, which means the provision of physical therapy,  
17 occupational therapy, speech or audiology services or training in independent  
18 living, special developmental skills, sensory-motor development, behavior  
19 intervention, and orientation and mobility in accordance with federal law.

20          7. Respite care, which means a service that provides short-term care  
21 and supervision available on a twenty-four hour basis.

22          8. Transportation, which means a service that provides or assists in  
23 obtaining transportation for the member.

24          9. Home delivered meals, which means a service that provides for a  
25 nutritious meal containing at least one-third of the recommended dietary  
26 allowance for an individual and which is delivered to the member's residence.

27          10. Other services or licensed or certified settings approved by the  
28 director.

29          D. The amount of money expended by program contractors on home and  
30 community based services pursuant to subsection C of this section shall be  
31 limited by the director in accordance with the federal monies made available  
32 to this state for home and community based services pursuant to subsection  
33 C of this section. The director shall establish methods for the allocation  
34 of monies for home and community based services to program contractors and  
35 shall monitor expenditures on home and community based services by program  
36 contractors.

37          E. Notwithstanding subsections A, B, C and F of this section, no  
38 service may be provided that does not qualify for federal monies available  
39 under title XIX of the social security act or the section 1115 waiver.

40          F. In addition to services provided pursuant to subsections A, B and  
41 C of this section, the director may implement a demonstration project to  
42 provide home and community based services to special populations, including  
43 disabled persons who are eighteen years of age or younger, medically fragile,  
44 reside at home and would be eligible for supplemental security income for the  
45 aged, blind or disabled or the state supplemental payment program, except for

1 the amount of their parent's income or resources. In implementing this  
2 project, the director may provide for parental contributions for the care of  
3 their child.

4 G. SUBJECT TO SECTION 36-562, THE ADMINISTRATION BY RULE SHALL  
5 PRESCRIBE A DEDUCTIBLE SCHEDULE FOR PROGRAMS PROVIDED TO MEMBERS WHO ARE  
6 ELIGIBLE PURSUANT TO SUBSECTION B OF THIS SECTION, EXCEPT THAT THE  
7 ADMINISTRATION SHALL IMPLEMENT A DEDUCTIBLE BASED ON FAMILY INCOME. IN  
8 DETERMINING DEDUCTIBLE AMOUNTS AND WHETHER A FAMILY IS REQUIRED TO HAVE  
9 DEDUCTIBLES, THE DEPARTMENT SHALL USE ADJUSTED GROSS INCOME. FAMILIES WHOSE  
10 ADJUSTED GROSS INCOME IS AT LEAST FOUR HUNDRED PER CENT AND LESS THAN OR  
11 EQUAL TO FIVE HUNDRED PER CENT OF THE FEDERAL POVERTY LEVEL SHALL HAVE A  
12 DEDUCTIBLE OF TWO PER CENT OF ADJUSTED GROSS INCOME. FAMILIES WHOSE ADJUSTED  
13 GROSS INCOME IS MORE THAN FIVE HUNDRED PER CENT OF ADJUSTED GROSS INCOME  
14 SHALL HAVE A DEDUCTIBLE OF FOUR PER CENT OF ADJUSTED GROSS INCOME. ONLY  
15 FAMILIES WHOSE CHILDREN ARE UNDER EIGHTEEN YEARS OF AGE AND WHO ARE MEMBERS  
16 WHO ARE ELIGIBLE PURSUANT TO SUBSECTION B OF THIS SECTION MAY BE REQUIRED TO  
17 HAVE A DEDUCTIBLE FOR SERVICES. FOR THE PURPOSES OF THIS SUBSECTION,  
18 "DEDUCTIBLE" MEANS AN AMOUNT A FAMILY, WHOSE CHILDREN ARE UNDER EIGHTEEN  
19 YEARS OF AGE AND WHO ARE MEMBERS WHO ARE ELIGIBLE PURSUANT TO SUBSECTION B  
20 OF THIS SECTION, PAYS FOR SERVICES, OTHER THAN DEPARTMENTAL CASE MANAGEMENT  
21 AND ACUTE CARE SERVICES, BEFORE THE DEPARTMENT WILL PAY FOR SERVICES OTHER  
22 THAN DEPARTMENTAL CASE MANAGEMENT AND ACUTE CARE SERVICES.

23 Sec. 35. Delayed repeal

24 Section 36-2981.01, Arizona Revised Statutes, is repealed from and  
25 after June 30, 2004.

26 Sec. 36. Section 36-2983, Arizona Revised Statutes, is amended to  
27 read:

28 36-2983. Eligibility for the program

29 A. The administration shall establish a streamlined eligibility  
30 process for applicants to the program and shall issue a certificate of  
31 eligibility at the time eligibility for the program is determined.  
32 Eligibility shall be based on gross household income for a member as defined  
33 in section 36-2981. ~~and for parents of children enrolled in the children's~~  
34 ~~health insurance program pursuant to section 36-2981.01. Eligibility for a~~  
35 ~~parent who has a child enrolled in article 1 of this chapter but who is~~  
36 ~~eligible pursuant to section 36-2981.01 shall be based on requirements~~  
37 ~~established by the administration. The administration shall not apply a~~  
38 resource test in the eligibility determination or redetermination process.

39 B. The administration shall use a simplified eligibility form that may  
40 be mailed to the administration. Once a completed application is received,  
41 including adequate verification of income, the administration shall expedite  
42 the eligibility determination and enrollment on a prospective basis.

43 C. The date of eligibility is the first day of the month following a  
44 determination of eligibility if the decision is made by the twenty-fifth day  
45 of the month. A person who is determined eligible for the program after the

1 twenty-fifth day of the month is eligible for the program the first day of  
2 the second month following the determination of eligibility.

3 D. An applicant for the program who appears to be eligible pursuant  
4 to section 36-2901, paragraph 6, subdivision (a) shall have a social security  
5 number or shall apply for a social security number within thirty days after  
6 the applicant submits an application for the program.

7 E. In order to be eligible for the program, a person shall be a  
8 resident of this state and shall meet title XIX requirements for United  
9 States citizenship or qualified alien status in the manner prescribed in  
10 section 36-2903.03.

11 F. In determining the eligibility for all qualified aliens pursuant  
12 to this article, the income and resources of a person who executed an  
13 affidavit of support pursuant to section 213A of the immigration and  
14 nationality act on behalf of the qualified alien and the income and resources  
15 of the spouse, if any, of the sponsoring individual shall be counted at the  
16 time of application and for the redetermination of eligibility for the  
17 duration of the attribution period as specified in federal law.

18 G. Pursuant to federal law, a person is not eligible for the program  
19 if that person is:

20 1. Eligible for title XIX, ~~except for a person who is eligible~~  
21 ~~pursuant to section 36-2981.01~~, or other federally operated or financed  
22 health care insurance programs, except the Indian health service.

23 2. Covered by any group health plan or other health insurance coverage  
24 as defined in section 2791 of the public health service act. Group health  
25 plan or other health insurance coverage does not include coverage to persons  
26 who are defined as eligible pursuant to the premium sharing program.

27 3. A member of a family that is eligible for health benefits coverage  
28 under a state health benefit plan based on a family member's employment with  
29 a public agency in this state.

30 4. An inmate of a public institution or a patient in an institution  
31 for mental diseases. This paragraph does not apply to services furnished in  
32 a state operated mental hospital or to residential or other twenty-four hour  
33 therapeutically planned structured services.

34 H. A child who is covered under an employer's group health insurance  
35 plan or through family or individual health care coverage shall not be  
36 enrolled in the program. If the health insurance coverage is voluntarily  
37 discontinued for any reason, except for the loss of health insurance due to  
38 loss of employment or other involuntary reason, the child is not eligible for  
39 the program for a period of three months from the date that the health care  
40 coverage was discontinued. The administration may waive the three month  
41 period for any child who is seriously or chronically ill. For the purposes  
42 of the waiver, "chronically ill" means a medical condition that requires  
43 frequent and ongoing treatment and that if not properly treated will  
44 seriously affect the child's overall health. The administration shall  
45 establish rules to further define conditions that constitute a serious or

1 chronic illness. Beginning on January 1, 2002, in the annual report required  
2 pursuant to section 36-2996, the administration shall provide the conditions  
3 and the number of children included in each category.

4 I. Pursuant to federal law, a private insurer, as defined by the  
5 secretary of the United States department of health and human services, shall  
6 not limit enrollment by contract or any other means based on the presumption  
7 that a child may be eligible for the program.

8 Sec. 37. Section 36-2986, Arizona Revised Statutes, is amended to  
9 read:

10 36-2986. Administration; powers and duties of director

11 A. The director has full operational authority to adopt rules or to  
12 use the appropriate rules adopted for article 1 of this chapter to implement  
13 this article, including any of the following:

14 1. Contract administration and oversight of contractors.

15 2. Development of a complete system of accounts and controls for the  
16 program including provisions designed to ensure that covered health and  
17 medical services provided through the system are not used unnecessarily or  
18 unreasonably including inpatient behavioral health services provided in a  
19 hospital.

20 3. Establishment of peer review and utilization review functions for  
21 all contractors.

22 4. Development and management of a contractor payment system.

23 5. Establishment and management of a comprehensive system for assuring  
24 quality of care.

25 6. Establishment and management of a system to prevent fraud by  
26 members, contractors and health care providers.

27 7. Development of an outreach program. The administration shall  
28 coordinate with public and private entities to provide outreach services for  
29 children under this article. Priority shall be given to those families who  
30 are moving off welfare. Outreach activities shall include strategies to  
31 inform communities, including tribal communities, about the program, ensure  
32 a wide distribution of applications and provide training for other entities  
33 to assist with the application process.

34 8. Coordination of benefits provided under this article for any  
35 member. The director may require that contractors and noncontracting  
36 providers are responsible for the coordination of benefits for services  
37 provided under this article. Requirements for coordination of benefits by  
38 noncontracting providers under this section are limited to coordination with  
39 standard health insurance and disability insurance policies and similar  
40 programs for health coverage. The director may require members to assign to  
41 the administration rights to all types of medical benefits to which the  
42 person is entitled, including first party medical benefits under automobile  
43 insurance policies. The state has a right of subrogation against any other  
44 person or firm to enforce the assignment of medical benefits. The provisions  
45 of this paragraph are controlling over the provisions of any insurance policy

1 that provides benefits to a member if the policy is inconsistent with this  
2 paragraph.

3 9. Development and management of an eligibility, enrollment and  
4 redetermination system including a process for quality control.

5 10. Establishment and maintenance of an encounter claims system that  
6 ensures that ninety per cent of the clean claims are paid within thirty days  
7 after receipt and ninety-nine per cent of the remaining clean claims are paid  
8 within ninety days after receipt by the administration or contractor unless  
9 an alternative payment schedule is agreed to by the contractor and the  
10 provider. For the purposes of this paragraph, "clean claims" has the same  
11 meaning prescribed in section 36-2904, subsection H- G.

12 11. Establishment of standards for the coordination of medical care and  
13 member transfers.

14 12. Require contractors to submit encounter data in a form specified  
15 by the director.

16 B. Notwithstanding any other law, if Congress amends title XXI of the  
17 social security act and the administration is required to make conforming  
18 changes to rules adopted pursuant to this article, the administration shall  
19 request a hearing with the joint health committee of reference for review of  
20 the proposed rule changes.

21 C. The director may subcontract distinct administrative functions to  
22 one or more persons who may be contractors within the system.

23 D. The director shall require as a condition of a contract with any  
24 contractor that all records relating to contract compliance are available for  
25 inspection by the administration and that these records be maintained by the  
26 contractor for five years. The director shall also require that these  
27 records are available by a contractor on request of the secretary of the  
28 United States department of health and human services.

29 E. Subject to existing law relating to privilege and protection, the  
30 director shall prescribe by rule the types of information that are  
31 confidential and circumstances under which this information may be used or  
32 released, including requirements for physician-patient confidentiality.  
33 Notwithstanding any other law, these rules shall be designed to provide for  
34 the exchange of necessary information for the purposes of eligibility  
35 determination under this article. Notwithstanding any other law, a member's  
36 medical record shall be released without the member's consent in situations  
37 of suspected cases of fraud or abuse relating to the system to an officer of  
38 this state's certified Arizona health care cost containment system fraud  
39 control unit who has submitted a written request for the medical record.

40 F. The director shall provide for the transition of members between  
41 contractors and noncontracting providers and the transfer of members who have  
42 been determined eligible from hospitals that do not have contracts to care  
43 for these persons.

44 G. To the extent that services are furnished pursuant to this article  
45 a contractor is not subject to the provisions of title 20 unless the

1 contractor is a qualifying plan and has elected to provide services pursuant  
2 to this article.

3 H. As a condition of a contract, the director shall require contract  
4 terms that are necessary to ensure adequate performance by the contractor.  
5 Contract provisions required by the director include the maintenance of  
6 deposits, performance bonds, financial reserves or other financial security.  
7 The director may waive requirements for the posting of bonds or security for  
8 contractors who have posted other security, equal to or greater than that  
9 required by the administration, with a state agency for the performance of  
10 health service contracts if monies would be available from that security for  
11 the system on default by the contractor.

12 I. The director shall establish solvency requirements in contract that  
13 may include withholding or forfeiture of payments to be made to a contractor  
14 by the administration for the failure of the contractor to comply with a  
15 provision of the contract with the administration. The director may also  
16 require contract terms allowing the administration to operate a contractor  
17 directly under circumstances specified in the contract. The administration  
18 shall operate the contractor only as long as it is necessary to assure  
19 delivery of uninterrupted care to members enrolled with the contractor and  
20 to accomplish the orderly transition of members to other contractors or until  
21 the contractor reorganizes or otherwise corrects the contract performance  
22 failure. The administration shall not operate a contractor unless, before  
23 that action, the administration delivers notice to the contractor providing  
24 an opportunity for a hearing in accordance with procedures established by the  
25 director. Notwithstanding the provisions of a contract, if the  
26 administration finds that the public health, safety or welfare requires  
27 emergency action, it may operate as the contractor on notice to the  
28 contractor and pending an administrative hearing, which it shall promptly  
29 institute.

30 J. For the sole purpose of matters concerning and directly related to  
31 this article, the administration is exempt from section 41-192.

32 K. The director may withhold payments to a noncontracting provider if  
33 the noncontracting provider does not comply with this article or adopted  
34 rules that relate to the specific services rendered and billed to the  
35 administration.

36 L. The director shall:

37 1. Prescribe uniform forms to be used by all contractors and furnish  
38 uniform forms and procedures, including methods of identification of members.  
39 The rules shall include requirements that an applicant personally complete  
40 or assist in the completion of eligibility application forms, except in  
41 situations in which the person is disabled.

42 2. By rule, establish a grievance and appeal procedure that conforms  
43 with the process and the time frames specified in article 1 of this chapter.  
44 If the program is suspended or terminated pursuant to section 36-2985, an

1 applicant or member is not entitled to contest the denial, suspension or  
2 termination of eligibility for the program.

3 3. Apply for and accept federal monies available under title XXI of  
4 the social security act. Available state monies appropriated to the  
5 administration for the operation of the program shall be used as matching  
6 monies to secure federal monies pursuant to this subsection.

7 M. The administration is entitled to all rights provided to the  
8 administration for liens and release of claims as specified in sections  
9 36-2915 and 36-2916 and shall coordinate benefits pursuant to section  
10 36-2903, subsection F and be a payor of last resort for persons who are  
11 eligible pursuant to this article.

12 N. The director shall follow the same procedures for review  
13 committees, immunity and confidentiality that are prescribed in article 1 of  
14 this chapter.

15 Sec. 38. Section 36-2987, Arizona Revised Statutes, is amended to  
16 read:

17 36-2987. Reimbursement for the program

18 A. For inpatient hospital services, the administration shall reimburse  
19 the Indian health service or a tribal facility based on the reimbursement  
20 rates for the Indian health service as published annually in the federal  
21 register. For outpatient services, the administration shall reimburse the  
22 Indian health service or a tribal facility based on the capped  
23 fee-for-service schedule established by the director. If Congress authorizes  
24 one hundred per cent pass-through of title XXI monies for services provided  
25 in an Indian health service facility or a tribal facility, the administration  
26 shall reimburse the Indian health service or the tribal facility with this  
27 enhanced federal funding based on the reimbursement rates for the Indian  
28 health service or the tribal facility as published annually in the federal  
29 register.

30 B. Contractors shall reimburse inpatient and outpatient services based  
31 on the reimbursement methodology established in section 36-2904 or the  
32 hospital reimbursement pilot program established by this state.

33 C. For services rendered on and after October 1, 1998, the  
34 administration and the contractors shall pay a hospital's rate established  
35 according to this section subject to the following:

36 1. If the hospital's bill is paid within thirty days after the date  
37 the bill was received, the administration shall pay ninety-nine per cent of  
38 the rate.

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

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

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

3 D. The administration and the contractors shall pay claims pursuant  
4 to the methodology, definitions and time frames specified for clean claims  
5 in section 36-2904, subsection H- G.

6 E. The director shall specify enrollment procedures including notice  
7 to contractors of enrollment. The administration shall specify in contract  
8 when a person who has been determined eligible will be enrolled with a  
9 contractor and the date on which the contractor will be financially  
10 responsible for health and medical services to the person.

11 F. The director shall monitor any third party payment collections  
12 collected by contractors and noncontracting providers according to the same  
13 procedures specified for title XIX pursuant to section 36-2903.01,  
14 subsection K.

15 G. On oral or written notice from the member, or the member's parent  
16 or legal guardian, that the member, parent or legal guardian believes a claim  
17 should be covered by the program, a contractor or noncontracting provider  
18 shall not do either of the following unless the contractor or noncontracting  
19 provider has verified through the administration that the person is  
20 ineligible for the program, has not yet been determined eligible or, at the  
21 time services were rendered, was not eligible or enrolled in the program:

22 1. Charge, submit a claim to or demand or otherwise collect payment  
23 from a member or person who has been determined eligible.

24 2. Refer or report a member or person who has been determined eligible  
25 to a collection agency or credit reporting agency for the failure of the  
26 member or person who has been determined eligible to pay charges for covered  
27 services unless specifically authorized by this article or rules adopted  
28 pursuant to this article.

29 H. The administration may conduct postpayment review of all payments  
30 made by the administration and may recoup any monies erroneously paid. The  
31 director may adopt rules that specify procedures for conducting postpayment  
32 review. Contractors may conduct a postpayment review of all claims paid to  
33 providers and may recoup monies that are erroneously paid.

34 I. The director or the director's designee may employ and supervise  
35 personnel necessary to assist the director in performing the functions of the  
36 program.

37 Sec. 39. Section 36-2995, Arizona Revised Statutes, is amended to  
38 read:

39 36-2995. Children's health insurance program fund; sources of  
40 monies; use; reversion; claims

41 A. The children's health insurance program fund is established. The  
42 administration shall administer the fund and shall use fund monies to pay  
43 administrative and program costs associated with the operation of the program  
44 established by this article.

1 B. Separate accounting shall be made for each source of monies  
2 received pursuant to subsection C of this section for expenses and income  
3 activity associated with the program established pursuant to this article.

4 C. Monies in the fund are comprised of:

5 1. Federal monies available to this state for the operation of the  
6 program.

7 2. Tobacco tax AND STATE GENERAL FUND monies appropriated as state  
8 matching monies.

9 3. Gifts, donations and grants from any source.

10 4. Interest paid on monies deposited in the fund.

11 5. Third party liability recoveries.

12 D. If a gift, a donation or a grant of over ten thousand dollars  
13 received from any private source contains a condition, the administration  
14 shall first meet with the joint legislative study committee on the  
15 integration of health care services to review the condition before it spends  
16 that gift, donation or grant.

17 E. All monies in the fund other than monies appropriated by this state  
18 do not lapse.

19 F. Monies appropriated from the medically needy account of the tobacco  
20 tax and health care fund pursuant to ~~section 36-2921~~ are exempt from section  
21 35-190 relating to lapsing of appropriations. Notwithstanding section  
22 35-191, subsection B, the period for administrative adjustments extends for  
23 only six months for appropriations made for administration covered services.

24 G. Notwithstanding sections 35-190 and 35-191, all approved claims for  
25 system covered services presented after the end of the fiscal year in which  
26 they were incurred shall be paid either in accordance with this section or  
27 in the current fiscal year with the monies available in the funds established  
28 by this section.

29 H. Claims for covered services that are determined to be valid by the  
30 director and the grievance and appeal procedure shall be paid from the  
31 children's health insurance program fund.

32 I. All payments for claims from the children's health insurance  
33 program fund shall be accounted for by the administration by the fiscal year  
34 in which the claims were incurred, regardless of the fiscal year in which the  
35 payments were made.

36 J. Notwithstanding any other law, county owned or contracted providers  
37 are subject to all claims processing and payment requirements or limitations  
38 of this chapter that are applicable to noncounty providers.

39 Sec. 40. Section 36-3411, Arizona Revised Statutes, is amended to  
40 read:

41 36-3411. Behavioral health services; timely reimbursement;  
42 penalties

43 A. The division shall ensure that behavioral health service providers  
44 are reimbursed within ninety days after the service provider submits a clean  
45 claim to a regional behavioral health authority.

1 B. Any contract issued by or on behalf of the division for the  
2 provision of behavioral health services shall include language outlining  
3 provisions for penalties for noncompliance with contract requirements.

4 C. If the regional behavioral health authority does not reimburse a  
5 provider as required by this section, the director shall subject the regional  
6 behavioral health authority to the penalty provisions prescribed in the  
7 contract which shall not exceed the interest charges prescribed in section  
8 44-1201, subsection A. The director shall impose any financial penalties  
9 levied upon the regional behavioral health authority through a reduction in  
10 the amount of funds payable to the regional behavioral health authority for  
11 administrative expenses.

12 D. The ninety day deadline imposed by this section is suspended while  
13 a formal grievance regarding the legitimacy of a claim is pending.

14 E. The department or a regional behavioral health authority shall not  
15 pay claims for covered services that are initially submitted more than nine  
16 months after the date of the services for which payment is claimed or that  
17 are submitted as clean claims more than twelve months after the date of  
18 service for which payment is claimed. A person dissatisfied with the denial  
19 of a claim by the department or by the regional behavioral health authority  
20 has twelve months from the date of the service for which payment is claimed  
21 to institute a grievance against the department or regional behavioral health  
22 authority.

23 F. For claims paid by the department, either directly or through a  
24 third party payor, the director may impose a penalty on a regional behavioral  
25 health authority or a service provider who submits a claim to the department  
26 for payment more than one time after the same claim had been previously  
27 denied by the department without having attempted to address the reason given  
28 for the denial. The penalty imposed by the director shall not exceed the  
29 average cost incurred by the department for processing a claim and shall be  
30 levied upon the regional behavioral health authority or service provider  
31 through reducing any future payment or payments until the amount of the  
32 penalty has been paid.

33 G. This section does not apply to services provided by a hospital  
34 pursuant to section 36-2903.01, subsection G or H, or section 36-2904,  
35 subsection I or J.

36 ~~Sec. 41. Section 41-3203, Arizona Revised Statutes, is amended to~~  
37 ~~read:~~

38 ~~41-3203. Spinal and head injuries trust fund; purpose~~

39 ~~A. The spinal and head injuries trust fund is established. The trust~~  
40 ~~fund shall be administered by the director of the department of economic~~  
41 ~~security, subject to legislative appropriation. The spinal and head injuries~~  
42 ~~trust fund shall consist of revenues derived from assessments imposed~~  
43 ~~pursuant to section 12-116.02 and distributed pursuant to section 36-2219.01,~~  
44 ~~subsection B, paragraph 3 2.~~

1 ~~B. On notice from the department of economic security, the state~~  
2 treasurer shall invest and divest monies in the fund as provided by section  
3 35-313, and monies earned from investment shall be credited to the trust  
4 fund. Monies in the fund do not revert to the state general fund.

5 C. Trust fund monies shall be spent on approval of the department of  
6 economic security's rehabilitation services administration only if comparable  
7 resources are not available or are not able to be delivered in a timely  
8 manner and in accordance with guidelines for the following purposes:

9 1. Public information, prevention and education of the general public  
10 and professionals.

11 2. Rehabilitation, transitional living and equipment necessary for  
12 activities of daily living.

13 3. A portion of the disease surveillance system and statewide referral  
14 services for those with head and spinal injuries.

15 4. Costs incurred by the advisory council on spinal and head injuries  
16 established pursuant to section 41-3201.

17 5. Administrative costs incurred by the department of economic  
18 security to administer the provisions of this article.

19 Sec. 42. Section 46-231, Arizona Revised Statutes, is amended to read:  
20 46-231. Administration; expenditure limitation

21 A. General assistance provided for in this article shall be  
22 administered by the department, subject to the provisions of chapter 1 and  
23 chapter 2, article 1 of this title.

24 B. The total amount of state monies that may be spent in any fiscal  
25 year by the department for general assistance shall not exceed the amount  
26 appropriated or authorized by section 35-173 for that purpose. This section  
27 shall not be construed to impose a duty on an officer, agent or employee of  
28 this state to discharge a responsibility or to create any right in a person  
29 or group if the discharge or right would require an expenditure of state  
30 monies in excess of the expenditure authorized by legislative appropriation  
31 for that specific purpose.

32 C. NOTWITHSTANDING ANY OTHER STATUTE, THE DEPARTMENT MAY IMPLEMENT A  
33 WAITING LIST OR OTHER COST-SAVING MEASURES IN THE GENERAL ASSISTANCE PROGRAM  
34 SO THAT THE TOTAL AMOUNT OF STATE MONIES SPENT IN ANY FISCAL YEAR ON GENERAL  
35 ASSISTANCE DOES NOT EXCEED THE AMOUNT APPROPRIATED OR AUTHORIZED BY SECTION  
36 35-173 FOR THAT PURPOSE. THE DEPARTMENT SHALL NOTIFY THE JOINT LEGISLATIVE  
37 BUDGET COMMITTEE OF ANY ACTION TAKEN PURSUANT TO THIS SUBSECTION WITHIN  
38 FIFTEEN DAYS OF IMPLEMENTING THAT ACTION.

39 Sec. 43. Repeal  
40 Laws 2001, chapter 344, section 100, as amended by Laws 2002, chapter  
41 321, section 6, is repealed.

42 Sec. 44. County acute care contribution; fiscal year 2003-2004

43 A. Notwithstanding section 11-292, Arizona Revised Statutes, for  
44 fiscal year 2003-2004 for the provision of hospitalization and medical care,

1 the counties shall contribute a total of \$66,689,500 based on the following  
2 percentages:

3	1. Apache:	0.403%
4	2. Cochise:	3.321%
5	3. Coconino:	1.114%
6	4. Gila:	2.119%
7	5. Graham:	0.804%
8	6. Greenlee:	0.286%
9	7. La Paz:	0.318%
10	8. Maricopa:	57.969%
11	9. Mohave:	1.856%
12	10. Navajo:	0.466%
13	11. Pima:	22.420%
14	12. Pinal:	4.072%
15	13. Santa Cruz:	0.724%
16	14. Yavapai:	2.141%
17	15. Yuma:	1.987%

18 B. If any county does not provide funding as specified in subsection  
19 A of this section, the state treasurer shall subtract the amount owed to the  
20 Arizona health care cost containment system and long-term care system funds  
21 established pursuant to section 36-2913, Arizona Revised Statutes, by the  
22 county from any payments required to be made by the state treasurer to that  
23 county pursuant to section 42-5029, subsection D, paragraph 2, Arizona  
24 Revised Statutes, plus interest on that amount pursuant to section 44-1201,  
25 Arizona Revised Statutes, retroactive to the first day the funding was due.  
26 If the monies the state treasurer withholds are insufficient to meet that  
27 county's funding requirements as specified in subsection A of this section,  
28 the state treasurer shall withhold from any other monies payable to that  
29 county from whatever state funding source is available an amount necessary  
30 to fulfill that county's requirement. The state treasurer shall not withhold  
31 distributions from the highway user revenue fund pursuant to title 28,  
32 chapter 18, article 2, Arizona Revised Statutes.

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

39 D. The state treasurer shall deposit the amounts paid pursuant to  
40 subsection C of this section and amounts withheld pursuant to subsection B  
41 of this section in the Arizona health care cost containment system and  
42 long-term care system funds established by section 36-2913, Arizona Revised  
43 Statutes.

44 E. If payments made pursuant to subsection C of this section exceed  
45 the amount required to meet the costs incurred by the Arizona health care

1 cost containment system for the hospitalization and medical care of those  
2 persons defined as eligible pursuant to section 36-2901, paragraph 6,  
3 subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of the  
4 Arizona health care cost containment system administration may instruct the  
5 state treasurer either to reduce remaining payments to be paid pursuant to  
6 this section by a specified amount or to provide to the counties specified  
7 amounts from the Arizona health care cost containment system and long-term  
8 care system funds.

9       Sec. 45. County uncompensated care contribution

10       A. Notwithstanding any law to the contrary, for fiscal year 2003-2004,  
11 beginning with the second monthly distribution of transaction privilege tax  
12 revenues, the state treasurer shall withhold the following amounts from state  
13 transaction privilege revenues otherwise distributable, after any amounts  
14 withheld for the county long-term care contribution or the county  
15 administration contribution pursuant to section 11-292, subsection P, Arizona  
16 Revised Statutes, for deposit in the Arizona health care cost containment  
17 system fund established by section 36-2913, Arizona Revised Statutes, for the  
18 provision of hospitalization and medical care:

- 19           1. Apache, \$87,300.
- 20           2. Cochise, \$162,700.
- 21           3. Coconino, \$160,500.
- 22           4. Gila, \$65,900.
- 23           5. Graham, \$46,800.
- 24           6. Greenlee, \$12,000.
- 25           7. La Paz, \$24,900.
- 26           8. Maricopa, \$3,853,800.
- 27           9. Mohave, \$187,400.
- 28           10. Navajo, \$122,800.
- 29           11. Pima, \$1,115,900.
- 30           12. Pinal, \$218,300.
- 31           13. Santa Cruz, \$51,600.
- 32           14. Yavapai, \$206,200.
- 33           15. Yuma, \$183,900.

34       B. If a county does not provide funding as specified in subsection A  
35 of this section, the state treasurer shall subtract the amount owed to the  
36 Arizona health care cost containment system fund by the county from any  
37 payments required to be made by the state treasurer to that county pursuant  
38 to section 42-5029, subsection D, paragraph 2, Arizona Revised Statutes, plus  
39 interest on that amount pursuant to section 44-1201, Arizona Revised  
40 Statutes, retroactive to the first day the funding was due. If the monies  
41 the state treasurer withholds are insufficient to meet that county's funding  
42 requirement as specified in subsection A of this section, the state treasurer  
43 shall withhold from any other monies payable to that county from whatever  
44 state funding source is available an amount necessary to fulfill that  
45 county's requirement. The state treasurer shall not withhold distributions

1 from the highway user revenue fund pursuant to title 28, chapter 18, article  
2 2, Arizona Revised Statutes.

3 C. Payment of an amount equal to one-twelfth of the total monies  
4 prescribed pursuant to subsection A of this section shall be made to the  
5 state treasurer on or before the fifth day of each month. On request from  
6 the director of the Arizona health care cost containment system  
7 administration, the state treasurer shall require that up to three months'  
8 payments be made in advance, if necessary.

9 D. The state treasurer shall deposit the monies paid pursuant to  
10 subsection C of this section in the Arizona health care cost containment  
11 system fund established by section 36-2913, Arizona Revised Statutes.

12 E. In fiscal year 2003-2004, the sum of \$6,500,000 withheld pursuant  
13 to subsection B of this section is allocated for the county acute care  
14 contribution for the provision of hospitalization and medical care services  
15 administered by the Arizona health care cost containment system  
16 administration.

17 Sec. 46. Withholding state shared revenues; fiscal year  
18 2003-2004

19 A. Based on the distribution of disproportionate share funding to  
20 county operated hospitals made pursuant to section 36-2903.01, subsection P,  
21 Arizona Revised Statutes, for fiscal year 2003-2004, the staff director of  
22 the joint legislative budget committee shall compute amounts to be withheld  
23 from transaction privilege tax revenues for counties with a population of at  
24 least one million five hundred thousand persons in accordance with subsection  
25 B of this section.

26 B. Notwithstanding section 42-5029, subsection D, paragraph 2, Arizona  
27 Revised Statutes, beginning with the first monthly distribution of  
28 transaction privilege tax revenues and at the direction of the governor, the  
29 state treasurer shall withhold an amount totaling \$78,041,900 from state  
30 transaction privilege tax revenues otherwise distributable, after any amounts  
31 withheld for the county long-term care contribution for fiscal year 2003-2004  
32 from counties with a population of at least one million five hundred thousand  
33 persons. Amounts withheld from individual counties under this subsection  
34 shall be determined pursuant to subsection A of this section.

35 C. In addition to the amount specified in subsection B of this  
36 section, the state treasurer may also withhold transaction privilege tax  
37 revenues in fiscal year 2004-2005 if amounts withheld pursuant to subsection  
38 B of this section for fiscal year 2003-2004 were insufficient.

39 D. If changes in federal policies regarding the disproportionate share  
40 funding to county operated hospitals reduces payment levels below the amount  
41 specified in the fiscal year 2003-2004 general appropriations act, the  
42 governor, after consultation with chairpersons of the house and senate  
43 appropriations committees, may direct the state treasurer to suspend  
44 withholdings of transaction privilege tax revenues specified in subsection  
45 B of this section to accommodate the federal policy change.

1           Sec. 47. County expenditure limitations; disproportionate  
2           share; fiscal year 2003-2004 adjustment formula

3           A. As a result of the transfer of funding for disproportionate share  
4 health services, as provided in this act, from the counties to the state and  
5 federal governments for fiscal year 1991-1992 through fiscal year 2003-2004  
6 the economic estimates commission shall decrease the base limit of each  
7 county in which the county hospital receives state and federal  
8 disproportionate share payments in fiscal year 2003-2004 as follows:

9           1. Divide the amount of the state and federal disproportionate share  
10 payments received by the county hospital in fiscal year 2003-2004 by the GDP  
11 price deflator, as defined in section 41-563, Arizona Revised Statutes, for  
12 the same fiscal year used to calculate expenditure limitations for fiscal  
13 year 2003-2004 and multiply the resulting quotient by the GDP price deflator  
14 determined for fiscal year 1979-1980.

15           2. Divide the amount determined in paragraph 1 for fiscal year  
16 2003-2004 by the population of the county, as defined in article IX, section  
17 20, subsection (3), paragraph (f), Constitution of Arizona, for the same  
18 fiscal year used to calculate expenditure limitations for fiscal year  
19 2003-2004 and multiply the resulting quotient by the population of the county  
20 for fiscal year 1979-1980.

21           B. The economic estimates commission shall adjust the county  
22 expenditure limitations for fiscal year 2003-2004 based on this section. The  
23 calculation shall use the same base limit of \$156,635,737 for Maricopa county  
24 for the purpose of determining the adjustment.

25           Sec. 48. County expenditure limitations; disproportionate  
26           share; fiscal year 2004-2005

27           As a result of the elimination of the transfer of funding for  
28 disproportionate share hospital services from the counties to the state and  
29 federal governments beginning with fiscal year 2004-2005, the county  
30 expenditure limitations shall be adjusted beginning with fiscal year  
31 2004-2005. The economic estimates commission shall increase the base limit  
32 of each county by the amount the base limit was decreased for fiscal year  
33 2003-2004 pursuant to this act.

34           Sec. 49. Competency restoration treatment; county  
35           reimbursement; fiscal years 2003-2004 and 2004-2005;  
36           deposit; tax withholding

37           A. Notwithstanding section 13-4512, Arizona Revised Statutes, for  
38 counties with populations of less than one million five hundred thousand  
39 persons according to the most recent United States decennial census, if the  
40 state pays the costs of a defendant's inpatient competency restoration  
41 treatment pursuant to section 13-4512, Arizona Revised Statutes, the county  
42 shall reimburse the department of health services for eighty-six per cent of  
43 these costs for fiscal year 2003-2004 and fiscal year 2004-2005. The  
44 department shall deposit the monies, pursuant to sections 35-146 and 35-147,

1 Arizona Revised Statutes, in the Arizona state hospital fund established by  
2 section 36-545.08, Arizona Revised Statutes.

3 B. Notwithstanding section 13-4512, Arizona Revised Statutes, for  
4 counties with populations of one million five hundred thousand or more  
5 persons according to the most recent United States decennial census, if the  
6 state pays the costs of a defendant's inpatient competency restoration  
7 treatment pursuant to section 13-4512, Arizona Revised Statutes, the county  
8 shall reimburse the department of health services for one hundred per cent  
9 of these costs for fiscal year 2003-2004 and fiscal year 2004-2005. The  
10 department shall deposit the monies, pursuant to sections 35-146 and 35-147,  
11 Arizona Revised Statutes, in the Arizona state hospital fund established by  
12 section 36-545.08, Arizona Revised Statutes.

13 C. Each county shall make the reimbursements for these costs as  
14 specified in subsections A and B of this section within thirty days after a  
15 request by the department. If the county does not make the reimbursement,  
16 the superintendent of the Arizona state hospital shall notify the state  
17 treasurer of the amount owed and the treasurer shall withhold the amount,  
18 including any additional interest as provided in section 42-1123, Arizona  
19 Revised Statutes, from any transaction privilege tax distributions to the  
20 county. The treasurer shall deposit the withholdings, pursuant to sections  
21 35-146 and 35-147, Arizona Revised Statutes, in the Arizona state hospital  
22 fund established by section 36-545.08, Arizona Revised Statutes.

23 Sec. 50. Department of economic security; use of monies;  
24 utility assistance fund

25 Notwithstanding section 46-731, Arizona Revised Statutes, the utility  
26 assistance fund may also be used in fiscal year 2003-2004 by the department  
27 of economic security for the purpose of providing low income households with  
28 short-term crisis services. Short-term crisis services may include  
29 assistance for utilities, shelter, repairs, case management and emergency  
30 needs.

31 Sec. 51. Department of veterans' services; use of monies;  
32 southern Arizona veterans' cemetery

33 Notwithstanding section 41-608.02, Arizona Revised Statutes, for fiscal  
34 year 2003-2004, the Arizona department of veterans' services may use, as  
35 necessary, an amount of not to exceed \$179,000 from the state veterans'  
36 cemetery fund for the purposes of operating the Southern Arizona veterans'  
37 cemetery.

38 Sec. 52. Reappropriation; character education

39 Notwithstanding any other law, all unexpended and unencumbered monies  
40 remaining in the appropriation in Laws 1999, chapter 328, section 1,  
41 subsection A, paragraph 3, as amended by Laws 2000, chapter 393, section 14,  
42 are reappropriated to the department of economic security for fiscal year  
43 2003-2004 for the purpose of contracting with a statewide group serving youth  
44 to provide character education programs.

1           Sec. 53. Exemption from rule making; department of economic  
2                                   security

3           A. The department of economic security is exempt from the rule making  
4 requirements of title 41, chapter 6, Arizona Revised Statutes, for two years  
5 after the effective date of this act to implement the expanded eligibility  
6 process regarding medicaid qualifying trusts pursuant to section 36-559,  
7 Arizona Revised Statutes, as amended by this act, and to implement the  
8 financial contributions provisions of section 36-562, Arizona Revised  
9 Statutes, as amended by this act.

10          B. The department shall hold at least two public hearings to allow the  
11 public an opportunity to comment on the proposed rules.

12          C. The department shall publish rules adopted pursuant to this section  
13 as required by title 41, chapter 6, article 2, Arizona Revised Statutes.

14           Sec. 54. Exemption from rule making; Arizona health care cost  
15                                   containment system administration

16          A. The Arizona health care cost containment system administration is  
17 exempt from the rule making requirements of title 41, chapter 6, Arizona  
18 Revised Statutes, for two years after the effective date of this act to  
19 implement the provisions of section 36-2901.03, subsection D and section  
20 36-2903.01, subsection D, Arizona Revised Statutes, as amended by this act,  
21 and section 36-2905.01, Arizona Revised Statutes, as added by this act and  
22 to implement deductible schedules prescribed by section 36-2939, Arizona  
23 Revised Statutes, as amended by this act.

24          B. The department shall hold at least two public hearings to allow the  
25 public an opportunity to comment on the proposed rules.

26          C. The department shall publish rules adopted pursuant to this section  
27 as required by title 41, chapter 6, article 2, Arizona Revised Statutes.

28           Sec. 55. Arizona health care cost containment system; submittal  
29                                   of pharmaceutical claims; waiver

30          A. Notwithstanding section 36-2904, subsection G, Arizona Revised  
31 Statutes, as amended by this act, and subject to the availability of Title  
32 XIX funding and federal requirements, the Arizona health care cost  
33 containment system shall allow a not for profit hospital located in a county  
34 with less than five hundred thousand persons according to the last United  
35 States decennial census that is located on private land that is next to a  
36 federally designated Indian reservation to submit Title XIX clean claims  
37 within twelve months of the date of service. The Arizona health care cost  
38 containment system shall only pay claims for persons who were eligible for  
39 the Arizona health care cost containment system pursuant to sections 36-2901,  
40 paragraph 6, subdivision (a) or 36-2901.06, Arizona Revised Statutes, and who  
41 received a covered prescription drug from the hospital described in this  
42 section.

43          B. For the purposes of this section:

1           1. "Hospital" does not include an Indian health services facility or  
2 a 638 tribal facility as defined in section 36-2981, Arizona Revised  
3 Statutes.

4           2. "Clean claim" means a claim that may be processed without obtaining  
5 additional information from the subcontracted provider of care, from a  
6 non-contracting provider or from a third party but does not include claims  
7 under investigation for fraud or abuse or claims under review for medical  
8 necessity.

9           C. This section is repealed one year from the effective date of this  
10 act.

11           Sec. 56. Retroactivity

12           A. Sections 8-514.05 and 36-568.02, Arizona Revised Statutes, as added  
13 by this act, are effective retroactively from and after April 13, 2003.

14           B. Section 30 of this act is effective retroactively to from and after  
15 June 30, 2003.

16           C. Section 36-2921, Arizona Revised Statutes, as added by this act,  
17 is effective retroactively to from and after June 30, 2003.

18           D. Section 43 of this act is effective retroactively to from and after  
19 June 30, 2002.

20           E. Section 49 of this act, relating to competency restoration  
21 treatment, is effective retroactively to from and after June 30, 2003.

22           Sec. 57. Effective date

23           Section 36-2907.07, Arizona Revised Statutes, as amended by Laws 2001,  
24 chapter 313, section 2 and this act, is effective from and after December 31,  
25 2003.

26           Sec. 58. Effective date

27           Section 36-2983, Arizona Revised Statutes, as amended by this act, is  
28 effective from and after June 30, 2004.

29           Sec. 59. Suicide prevention program

30           Notwithstanding section 36-3415, Arizona Revised Statutes, the  
31 department shall not operate a suicide prevention program in fiscal year  
32 2003-2004.

33           Sec. 60. Institutional support payments

34           Notwithstanding any other law, persons eligible pursuant to section  
35 46-252, Arizona Revised Statutes, shall not receive institutional support  
36 payments in fiscal year 2003-2004.

37           Sec. 61. ALTCS costs

38           Notwithstanding section 11-292, Arizona Revised Statutes, to implement  
39 temporary changes to the federal matching assistance percentage designed to  
40 give fiscal relief to states and to give counties savings proportional to  
41 their share of the total non-federal Arizona long-term care system costs, the  
42 total county contributions for the Arizona long-term care system shall be set  
43 in the general appropriation act for fiscal year 2003-2004.

~~1     Sec. 62. Medically needy account~~

~~2           Notwithstanding section 36-797, Arizona Revised Statutes, no monies  
3 from the medically needy account of the tobacco tax and health care fund  
4 established pursuant to section 36-774, Arizona Revised Statutes, shall be  
5 transferred to the health crisis fund established pursuant to section 36-797,  
6 Arizona Revised Statutes, in fiscal year 2003-2004. The governor shall not  
7 authorize any specific liabilities or expenses to be incurred and paid as  
8 claims against this state from monies in the health crisis fund for fiscal  
9 year 2003-2004.~~

**VETO**

10           Sec. 63. Child care eligibility levels; report

11           Notwithstanding section 46-803, Arizona Revised Statutes, for fiscal  
12 year 2003-2004, the department of economic security may reduce maximum income  
13 eligibility levels for child care assistance in order to manage within  
14 appropriated and available monies. The department shall notify the joint  
15 legislative budget committee of any change in maximum income eligibility  
16 levels for child care within fifteen days of implementing that change.

APPROVED BY THE GOVERNOR JUNE 17, 2003.

FILED IN THE OFFICE OF THE SECRETARY OF STATE JUNE 17, 2003.



HOUSE CONCURS IN SENATE  
AMENDMENTS AND FINAL PASSAGE

June 11, 2003,

by the following vote: 33 Ayes,

26 Nays, 1 Not Voting

Jake Flake  
Speaker of the House

Norman L. Moore  
Chief Clerk of the House

EXECUTIVE DEPARTMENT OF ARIZONA  
OFFICE OF GOVERNOR

This Bill was received by the Governor this

12 day of June, 2003

at 8:26 o'clock A M.

Sandra Gamig  
Secretary to the Governor

Approved this 17 day of

June, 2003,

at 12<sup>35</sup> o'clock P. M.

J. T. Nagel  
Governor of Arizona

H.B. 2535

EXECUTIVE DEPARTMENT OF ARIZONA  
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this 17<sup>th</sup> day of June, 2003

at 3:40 o'clock P. M.

Janice K. Brewer  
Secretary of State

Passed the House May 16, 2003,

Passed the Senate June 6, 2003

by the following vote: 39 Ayes,  
20 Nays, 1 Not Voting

by the following vote: 25 Ayes,  
4 Nays, 1 Not Voting

Gabe Flake  
Speaker of the House

Ken Bennett  
President of the Senate

Norman L. Moore  
Chief Clerk of the House

Chamin B. Bunting  
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

**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

H.B. 2535

Passed the House May 16, 2003,

Passed the Senate June 6, 2003,

by the following vote: 39 Ayes,

by the following vote: 25 Ayes,

20 Nays, 1 Not Voting

4 Nays, 1 Not Voting

Gabe Flake  
Speaker of the House

Klu Flinneth  
President of the Senate

Speman L. Moore  
Chief Clerk of the House

Chamin B. Bellington  
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

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

H.B. 2535

HOUSE CONCURS IN SENATE  
AMENDMENTS AND FINAL PASSAGE

June 11, 2003,

by the following vote: 33 Ayes,

26 Nays, 1 Not Voting

Jake Flake  
Speaker of the House

Norman L. Moore  
Chief Clerk of the House

EXECUTIVE DEPARTMENT OF ARIZONA  
OFFICE OF GOVERNOR

This Bill was received by the Governor this

12 day of June, 2003

at 8:26 o'clock A M.

Jandra Ramirez  
Secretary to the Governor

Approved this 17 day of

June, 2003,

at 12<sup>35</sup> o'clock P. M.

Jt. Nagel  
Governor of Arizona

H.B. 2535

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