Senate Engrossed

State of Arizona
Senate
Forty-third Legislature
Fourth Special Session
1998

SENATE BILL 1008

AN ACT

AMENDING SECTIONS 36-2907.06, 36-2907.08, 36-2921 AND 36-2923, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 4; AMENDING LAWS 1997, CHAPTER 186, SECTION 6; AMENDING LAWS 1997, CHAPTER 186, SECTION 8; MAKING APPROPRIATIONS; RELATING TO THE CHILDREN'S HEALTH INSURANCE PROGRAM; PROVIDING FOR CONDITIONAL ENACTMENT.

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

Section 1. Section 36-2907.06, Arizona Revised Statutes, is amended to read:

36-2907.06. Qualifying community health centers; contracts; requirements; definition

A. Subject to the availability of monies as prescribed in section 36-2921, the administration shall enter into an intergovernmental agreement pursuant to title 11, chapter 7, article 3 with the department of health services to contract with qualifying community health centers to provide primary health care services to indigent or uninsured Arizonans. The department of health services shall enter into one year contracts with qualifying community health centers for the centers to provide the following primary health care services:

1. Medical care provided through licensed primary care physicians and licensed mid-level providers as defined in section 36-2171.

2. Prenatal care services.

3. Diagnostic laboratory and imaging services that are necessary to complete a diagnosis and treatment, including referral services.

4. Pharmacy services that are necessary to complete treatment, including referral services.

5. Preventive health services.

6. Preventive dental services.

7. Emergency services performed at the qualifying community health center.

8. Transportation for patients to and from the qualifying community health center if these patients would not receive care without this assistance.

B. Each contract shall require that the qualifying community health center provide the services prescribed in subsection A of this section to persons who the center determines:

1. Are residents of this state.

2. Are without medical insurance policy coverage.

3. Do not have a family income of more than two hundred per cent of the federal poverty guidelines as established annually by the United States department of health and human services.

4. Have provided verification that the person is not eligible for enrollment in the Arizona health care cost containment system pursuant to this chapter.

5. Have provided verification that the person is not eligible for medicare.

C. The department of health services shall directly administer the program and issue requests for proposals for the contracts prescribed in this section. Contracts established pursuant to subsection A OR G of this section shall be signed by the department and the contractor prior to the transmission of any tobacco tax and health care fund monies to the contractor.

D. Persons who meet the eligibility criteria established in subsection B OR G of this section shall be charged for services based upon a sliding fee schedule approved by the department of health services.

E. In awarding contracts the department of health services may give preference to qualifying community health centers that have a sliding fee schedule. Monies shall be used for the number of patients that exceeds the number of uninsured sliding fee schedule patients that the qualifying community health center served during fiscal year 1994. Each qualifying community health center shall make its sliding fee schedule available to the public on request. The contract shall require the qualifying community health center to apply a sliding fee schedule to all of its uninsured patients.

F. The department of health services may examine the records of each qualifying community health center and conduct audits necessary to determine that the eligibility determinations were performed accurately and to verify the number of uninsured patients served by the qualifying community health center as a result of receiving tobacco tax and health care fund monies by the contract established pursuant to subsection A of this section.

G. AFTER THE HEALTH CARE FINANCING ADMINISTRATION APPROVES THE CHILDREN'S HEALTH INSURANCE PROGRAM ESTABLISHED PURSUANT TO ARTICLE 4 OF THIS CHAPTER, THE DEPARTMENT OF HEALTH SERVICES SHALL CONTRACT WITH QUALIFYING HEALTH CENTERS TO ALLOW THE QUALIFYING HEALTH CENTERS TO DELIVER OR ARRANGE TO PROVIDE THE HEALTH BENEFITS PURSUANT TO THIS SECTION TO CHILDREN WHO ARE DETERMINED ELIGIBLE PURSUANT TO SECTION 36-2983 AND WHO ELECT TO RECEIVE DIRECT, SLIDING FEE SCALE MEDICAL AND HEALTH CARE SERVICES FROM QUALIFYING HEALTH CENTERS PURSUANT TO THIS SECTION AND WITH HOSPITALS PURSUANT TO SECTION 36-2907.08. THE QUALIFYING HEALTH CENTERS SHALL PROVIDE DATA THE ADMINISTRATION DETERMINES IS SUFFICIENT TO ALLOW THE STATE TO APPLY FOR FEDERAL FUNDING UNDER THE PROGRAM ESTABLISHED PURSUANT TO ARTICLE 4 OF THIS CHAPTER. FOR THE PURPOSES OF THIS SUBSECTION, "QUALIFYING HEALTH CENTER" MEANS A COMMUNITY BASED FACILITY THAT ARRANGES TO PROVIDE OR DELIVER MEDICAL CARE ON A SLIDING FEE SCALE THROUGH THE EMPLOYMENT OF PHYSICIANS, PROFESSIONAL NURSES, PHYSICIANS ASSISTANTS OR OTHER HEALTH CARE TECHNICAL AND PARAPROFESSIONAL PERSONNEL.

~~G.~~ H. Contracts established pursuant to subsection A OR G of this section shall require qualifying community health center contractors AND QUALIFYING HEALTH CENTERS AS DEFINED IN SUBSECTION G OF THIS SECTION to submit information as required pursuant to section 36-2907.07 for program evaluations.

~~H.~~ I. For the purposes of this section "qualifying community health center" means a community based primary care facility that provides medical care in medically underserved areas as ~~defined pursuant to~~ PROVIDED IN section 36-2352, or in medically underserved areas or medically underserved populations as designated by the United States department of health and human services, through the employment of physicians, professional nurses, physician assistants or other health care technical and paraprofessional personnel.

Sec. 2. Section 36-2907.08, Arizona Revised Statutes, is amended to read:

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

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

B. To receive a grant under this section, a hospital shall submit an application as prescribed by the director of the department of health

services in a request for proposal that indicates to the director's satisfaction that the applicant agrees to:

1. Use grant program monies to enhance the applicant's provision of additional medical services to children and to improve the applicant's ability to deliver inpatient, outpatient and specialized clinical services to indigent, uninsured or underinsured children who are not eligible ~~to receive services under this article~~ PURSUANT TO SECTION 36-2901, PARAGRAPH 4, SUBDIVISIONS (a), (b), (c), (h) OR (j) OR SECTION 36-2931, PARAGRAPH 5.

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

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

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

5. Match the grant as prescribed by the director by rule with private monies the applicant has pledged from private sources. The director shall waive this requirement if the applicant is seeking the grant to qualify for a private or public grant for the delivery of inpatient, outpatient or specialized clinical ~~care of~~ SERVICES TO indigent, uninsured or underinsured children who are not eligible ~~to receive services under this article~~ PURSUANT TO SECTION 36-2901, PARAGRAPH 4, SUBDIVISIONS (a), (b), (c), (h) OR (j) OR SECTION 36-2931, PARAGRAPH 5.

6. Provide a mechanism to ensure that grant program monies are not used for children who are OTHERWISE eligible ~~for services under this article~~ PURSUANT TO SECTION 36-2901, PARAGRAPH 4, SUBDIVISIONS (a), (b), (c), (h) OR (j) OR SECTION 36-2931, PARAGRAPH 5.

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

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

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

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

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

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

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

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

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

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

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

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

E. If the department of health services determines that a hospital has used grant monies in violation of this section it shall prohibit that hospital from receiving additional grant program monies until the hospital reimburses the department. The department shall impose an interest penalty as prescribed by the director of the department of health services by rule. The director shall transmit penalties collected under this section to the state treasurer for deposit in the medically needy account of the tobacco tax and health care fund.

~~F. The director of the department of health services may expend monies from the medically needy account of the tobacco tax and health care fund transferred pursuant to section 36-2921, subsection A, paragraph 7 for the purpose of funding evaluations of the grant program established by this section. The director shall ensure that any evaluation is structured to meet at least the base requirements prescribed in section 36-2907.07.~~

~~G. The director of the department of health services may expend monies from the medically needy account of the tobacco tax and health care fund transferred pursuant to section 36-2921, subsection A, paragraph 7 for administrative costs associated with the establishment or the operation of the grant program. The amount withdrawn annually for grant program administrative costs shall not exceed two per cent of the sum of any transfers of monies made pursuant to section 36-2921 and any appropriation of monies for the specified purpose of supporting the nonentitlement basic children's medical services program established in this section.~~

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

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

H. AFTER THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION APPROVES THE CHILDREN'S HEALTH INSURANCE PROGRAM ESTABLISHED PURSUANT TO ARTICLE 4 OF THIS CHAPTER, THE DEPARTMENT OF HEALTH SERVICES SHALL CONTRACT WITH HOSPITALS TO ENABLE THE HOSPITALS TO DELIVER OR ARRANGE TO PROVIDE COVERAGE SPECIFIED IN THIS SECTION TO CHILDREN WHO ARE DETERMINED ELIGIBLE PURSUANT TO SECTION 36-2983 AND WHO ELECT TO RECEIVE DIRECT, SLIDING FEE SCALE MEDICAL AND HEALTH CARE SERVICES FROM QUALIFYING HEALTH CENTERS PURSUANT TO SECTION 36-2907.06, SUBSECTION G AND FROM HOSPITALS PURSUANT TO THIS SECTION. THE CONTRACTING HOSPITALS SHALL PROVIDE DATA THE ADMINISTRATION DETERMINES IS SUFFICIENT TO ALLOW THE STATE TO APPLY FOR FEDERAL FUNDING UNDER THE PROGRAM ESTABLISHED PURSUANT TO ARTICLE 4 OF THIS CHAPTER.

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

Sec. 3. Section 36-2921, Arizona Revised Statutes, is amended to read:

36-2921. Tobacco tax allocation

A. Subject to the availability of monies in the medically needy account established pursuant to section 42-1241, subsection C, paragraph 3 the administration shall use the monies in the account in the following order:

1. The administration shall withdraw the amount necessary to pay the state share of costs for providing health care services to any person who is eligible pursuant to section 36-2901, paragraph 4, subdivisions (a), (c) and (h) and who becomes eligible for a heart, lung, heart-lung, liver or autologous and allogeneic bone marrow transplant pursuant to section 36-2907, subsection A, paragraph 11, subdivision (d) as determined by the administrator and to any person who is eligible pursuant to section 36-2901, paragraph 4, subdivision (b) and who becomes eligible for a lung or heart-lung transplant pursuant to section 36-2907, subsection A, paragraph 11, subdivision (b), as determined by the administrator.

2. Beginning on August 1, 1995 and on the first day of each month ~~thereafter~~ UNTIL JULY 1, 1998, the sum of one million two hundred fifty thousand dollars shall be transferred from the medically needy account to the

medical services stabilization fund for uses as prescribed in section 36-2922.

3. THE ADMINISTRATION SHALL WITHDRAW THE SUM OF NINE MILLION TWO HUNDRED FIFTY-ONE THOUSAND ONE HUNDRED DOLLARS IN FISCAL YEAR 1998-1999 FOR DEPOSIT IN THE CHILDREN'S HEALTH INSURANCE PROGRAM FUND ESTABLISHED BY SECTION 36-2995 TO PAY THE STATE SHARE OF THE CHILDREN'S HEALTH INSURANCE PROGRAM ESTABLISHED PURSUANT TO ARTICLE 4 OF THIS CHAPTER.

~~3.~~ 4. From and after August 1, 1995 and each year thereafter, the administration shall transfer the following monies to the department of health services to be allocated as follows if the department awards a contract:

(a) Five million dollars, for the mental health grant program established pursuant to section 36-3414.

(b) Six million dollars, for primary care services established pursuant to section 36-2907.05.

(c) Five million dollars, for grants to the QUALIFYING community health centers established pursuant to section 36-2907.06, SUBSECTION A.

~~4.~~ 5. ~~From and after August 1, 1995,~~ The administration shall transfer up to five hundred thousand dollars ~~annually~~ for fiscal ~~years~~ YEAR 1997-1998 for pilot programs providing detoxification services in counties having a population of five hundred thousand persons or less according to the most recent United States decennial census. The department OF HEALTH SERVICES shall report to the joint legislative oversight committee on the tobacco tax and health care fund no later than October 1, 1998 regarding the operation and effectiveness of the detoxification pilot programs funded pursuant to this ~~section~~ SUBSECTION. The report shall also include recommendations regarding the continued funding of these programs.

~~5.~~ 6. The administration shall transfer up to two hundred fifty thousand dollars annually for fiscal years 1995-1996, 1996-1997 and 1997-1998 for telemedicine pilot programs designed to facilitate the provision of medical services to persons living in medically underserved areas as provided in section 36-2352.

~~6.~~ 7. The administration shall transfer up to two hundred fifty thousand dollars annually beginning in fiscal year 1996-1997 for contracts by the department of health services with nonprofit organizations that primarily assist in the management of end stage renal disease and related problems. Contracts shall not include payments for transportation of patients for dialysis.

~~7.~~ 8. Contingent on the existence of a premium sharing demonstration project fund, beginning October 1, 1996 and until September 30, 1999, the administration shall withdraw the sum of twenty million dollars in each of fiscal years 1996-1997, 1997-1998 and 1998-1999 for deposit in the premium sharing demonstration project fund established by section 36-2923 to provide

health care services to any person who is eligible for an Arizona health care cost containment system premium sharing demonstration program enacted by the legislature. The Arizona health care cost containment system premium sharing demonstration program enacted by the legislature shall not be an entitlement program. BEGINNING ON OCTOBER 1, 1997, the administration shall annually withdraw monies from the medically needy account not to exceed two per cent of the sum of any monies transferred pursuant to this paragraph for administrative costs associated with the premium sharing demonstration project.

~~8.~~ 9. Subject to the availability of monies, the Arizona health care cost containment system administration shall transfer to the department of health services up to five million dollars ~~annually beginning~~ in fiscal ~~year~~ YEARS 1996-1997 AND 1997-1998 AND TWO MILLION FIVE HUNDRED THOUSAND DOLLARS IN FISCAL YEAR 1998-1999 for providing nonentitlement funding for a basic children's medical services program established by section 36-2907.08. The administration may also withdraw and transfer to the department amounts for program evaluation and for administrative costs as prescribed in section 36-2907.08.

~~9.~~ 10. Subject to the availability of monies, the sum of one million dollars shall be transferred to the health crisis fund for use as prescribed in section 36-797.

~~10.~~ 11. Subject to the availability of monies, the Arizona health care cost containment system shall transfer to the aging and adult administration in the department of economic security the sum of five hundred thousand dollars annually beginning in fiscal year 1997-1998 for services provided pursuant to section 46-192, subsection A, paragraph 4. Services shall be used for persons who meet the low income eligibility criteria developed by the aging and adult administration.

B. The department of health services shall establish an accounting procedure to ensure that all funds transferred pursuant to this section are maintained separately from any other funds.

C. The administration shall annually withdraw monies from the medically needy account in the amount necessary to reimburse the department of health services for administrative costs to implement each program established pursuant to subsection A of this section not to exceed four per cent of the amount transferred for each program.

D. The administration shall annually withdraw monies from the medically needy account in the amount necessary to reimburse the department of health services for the evaluations as prescribed by section 36-2907.07.

E. The administration shall annually report, no later than November 1 of each year, to the joint legislative oversight committee on the tobacco tax and health care fund the annual revenues deposited in the medically needy account and the estimated expenditures needed in the subsequent year to

provide funding for services provided in subsection A, paragraph 1 of this section. The administration shall immediately report to the cochairs of the oversight committee if at any time the administration estimates that the amount available in the medically needy account will not be sufficient to fund the maximum allocations established in this section.

Sec. 4. Section 36-2923, Arizona Revised Statutes, is amended to read:

36-2923. Premium sharing demonstration project fund; purpose; expenditures; nonlapsing; investment; definition

A. A premium sharing demonstration project fund is established for costs associated with an Arizona health care cost containment system premium sharing demonstration project that is to provide uninsured persons access to medical services provided by system providers. The fund consists of monies deposited from the medically needy account of the tobacco tax and health care fund pursuant to section 36-2921, subsection A, paragraph ~~7~~ 8 and premiums collected from demonstration project participants. The administration shall administer the fund as a continuing appropriation.

B. Beginning on October 1, 1997, if a premium sharing demonstration project is established, the administration shall spend monies in the fund through the first quarter of fiscal year ~~2000-2001~~ 2001-2002 to cover demonstration project expenditures. The administration may continue to make expenditures from the fund, subject to the availability of monies in the fund, for covering program costs incurred but not processed by the administration during the fiscal years in which the program officially operated.

C. The director may withdraw not more than seventy-five thousand dollars from the fund for the fifteen month period beginning July 1, 1996 and ending September 30, 1997 to cover administrative expenditures related to the development of a premium sharing demonstration project proposal or any premium sharing demonstration project analysis requested by a committee of the legislature.

D. Monies in the fund are CONTINUOUSLY APPROPRIATED THROUGH SEPTEMBER 30, 2001 AND ARE exempt from the provisions of section 35-190 relating to lapsing of appropriations, except that all unexpended and unencumbered monies remaining on October 1, ~~2001~~ 2002 revert to the medically needy account of the tobacco tax and health care fund.

E. The state treasurer shall invest the monies in the fund, and investment income shall be credited to the fund.

F. For purposes of this section, unless otherwise noted, "fund" means the premium sharing demonstration project fund.

Sec. 5. Title 36, chapter 29, Arizona Revised Statutes, is amended by adding article 4, to read:

ARTICLE 4. CHILDREN'S HEALTH INSURANCE PROGRAM

36-2981. Definitions

IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "ADMINISTRATION" MEANS THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION.

2. "DIRECTOR" MEANS THE DIRECTOR OF THE ADMINISTRATION.

3. "CONTRACTOR" MEANS A HEALTH PLAN THAT CONTRACTS WITH THE ADMINISTRATION FOR THE PROVISION OF HOSPITALIZATION AND MEDICAL CARE TO MEMBERS ACCORDING TO THE PROVISIONS OF THIS ARTICLE OR A QUALIFYING PLAN.

4. "FEDERAL POVERTY LEVEL" MEANS THE FEDERAL POVERTY LEVEL GUIDELINES PUBLISHED ANNUALLY BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

5. "HEALTH PLAN" MEANS AN ENTITY THAT CONTRACTS WITH THE ADMINISTRATION FOR SERVICES PROVIDED PURSUANT TO ARTICLE 1 OF THIS CHAPTER.

6. "MEMBER" MEANS A PERSON WHO IS ELIGIBLE FOR AND ENROLLED IN THE PROGRAM, WHO IS UNDER NINETEEN YEARS OF AGE AND WHOSE GROSS HOUSEHOLD INCOME MEETS THE FOLLOWING REQUIREMENTS:

(a) FOR FISCAL YEAR 1998-1999, HAS INCOME AT OR BELOW ONE HUNDRED FIFTY PER CENT OF THE FEDERAL POVERTY LEVEL.

(b) FOR FISCAL YEAR 1999-2000, HAS INCOME AT OR BELOW ONE HUNDRED SEVENTY-FIVE PER CENT OF THE FEDERAL POVERTY LEVEL.

(c) FOR FISCAL YEAR 2000-2001 AND EACH FISCAL YEAR THEREAFTER, HAS INCOME AT OR BELOW TWO HUNDRED PER CENT OF THE FEDERAL POVERTY LEVEL.

7. "NONCONTRACTING PROVIDER" MEANS AN ENTITY THAT PROVIDES HOSPITAL OR MEDICAL CARE BUT DOES NOT HAVE A CONTRACT OR SUBCONTRACT WITH THE ADMINISTRATION.

8. "PHYSICIAN" MEANS A PERSON LICENSED PURSUANT TO TITLE 32, CHAPTER 13 OR 17.

9. "PREPAID CAPITATED" MEANS A METHOD OF PAYMENT BY WHICH A CONTRACTOR DELIVERS HEALTH CARE SERVICES FOR THE DURATION OF A CONTRACT TO A SPECIFIED NUMBER OF MEMBERS BASED ON A FIXED RATE PER MEMBER, PER MONTH WITHOUT REGARD TO THE NUMBER OF MEMBERS WHO RECEIVE CARE OR THE AMOUNT OF HEALTH CARE SERVICES PROVIDED TO A MEMBER.

10. "PROGRAM" MEANS THE CHILDREN'S HEALTH INSURANCE PROGRAM.

11. "PRIMARY CARE PHYSICIAN" MEANS A PHYSICIAN WHO IS A FAMILY PRACTITIONER, GENERAL PRACTITIONER, PEDIATRICIAN, GENERAL INTERNIST, OBSTETRICIAN OR GYNECOLOGIST.

12. "PRIMARY CARE PRACTITIONER" MEANS A NURSE PRACTITIONER WHO IS CERTIFIED PURSUANT TO TITLE 32, CHAPTER 15 OR A PHYSICIAN ASSISTANT WHO IS CERTIFIED PURSUANT TO TITLE 32, CHAPTER 25 AND WHO IS ACTING WITHIN THE RESPECTIVE SCOPE OF PRACTICE OF THOSE CHAPTERS.

13. "QUALIFYING PLAN" MEANS A CONTRACTOR THAT CONTRACTS WITH THE STATE PURSUANT TO SECTION 38-651 TO PROVIDE HEALTH AND ACCIDENT INSURANCE FOR STATE EMPLOYEES AND THAT PROVIDES SERVICES TO MEMBERS PURSUANT TO SECTION 36-2989, SUBSECTION A.

14. "TRIBAL FACILITY" MEANS A FACILITY THAT IS OPERATED BY AN INDIAN TRIBE AND THAT IS AUTHORIZED TO PROVIDE SERVICES PURSUANT TO PUBLIC LAW 93-638, AS AMENDED.

36-2982. Children's health insurance program; administration; nonentitlement; enrollment limitation; eligibility

A. THE CHILDREN'S HEALTH INSURANCE PROGRAM IS ESTABLISHED FOR CHILDREN WHO ARE ELIGIBLE PURSUANT TO SECTION 36-2981, PARAGRAPH 6. THE ADMINISTRATION SHALL ADMINISTER THE PROGRAM. ALL COVERED SERVICES SHALL BE PROVIDED BY HEALTH PLANS THAT HAVE CONTRACTS WITH THE ADMINISTRATION PURSUANT TO SECTION 36-2906, A QUALIFYING PLAN OR BY EITHER TRIBAL FACILITIES OR THE INDIAN HEALTH SERVICE FOR NATIVE AMERICANS WHO ARE ELIGIBLE FOR THE PROGRAM AND WHO ELECT TO RECEIVE SERVICES THROUGH THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY.

B. THIS ARTICLE DOES NOT CREATE A LEGAL ENTITLEMENT FOR ANY APPLICANT OR MEMBER WHO IS ELIGIBLE FOR THE PROGRAM. TOTAL ENROLLMENT IS LIMITED BASED ON THE ANNUAL APPROPRIATIONS MADE BY THE LEGISLATURE AND THE ENROLLMENT CAP PRESCRIBED IN SECTION 36-2985.

C. BEGINNING ON OCTOBER 1, 1997, THE DIRECTOR SHALL TAKE ALL STEPS NECESSARY TO IMPLEMENT THE ADMINISTRATIVE STRUCTURE FOR THE PROGRAM AND TO BEGIN DELIVERING SERVICES TO PERSONS WITHIN SIXTY DAYS AFTER APPROVAL OF THE STATE PLAN BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

D. THE ADMINISTRATION SHALL PERFORM ELIGIBILITY DETERMINATIONS AND REDETERMINATIONS FOR PERSONS APPLYING FOR ELIGIBILITY OR CONTINUED ELIGIBILITY PURSUANT TO THIS ARTICLE. IF AN ENTITY OTHER THAN THE ADMINISTRATION PERFORMS THE ELIGIBILITY DETERMINATIONS, THE ADMINISTRATION SHALL RECOUP ANY FEDERAL FISCAL SANCTIONS THAT RESULT FROM INACCURATE ELIGIBILITY DETERMINATIONS FOR THESE PERSONS.

E. THE ADMINISTRATION SHALL ADOPT RULES FOR THE COLLECTION OF COPAYMENTS FROM MEMBERS WHOSE INCOME DOES NOT EXCEED ONE HUNDRED FIFTY PER CENT OF THE FEDERAL POVERTY LEVEL AND FOR THE COLLECTION OF COPAYMENTS AND PREMIUMS FROM MEMBERS WHOSE INCOME EXCEEDS ONE HUNDRED FIFTY PER CENT OF THE FEDERAL POVERTY LEVEL. THE DIRECTOR SHALL ADOPT RULES FOR DISENROLLING A MEMBER IF THE MEMBER DOES NOT PAY THE PREMIUM REQUIRED PURSUANT TO THIS SECTION.

F. BEFORE ENROLLMENT, A MEMBER, OR IF THE MEMBER IS A MINOR, THAT MEMBER'S PARENT OR LEGAL GUARDIAN, SHALL SELECT AN AVAILABLE HEALTH PLAN IN THE MEMBER'S GEOGRAPHIC SERVICE AREA OR A QUALIFYING HEALTH PLAN OFFERED IN THE COUNTY, AND MAY SELECT A PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER FROM AMONG THE AVAILABLE PHYSICIANS AND PRACTITIONERS PARTICIPATING WITH THE CONTRACTOR IN WHICH THE MEMBER IS ENROLLED. THE CONTRACTORS SHALL ONLY REIMBURSE SERVICES OR COSTS OF RELATED SERVICES PROVIDED BY OR UNDER REFERRAL FROM A PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER PARTICIPATING IN THE CONTRACT IN WHICH THE MEMBER IS ENROLLED, EXCEPT FOR EMERGENCY SERVICES THAT SHALL BE REIMBURSED PURSUANT TO SECTION

36-2987. THE DIRECTOR SHALL ESTABLISH REQUIREMENTS AS TO THE MINIMUM TIME PERIOD THAT A MEMBER IS ASSIGNED TO SPECIFIC CONTRACTORS. AN ELIGIBLE CHILD, OR THAT CHILD'S PARENT OR GUARDIAN, MAY ELECT TO RECEIVE DIRECT, SLIDING FEE SCALE MEDICAL AND HEALTH CARE SERVICES FROM QUALIFYING HEALTH CENTERS PURSUANT TO SECTION 36-2907.06, SUBSECTION G, AND FROM HOSPITALS PURSUANT TO SECTION 36-2907.08. AN ELIGIBLE CHILD, OR THAT CHILD'S PARENT OR GUARDIAN, WHO ELECTS DIRECT SERVICES SHALL NOT BE ENROLLED WITH A QUALIFYING PLAN UNLESS THE CHILD, OR THAT CHILD'S PARENT OR GUARDIAN, ELECTS TO RECEIVE SERVICES PURSUANT TO THIS ARTICLE.

G. ELIGIBILITY FOR THE PROGRAM SHALL BE COUNTED AS CREDITABLE COVERAGE AS DEFINED IN SECTION 20-1379.

H. ON APPLICATION FOR ELIGIBILITY FOR THE PROGRAM, THE MEMBER, OR IF THE MEMBER IS A MINOR, THE MEMBER'S PARENT OR GUARDIAN, SHALL RECEIVE AN APPLICATION FOR AND A PROGRAM DESCRIPTION OF THE PREMIUM SHARING DEMONSTRATION PROJECT IF THE MEMBER RESIDES IN A COUNTY CHOSEN TO PARTICIPATE IN THAT PROJECT.

I. NOTWITHSTANDING SECTION 36-2983, THE ADMINISTRATION MAY PURCHASE FOR A MEMBER EMPLOYER SPONSORED GROUP HEALTH INSURANCE WITH STATE AND FEDERAL MONIES AVAILABLE PURSUANT TO THIS ARTICLE, SUBJECT TO ANY RESTRICTIONS IMPOSED BY THE FEDERAL HEALTH CARE FINANCING ADMINISTRATION. THIS SUBSECTION DOES NOT APPLY TO MEMBERS WHO ARE ELIGIBLE FOR HEALTH BENEFITS COVERAGE UNDER A STATE HEALTH BENEFITS PLAN BASED ON A FAMILY MEMBER'S EMPLOYMENT WITH A PUBLIC AGENCY IN THIS STATE.

36-2983. Eligibility for the program

A. THE ADMINISTRATION SHALL ESTABLISH A STREAMLINED ELIGIBILITY PROCESS FOR APPLICANTS TO THE PROGRAM AND SHALL ISSUE A CERTIFICATE OF ELIGIBILITY AT THE TIME ELIGIBILITY FOR THE PROGRAM IS DETERMINED. ELIGIBILITY SHALL BE BASED ON GROSS HOUSEHOLD INCOME FOR A MEMBER AS DEFINED IN SECTION 36-2981. THE ADMINISTRATION SHALL NOT APPLY A RESOURCE TEST IN THE ELIGIBILITY DETERMINATION OR REDETERMINATION PROCESS.

B. THE ADMINISTRATION SHALL USE A SIMPLIFIED ELIGIBILITY FORM THAT MAY BE MAILED TO THE ADMINISTRATION. ONCE A COMPLETED APPLICATION IS RECEIVED, INCLUDING ADEQUATE VERIFICATION OF INCOME, THE ADMINISTRATION SHALL EXPEDITE THE ELIGIBILITY DETERMINATION AND ENROLLMENT ON A PROSPECTIVE BASIS.

C. THE DATE OF ELIGIBILITY IS THE FIRST DAY OF THE MONTH FOLLOWING A DETERMINATION OF ELIGIBILITY IF THE DECISION IS MADE BY THE TWENTY-FIFTH DAY OF THE MONTH. A PERSON WHO IS DETERMINED ELIGIBLE FOR THE PROGRAM AFTER THE TWENTY-FIFTH DAY OF THE MONTH IS ELIGIBLE FOR THE PROGRAM THE FIRST DAY OF THE SECOND MONTH FOLLOWING THE DETERMINATION OF ELIGIBILITY.

D. AN APPLICANT FOR THE PROGRAM MUST HAVE A SOCIAL SECURITY NUMBER OR SHALL APPLY FOR A SOCIAL SECURITY NUMBER WITHIN THIRTY DAYS AFTER THE APPLICANT SUBMITS AN APPLICATION FOR THE PROGRAM.

E. IN ORDER TO BE ELIGIBLE FOR THE PROGRAM, A PERSON SHALL BE A RESIDENT OF THIS STATE AND SHALL MEET TITLE XIX REQUIREMENTS FOR UNITED

STATES CITIZENSHIP OR QUALIFIED ALIEN STATUS IN THE MANNER PRESCRIBED IN SECTION 36-2903.03.

F. IN DETERMINING THE ELIGIBILITY FOR ALL QUALIFIED ALIENS PURSUANT TO THIS ARTICLE, THE INCOME AND RESOURCES OF A PERSON WHO EXECUTED AN AFFIDAVIT OF SUPPORT PURSUANT TO SECTION 213A OF THE IMMIGRATION AND NATIONALITY ACT ON BEHALF OF THE QUALIFIED ALIEN AND THE INCOME AND RESOURCES OF THE SPOUSE, IF ANY, OF THE SPONSORING INDIVIDUAL SHALL BE COUNTED AT THE TIME OF APPLICATION AND FOR THE REDETERMINATION OF ELIGIBILITY FOR THE DURATION OF THE ATTRIBUTION PERIOD AS SPECIFIED IN FEDERAL LAW.

G. PURSUANT TO FEDERAL LAW, A PERSON IS NOT ELIGIBLE FOR THE PROGRAM IF THAT PERSON IS:

1. ELIGIBLE FOR TITLE XIX OR OTHER FEDERALLY OPERATED OR FINANCED HEALTH CARE INSURANCE PROGRAMS, EXCEPT THE INDIAN HEALTH SERVICE.

2. COVERED BY ANY GROUP HEALTH PLAN OR OTHER HEALTH INSURANCE COVERAGE AS DEFINED IN SECTION 2791 OF THE PUBLIC HEALTH SERVICE ACT. GROUP HEALTH PLAN OR OTHER HEALTH INSURANCE COVERAGE DOES NOT INCLUDE COVERAGE TO PERSONS WHO ARE DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 4, SUBDIVISION (a), (c) OR (h) OR THE PREMIUM SHARING PROGRAM.

3. A MEMBER OF A FAMILY THAT IS ELIGIBLE FOR HEALTH BENEFITS COVERAGE UNDER A STATE HEALTH BENEFIT PLAN BASED ON A FAMILY MEMBER'S EMPLOYMENT WITH A PUBLIC AGENCY IN THIS STATE.

4. AN INMATE OF A PUBLIC INSTITUTION OR A PATIENT IN AN INSTITUTION FOR MENTAL DISEASES. THIS PARAGRAPH DOES NOT APPLY TO SERVICES FURNISHED IN A STATE OPERATED MENTAL HOSPITAL OR TO RESIDENTIAL OR OTHER TWENTY-FOUR HOUR THERAPEUTICALLY PLANNED STRUCTURED SERVICES.

H. A CHILD WHO IS COVERED UNDER AN EMPLOYER'S GROUP HEALTH INSURANCE PLAN OR THROUGH FAMILY OR INDIVIDUAL HEALTH CARE COVERAGE SHALL NOT BE ENROLLED IN THE PROGRAM. IF THE HEALTH INSURANCE COVERAGE IS DISCONTINUED FOR ANY REASON, EXCEPT FOR THE LOSS OF HEALTH INSURANCE DUE TO LOSS OF EMPLOYMENT, THE CHILD IS NOT ELIGIBLE FOR THE PROGRAM FOR A PERIOD OF SIX MONTHS FROM THE DATE THAT THE HEALTH CARE COVERAGE WAS DISCONTINUED.

I. PURSUANT TO FEDERAL LAW, A PRIVATE INSURER, AS DEFINED BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, SHALL NOT LIMIT ENROLLMENT BY CONTRACT OR ANY OTHER MEANS BASED ON THE PRESUMPTION THAT A CHILD MAY BE ELIGIBLE FOR THE PROGRAM.

36-2984. Family coverage; payment of premiums; creditable coverage

A. THE CONTRACTORS SHALL OFFER HEALTH INSURANCE COVERAGE TO THE PARENT OR LEGAL GUARDIAN OF A CHILD WHO IS ELIGIBLE FOR THE PROGRAM. THE CONTRACTORS SHALL ESTABLISH RATES THAT ARE APPROVED BY THE ADMINISTRATION. THE CONTRACTORS SHALL INCLUDE PROVISIONS FOR PREEXISTING CONDITIONS AND ANY OTHER MEDICAL UNDERWRITING CONSIDERATIONS THAT ARE NECESSARY TO PROTECT THE CONTRACTORS FROM ADVERSE RISK.

B. A PARENT OR LEGAL GUARDIAN WHO SELECTS COVERAGE PURSUANT TO SUBSECTION A OF THIS SECTION SHALL PAY THE FULL COST OF THE PREMIUM.

C. HEALTH INSURANCE COVERAGE UNDER THIS SECTION IS CREDITABLE COVERAGE AS DEFINED IN SECTION 20-1379.

D. TITLE XXI FEDERAL MONIES SHALL NOT BE USED TO SUBSIDIZE THE USE OF FAMILY COVERAGE.

36-2985. Enrollment cap; program termination; spending limitation

A. IF THE DIRECTOR DETERMINES THAT MONIES MAY BE INSUFFICIENT FOR THE PROGRAM THE DIRECTOR SHALL IMMEDIATELY NOTIFY THE GOVERNOR, THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES. AFTER CONSULTING WITH THE GOVERNOR, THE ADMINISTRATION SHALL STOP PROCESSING NEW APPLICATIONS FOR THE PROGRAM UNTIL THE ADMINISTRATION IS ABLE TO VERIFY THAT FUNDING IS SUFFICIENT TO BEGIN PROCESSING APPLICATIONS AND THE GOVERNOR AGREES THAT THE ADMINISTRATION MAY BEGIN PROCESSING APPLICATIONS.

B. IF THE FEDERAL GOVERNMENT ELIMINATES FEDERAL FUNDING FOR THE PROGRAM OR SIGNIFICANTLY REDUCES THE FEDERAL FUNDING BELOW THE ESTIMATED FEDERAL EXPENDITURES, THE ADMINISTRATION SHALL IMMEDIATELY STOP PROCESSING ALL APPLICATIONS AND SHALL PROVIDE AT LEAST THIRTY DAYS' ADVANCE NOTICE TO CONTRACTORS AND MEMBERS THAT THE PROGRAM WILL TERMINATE.

C. THE TOTAL AMOUNT OF STATE MONIES THAT MAY BE SPENT IN ANY FISCAL YEAR BY THE ADMINISTRATION FOR HEALTH CARE PROVIDED UNDER THIS ARTICLE SHALL NOT EXCEED THE AMOUNT APPROPRIATED OR AUTHORIZED BY SECTION 35-173.

D. THIS ARTICLE DOES NOT IMPOSE A DUTY ON AN OFFICER, AGENT OR EMPLOYEE OF THIS STATE TO DISCHARGE A RESPONSIBILITY OR TO CREATE ANY RIGHT IN A PERSON OR GROUP IF THE DISCHARGE OR RIGHT WOULD REQUIRE AN EXPENDITURE OF STATE MONIES IN EXCESS OF THE EXPENDITURE AUTHORIZED BY LEGISLATIVE APPROPRIATION FOR THAT SPECIFIC PURPOSE.

36-2986. Administration; powers and duties of director

A. THE DIRECTOR HAS FULL OPERATIONAL AUTHORITY TO ADOPT RULES OR TO USE THE APPROPRIATE RULES ADOPTED FOR ARTICLE 1 OF THIS CHAPTER FOR ANY OF THE FOLLOWING:

1. CONTRACT ADMINISTRATION AND OVERSIGHT OF CONTRACTORS.

2. DEVELOPMENT OF A COMPLETE SYSTEM OF ACCOUNTS AND CONTROLS FOR THE PROGRAM INCLUDING PROVISIONS DESIGNED TO ENSURE THAT COVERED HEALTH AND MEDICAL SERVICES PROVIDED THROUGH THE SYSTEM ARE NOT USED UNNECESSARILY OR UNREASONABLY INCLUDING INPATIENT BEHAVIORAL HEALTH SERVICES PROVIDED IN A HOSPITAL.

3. ESTABLISHMENT OF PEER REVIEW AND UTILIZATION REVIEW FUNCTIONS FOR ALL CONTRACTORS.

4. DEVELOPMENT AND MANAGEMENT OF A CONTRACTOR PAYMENT SYSTEM.

5. ESTABLISHMENT AND MANAGEMENT OF A COMPREHENSIVE SYSTEM FOR ASSURING QUALITY OF CARE.

6. ESTABLISHMENT AND MANAGEMENT OF A SYSTEM TO PREVENT FRAUD BY MEMBERS, CONTRACTORS AND HEALTH CARE PROVIDERS.

7. DEVELOPMENT OF AN OUTREACH PROGRAM. THE ADMINISTRATION SHALL COORDINATE WITH PUBLIC AND PRIVATE ENTITIES TO PROVIDE OUTREACH SERVICES FOR CHILDREN UNDER THIS ARTICLE. PRIORITY SHALL BE GIVEN TO THOSE FAMILIES WHO ARE MOVING OFF WELFARE. OUTREACH ACTIVITIES SHALL INCLUDE STRATEGIES TO INFORM COMMUNITIES, INCLUDING TRIBAL COMMUNITIES, ABOUT THE PROGRAM, ENSURE A WIDE DISTRIBUTION OF APPLICATIONS AND PROVIDE TRAINING FOR OTHER ENTITIES TO ASSIST WITH THE APPLICATION PROCESS.

8. COORDINATION OF BENEFITS PROVIDED UNDER THIS ARTICLE FOR ANY MEMBER. THE DIRECTOR MAY REQUIRE THAT CONTRACTORS AND NONCONTRACTING PROVIDERS ARE RESPONSIBLE FOR THE COORDINATION OF BENEFITS FOR SERVICES PROVIDED UNDER THIS ARTICLE. REQUIREMENTS FOR COORDINATION OF BENEFITS BY NONCONTRACTING PROVIDERS UNDER THIS SECTION ARE LIMITED TO COORDINATION WITH STANDARD HEALTH INSURANCE AND DISABILITY INSURANCE POLICIES AND SIMILAR PROGRAMS FOR HEALTH COVERAGE. THE DIRECTOR MAY REQUIRE MEMBERS TO ASSIGN TO THE ADMINISTRATION RIGHTS TO ALL TYPES OF MEDICAL BENEFITS TO WHICH THE PERSON IS ENTITLED, INCLUDING FIRST PARTY MEDICAL BENEFITS UNDER AUTOMOBILE INSURANCE POLICIES. THE STATE HAS A RIGHT OF SUBROGATION AGAINST ANY OTHER PERSON OR FIRM TO ENFORCE THE ASSIGNMENT OF MEDICAL BENEFITS. THE PROVISIONS OF THIS PARAGRAPH ARE CONTROLLING OVER THE PROVISIONS OF ANY INSURANCE POLICY THAT PROVIDES BENEFITS TO A MEMBER IF THE POLICY IS INCONSISTENT WITH THIS PARAGRAPH.

9. DEVELOPMENT AND MANAGEMENT OF AN ELIGIBILITY AND ENROLLMENT SYSTEM INCLUDING A PROCESS FOR QUALITY CONTROL.

10. ESTABLISHMENT AND MAINTENANCE OF AN ENCOUNTER CLAIMS SYSTEM THAT ENSURES THAT NINETY PER CENT OF THE CLEAN CLAIMS ARE PAID WITHIN THIRTY DAYS AFTER RECEIPT AND NINETY-NINE PER CENT OF THE REMAINING CLEAN CLAIMS ARE PAID WITHIN NINETY DAYS AFTER RECEIPT BY THE ADMINISTRATION OR CONTRACTOR UNLESS AN ALTERNATIVE PAYMENT SCHEDULE IS AGREED TO BY THE CONTRACTOR AND THE PROVIDER. FOR THE PURPOSES OF THIS PARAGRAPH, "CLEAN CLAIMS" HAS THE SAME MEANING PRESCRIBED IN SECTION 36-2904, SUBSECTION H.

11. ESTABLISHMENT OF STANDARDS FOR THE COORDINATION OF MEDICAL CARE AND MEMBER TRANSFERS.

12. REQUIRE CONTRACTORS TO SUBMIT ENCOUNTER DATA IN A FORM SPECIFIED BY THE DIRECTOR.

B. NOTWITHSTANDING ANY OTHER LAW, IF CONGRESS AMENDS TITLE XXI OF THE SOCIAL SECURITY ACT AND THE ADMINISTRATION IS REQUIRED TO MAKE CONFORMING CHANGES TO RULES ADOPTED PURSUANT TO THIS ARTICLE, THE ADMINISTRATION SHALL REQUEST A HEARING WITH THE JOINT HEALTH COMMITTEE OF REFERENCE FOR REVIEW OF THE PROPOSED RULE CHANGES.

C. THE DIRECTOR MAY SUBCONTRACT DISTINCT ADMINISTRATIVE FUNCTIONS TO ONE OR MORE PERSONS WHO MAY BE CONTRACTORS WITHIN THE SYSTEM.

D. THE DIRECTOR SHALL REQUIRE AS A CONDITION OF A CONTRACT WITH ANY CONTRACTOR THAT ALL RECORDS RELATING TO CONTRACT COMPLIANCE ARE AVAILABLE FOR INSPECTION BY THE ADMINISTRATION AND THAT THESE RECORDS BE MAINTAINED BY THE CONTRACTOR FOR FIVE YEARS. THE DIRECTOR SHALL ALSO REQUIRE THAT THESE RECORDS ARE AVAILABLE BY A CONTRACTOR ON REQUEST OF THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

E. SUBJECT TO EXISTING LAW RELATING TO PRIVILEGE AND PROTECTION, THE DIRECTOR SHALL PRESCRIBE BY RULE THE TYPES OF INFORMATION THAT ARE CONFIDENTIAL AND CIRCUMSTANCES UNDER WHICH THIS INFORMATION MAY BE USED OR RELEASED, INCLUDING REQUIREMENTS FOR PHYSICIAN-PATIENT CONFIDENTIALITY. NOTWITHSTANDING ANY OTHER LAW, THESE RULES SHALL BE DESIGNED TO PROVIDE FOR THE EXCHANGE OF NECESSARY INFORMATION FOR THE PURPOSES OF ELIGIBILITY DETERMINATION UNDER THIS ARTICLE. NOTWITHSTANDING ANY OTHER LAW, A MEMBER'S MEDICAL RECORD SHALL BE RELEASED WITHOUT THE MEMBER'S CONSENT IN SITUATIONS OF SUSPECTED CASES OF FRAUD OR ABUSE RELATING TO THE SYSTEM TO AN OFFICER OF THIS STATE'S CERTIFIED ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM FRAUD CONTROL UNIT WHO HAS SUBMITTED A WRITTEN REQUEST FOR THE MEDICAL RECORD.

F. THE DIRECTOR SHALL PROVIDE FOR THE TRANSITION OF MEMBERS BETWEEN CONTRACTORS AND NONCONTRACTING PROVIDERS AND THE TRANSFER OF MEMBERS WHO HAVE BEEN DETERMINED ELIGIBLE FROM HOSPITALS THAT DO NOT HAVE CONTRACTS TO CARE FOR THESE PERSONS.

G. TO THE EXTENT THAT SERVICES ARE FURNISHED PURSUANT TO THIS ARTICLE A CONTRACTOR IS NOT SUBJECT TO THE PROVISIONS OF TITLE 20 UNLESS THE CONTRACTOR IS A QUALIFYING PLAN AND HAS ELECTED TO PROVIDE SERVICES PURSUANT TO THIS ARTICLE.

H. AS A CONDITION OF A CONTRACT, THE DIRECTOR SHALL REQUIRE CONTRACT TERMS THAT ARE NECESSARY TO ENSURE ADEQUATE PERFORMANCE BY THE CONTRACTOR. CONTRACT PROVISIONS REQUIRED BY THE DIRECTOR INCLUDE THE MAINTENANCE OF DEPOSITS, PERFORMANCE BONDS, FINANCIAL RESERVES OR OTHER FINANCIAL SECURITY. THE DIRECTOR MAY WAIVE REQUIREMENTS FOR THE POSTING OF BONDS OR SECURITY FOR CONTRACTORS WHO HAVE POSTED OTHER SECURITY, EQUAL TO OR GREATER THAN THAT REQUIRED BY THE ADMINISTRATION, WITH A STATE AGENCY FOR THE PERFORMANCE OF HEALTH SERVICE CONTRACTS IF MONIES WOULD BE AVAILABLE FROM THAT SECURITY FOR THE SYSTEM ON DEFAULT BY THE CONTRACTOR.

I. THE DIRECTOR SHALL ESTABLISH SOLVENCY REQUIREMENTS IN CONTRACT THAT MAY INCLUDE WITHHOLDING OR FORFEITURE OF PAYMENTS TO BE MADE TO A CONTRACTOR BY THE ADMINISTRATION FOR THE FAILURE OF THE CONTRACTOR TO COMPLY WITH A PROVISION OF THE CONTRACT WITH THE ADMINISTRATION. THE DIRECTOR MAY ALSO REQUIRE CONTRACT TERMS ALLOWING THE ADMINISTRATION TO OPERATE A CONTRACTOR DIRECTLY UNDER CIRCUMSTANCES SPECIFIED IN THE CONTRACT. THE ADMINISTRATION SHALL OPERATE THE CONTRACTOR ONLY AS LONG AS IT IS NECESSARY TO ASSURE DELIVERY OF UNINTERRUPTED CARE TO MEMBERS ENROLLED WITH THE CONTRACTOR AND TO ACCOMPLISH THE ORDERLY TRANSITION OF MEMBERS TO OTHER CONTRACTORS OR UNTIL THE CONTRACTOR REORGANIZES OR OTHERWISE CORRECTS THE CONTRACT PERFORMANCE

FAILURE. THE ADMINISTRATION SHALL NOT OPERATE A CONTRACTOR UNLESS, BEFORE THAT ACTION, THE ADMINISTRATION DELIVERS NOTICE TO THE CONTRACTOR PROVIDING AN OPPORTUNITY FOR A HEARING IN ACCORDANCE WITH PROCEDURES ESTABLISHED BY THE DIRECTOR. NOTWITHSTANDING THE PROVISIONS OF A CONTRACT, IF THE ADMINISTRATION FINDS THAT THE PUBLIC HEALTH, SAFETY OR WELFARE REQUIRES EMERGENCY ACTION, IT MAY OPERATE AS THE CONTRACTOR ON NOTICE TO THE CONTRACTOR AND PENDING AN ADMINISTRATIVE HEARING, WHICH IT SHALL PROMPTLY INSTITUTE.

J. FOR THE SOLE PURPOSE OF MATTERS CONCERNING AND DIRECTLY RELATED TO THIS ARTICLE, THE ADMINISTRATION IS EXEMPT FROM SECTION 41-192.

K. THE DIRECTOR MAY WITHHOLD PAYMENTS TO A NONCONTRACTING PROVIDER IF THE NONCONTRACTING PROVIDER DOES NOT COMPLY WITH THIS ARTICLE OR ADOPTED RULES THAT RELATE TO THE SPECIFIC SERVICES RENDERED AND BILLED TO THE ADMINISTRATION.

L. THE DIRECTOR SHALL:

1. PRESCRIBE UNIFORM FORMS TO BE USED BY ALL CONTRACTORS AND FURNISH UNIFORM FORMS AND PROCEDURES, INCLUDING METHODS OF IDENTIFICATION OF MEMBERS. THE RULES SHALL INCLUDE REQUIREMENTS THAT AN APPLICANT PERSONALLY COMPLETE OR ASSIST IN THE COMPLETION OF ELIGIBILITY APPLICATION FORMS, EXCEPT IN SITUATIONS IN WHICH THE PERSON IS DISABLED.

2. BY RULE, ESTABLISH A GRIEVANCE AND APPEAL PROCEDURE THAT CONFORMS WITH THE PROCESS IN ARTICLE 1 OF THIS CHAPTER. IF THE PROGRAM IS SUSPENDED OR TERMINATED PURSUANT TO SECTION 36-2985, AN APPLICANT OR MEMBER IS NOT ENTITLED TO CONTEST THE DENIAL, SUSPENSION OR TERMINATION OF ELIGIBILITY FOR THE PROGRAM.

3. APPLY FOR AND ACCEPT FEDERAL MONIES AVAILABLE UNDER TITLE XXI OF THE SOCIAL SECURITY ACT. AVAILABLE STATE MONIES APPROPRIATED TO THE ADMINISTRATION FOR THE OPERATION OF THE PROGRAM SHALL BE USED AS MATCHING MONIES TO SECURE FEDERAL MONIES PURSUANT TO THIS SUBSECTION.

M. THE ADMINISTRATION IS ENTITLED TO ALL RIGHTS PROVIDED TO THE ADMINISTRATION FOR LIENS AND RELEASE OF CLAIMS AS SPECIFIED IN SECTIONS 36-2915 AND 36-2916.

N. THE DIRECTOR SHALL FOLLOW THE SAME PROCEDURES FOR REVIEW COMMITTEES, IMMUNITY AND CONFIDENTIALITY THAT ARE PRESCRIBED IN ARTICLE 1 OF THIS CHAPTER.

36-2987. Reimbursement for the program

A. FOR INPATIENT HOSPITAL SERVICES, THE ADMINISTRATION SHALL REIMBURSE THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY FOR INPATIENT HOSPITAL SERVICES BASED ON THE REIMBURSEMENT RATES FOR THE INDIAN HEALTH SERVICE AS PUBLISHED ANNUALLY IN THE FEDERAL REGISTER. FOR OUTPATIENT SERVICES, THE ADMINISTRATION SHALL REIMBURSE THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY BASED ON THE CAPPED FEE-FOR-SERVICE SCHEDULE ESTABLISHED BY THE DIRECTOR. IF CONGRESS AUTHORIZES ONE HUNDRED PER CENT PASS-THROUGH OF TITLE XXI MONIES FOR SERVICES PROVIDED IN AN INDIAN HEALTH SERVICE FACILITY OR A TRIBAL

FACILITY, THE ADMINISTRATION SHALL REIMBURSE THE INDIAN HEALTH SERVICE OR THE TRIBAL FACILITY WITH THIS ENHANCED FEDERAL FUNDING BASED ON THE REIMBURSEMENT RATES FOR THE INDIAN HEALTH SERVICE OR THE TRIBAL FACILITY AS PUBLISHED ANNUALLY IN THE FEDERAL REGISTER.

B. CONTRACTORS SHALL REIMBURSE INPATIENT AND OUTPATIENT SERVICES BASED ON THE REIMBURSEMENT METHODOLOGY ESTABLISHED IN SECTION 36-2904 OR THE HOSPITAL REIMBURSEMENT PILOT PROGRAM ESTABLISHED BY THIS STATE.

C. FOR SERVICES RENDERED ON AND AFTER OCTOBER 1, 1998, THE ADMINISTRATION AND THE CONTRACTORS SHALL PAY A HOSPITAL'S RATE ESTABLISHED ACCORDING TO THIS SECTION SUBJECT TO THE FOLLOWING:

1. IF THE HOSPITAL'S BILL IS PAID WITHIN THIRTY DAYS AFTER THE DATE THE BILL WAS RECEIVED, THE ADMINISTRATION SHALL PAY NINETY-NINE PER CENT OF THE RATE.

2. IF THE HOSPITAL'S BILL IS PAID AFTER THIRTY DAYS BUT WITHIN SIXTY DAYS AFTER THE DATE THE BILL WAS RECEIVED, THE ADMINISTRATION SHALL PAY ONE HUNDRED PER CENT OF THE RATE.

3. IF THE HOSPITAL'S BILL IS PAID ANY TIME AFTER SIXTY DAYS AFTER THE DATE THE BILL WAS RECEIVED, THE ADMINISTRATION SHALL PAY ONE HUNDRED PER CENT OF THE RATE PLUS A FEE OF ONE PER CENT A MONTH FOR EACH MONTH OR PORTION OF A MONTH FOLLOWING THE SIXTIETH DAY OF RECEIPT OF THE BILL UNTIL THE DATE OF PAYMENT.

D. THE ADMINISTRATION AND THE CONTRACTORS SHALL PAY CLAIMS PURSUANT TO THE METHODOLOGY, DEFINITIONS AND TIME FRAMES SPECIFIED FOR CLEAN CLAIMS IN SECTION 36-2904, SUBSECTION H.

E. THE DIRECTOR SHALL SPECIFY ENROLLMENT PROCEDURES INCLUDING NOTICE TO CONTRACTORS OF ENROLLMENT. THE ADMINISTRATION SHALL SPECIFY IN CONTRACT WHEN A PERSON WHO HAS BEEN DETERMINED ELIGIBLE WILL BE ENROLLED WITH A CONTRACTOR AND THE DATE ON WHICH THE CONTRACTOR WILL BE FINANCIALLY RESPONSIBLE FOR HEALTH AND MEDICAL SERVICES TO THE PERSON.

F. THE DIRECTOR SHALL MONITOR ANY THIRD PARTY PAYMENT COLLECTIONS COLLECTED BY CONTRACTORS AND NONCONTRACTING PROVIDERS ACCORDING TO THE SAME PROCEDURES SPECIFIED FOR TITLE XIX PURSUANT TO SECTION 36-2903.01, SUBSECTION M.

G. ON ORAL OR WRITTEN NOTICE FROM THE MEMBER, OR THE MEMBER'S PARENT OR LEGAL GUARDIAN, THAT THE MEMBER, PARENT OR LEGAL GUARDIAN BELIEVES A CLAIM SHOULD BE COVERED BY THE PROGRAM, A CONTRACTOR OR NONCONTRACTING PROVIDER SHALL NOT DO EITHER OF THE FOLLOWING UNLESS THE CONTRACTOR OR NONCONTRACTING PROVIDER HAS VERIFIED THROUGH THE ADMINISTRATION THAT THE PERSON IS INELIGIBLE FOR THE PROGRAM, HAS NOT YET BEEN DETERMINED ELIGIBLE OR, AT THE TIME SERVICES WERE RENDERED, WAS NOT ELIGIBLE OR ENROLLED IN THE PROGRAM:

1. CHARGE, SUBMIT A CLAIM TO OR DEMAND OR OTHERWISE COLLECT PAYMENT FROM A MEMBER OR PERSON WHO HAS BEEN DETERMINED ELIGIBLE.

2. REFER OR REPORT A MEMBER OR PERSON WHO HAS BEEN DETERMINED ELIGIBLE TO A COLLECTION AGENCY OR CREDIT REPORTING AGENCY FOR THE FAILURE OF THE

MEMBER OR PERSON WHO HAS BEEN DETERMINED ELIGIBLE TO PAY CHARGES FOR COVERED SERVICES UNLESS SPECIFICALLY AUTHORIZED BY THIS ARTICLE OR RULES ADOPTED PURSUANT TO THIS ARTICLE.

H. THE ADMINISTRATION MAY CONDUCT POSTPAYMENT REVIEW OF ALL PAYMENTS MADE BY THE ADMINISTRATION AND MAY RECOUP ANY MONIES ERRONEOUSLY PAID. THE DIRECTOR MAY ADOPT RULES THAT SPECIFY PROCEDURES FOR CONDUCTING POSTPAYMENT REVIEW. CONTRACTORS MAY CONDUCT A POSTPAYMENT REVIEW OF ALL CLAIMS PAID TO PROVIDERS AND MAY RECOUP MONIES THAT ARE ERRONEOUSLY PAID.

I. THE DIRECTOR OR THE DIRECTOR'S DESIGNEE MAY EMPLOY AND SUPERVISE PERSONNEL NECESSARY TO ASSIST THE DIRECTOR IN PERFORMING THE FUNCTIONS OF THE PROGRAM.

36-2988. Delivery of services; health plans; requirements

A. TO THE EXTENT POSSIBLE, THE ADMINISTRATION SHALL USE CONTRACTORS THAT HAVE A CONTRACT WITH THE ADMINISTRATION PURSUANT TO ARTICLE 1 OF THIS CHAPTER OR QUALIFYING PLANS TO PROVIDE SERVICES TO MEMBERS WHO QUALIFY FOR THE PROGRAM.

B. THE ADMINISTRATION HAS FULL AUTHORITY TO AMEND EXISTING CONTRACTS AWARDED PURSUANT TO ARTICLE 1 OF THIS CHAPTER.

C. AS DETERMINED BY THE DIRECTOR, REINSURANCE MAY BE PROVIDED AGAINST EXPENSES IN EXCESS OF A SPECIFIED AMOUNT ON BEHALF OF ANY MEMBER FOR COVERED EMERGENCY SERVICES, INPATIENT SERVICES OR OUTPATIENT SERVICES IN THE SAME MANNER AS REINSURANCE PROVIDED UNDER ARTICLE 1 OF THIS CHAPTER. SUBJECT TO THE APPROVAL OF THE DIRECTOR, REINSURANCE MAY BE OBTAINED AGAINST EXPENSES IN EXCESS OF A SPECIFIED AMOUNT ON BEHALF OF ANY MEMBER.

D. NOTWITHSTANDING ANY OTHER LAW, THE ADMINISTRATION MAY PROCURE, PROVIDE OR COORDINATE COVERED SERVICES BY INTERAGENCY AGREEMENT WITH AUTHORIZED AGENCIES OF THIS STATE FOR DISTINCT GROUPS OF MEMBERS, INCLUDING PERSONS ELIGIBLE FOR CHILDREN'S REHABILITATIVE SERVICES THROUGH THE DEPARTMENT OF HEALTH SERVICES AND MEMBERS ELIGIBLE FOR COMPREHENSIVE MEDICAL AND DENTAL BENEFITS THROUGH THE DEPARTMENT OF ECONOMIC SECURITY.

E. AFTER CONTRACTS ARE AWARDED PURSUANT TO THIS SECTION, THE DIRECTOR MAY NEGOTIATE WITH ANY SUCCESSFUL BIDDER FOR THE EXPANSION OR CONTRACTION OF SERVICES OR SERVICE AREAS.

F. PAYMENTS TO CONTRACTORS SHALL BE MADE MONTHLY AND MAY BE SUBJECT TO CONTRACT PROVISIONS REQUIRING THE RETENTION OF A SPECIFIED PERCENTAGE OF THE PAYMENT BY THE DIRECTOR, A RESERVE FUND OR ANY OTHER CONTRACT PROVISIONS BY WHICH ADJUSTMENTS TO THE PAYMENTS ARE MADE BASED ON UTILIZATION EFFICIENCY, INCLUDING INCENTIVES FOR MAINTAINING QUALITY CARE AND MINIMIZING UNNECESSARY INPATIENT SERVICES. RESERVE MONIES WITHHELD FROM CONTRACTORS SHALL BE DISTRIBUTED TO PROVIDERS WHO MEET PERFORMANCE STANDARDS ESTABLISHED BY THE DIRECTOR. ANY RESERVE FUND ESTABLISHED PURSUANT TO THIS SUBSECTION SHALL BE ESTABLISHED AS A SEPARATE ACCOUNT WITHIN THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

G. THE DIRECTOR MAY NEGOTIATE AT ANY TIME WITH A HOSPITAL ON BEHALF OF A CONTRACTOR FOR INPATIENT HOSPITAL SERVICES AND OUTPATIENT HOSPITAL SERVICES PROVIDED PURSUANT TO THE REQUIREMENTS SPECIFIED IN SECTION 36-2904.

H. A CONTRACTOR MAY REQUIRE THAT SUBCONTRACTING PROVIDERS OR NONCONTRACTING PROVIDERS BE PAID FOR COVERED SERVICES, OTHER THAN HOSPITAL SERVICES, ACCORDING TO THE CAPPED FEE-FOR-SERVICE SCHEDULE ADOPTED BY THE ADMINISTRATION OR AT LOWER RATES AS MAY BE NEGOTIATED BY THE CONTRACTOR.

I. THE ADMINISTRATION AND CONTRACTORS SHALL NOT CONTRACT FOR ANY SERVICES OR FUNCTIONS RELATED TO THIS ARTICLE WITH A SCHOOL DISTRICT INCLUDING CONTRACTING FOR THE DELIVERY OF SERVICES, SCREENING, OUTREACH OR INFORMATION THAT INVOLVES THE USE OF SCHOOL STAFF AND FACILITIES.

J. THE ADMINISTRATION IS EXEMPT FROM THE PROCUREMENT CODE PURSUANT TO SECTION 41-2501.

36-2989. Covered health and medical services; modifications; related delivery of service requirements

A. EXCEPT AS PROVIDED IN THIS SECTION, THE DIRECTOR SHALL ESTABLISH A SPECIFIC HEALTH BENEFITS COVERAGE PACKAGE THAT IS AS NEARLY AS PRACTICABLE THE SAME AS THE LEAST EXPENSIVE HEALTH BENEFITS COVERAGE PLAN OR PLANS THAT ARE OFFERED THROUGH A HEALTH CARE SERVICES ORGANIZATION AVAILABLE TO STATE EMPLOYEES UNDER SECTION 38-651. THE PACKAGE SHALL INCLUDE THE FOLLOWING COVERED SERVICES:

1. INPATIENT HOSPITAL SERVICES THAT ARE ORDINARILY FURNISHED BY A HOSPITAL FOR THE CARE AND TREATMENT OF INPATIENTS, THAT ARE MEDICALLY NECESSARY AND THAT ARE PROVIDED UNDER THE DIRECTION OF A PHYSICIAN OR A PRIMARY CARE PRACTITIONER. FOR THE PURPOSES OF THIS PARAGRAPH, INPATIENT HOSPITAL SERVICES EXCLUDE SERVICES IN AN INSTITUTION FOR TUBERCULOSIS OR MENTAL DISEASES UNLESS AUTHORIZED BY FEDERAL LAW.

2. OUTPATIENT HEALTH SERVICES THAT ARE MEDICALLY NECESSARY AND ORDINARILY PROVIDED IN HOSPITALS, CLINICS, OFFICES AND OTHER HEALTH CARE FACILITIES BY LICENSED HEALTH CARE PROVIDERS. FOR THE PURPOSES OF THIS PARAGRAPH, "OUTPATIENT HEALTH SERVICES" INCLUDES SERVICES PROVIDED BY OR UNDER THE DIRECTION OF A PHYSICIAN OR A PRIMARY CARE PRACTITIONER.

3. OTHER LABORATORY AND X-RAY SERVICES ORDERED BY A PHYSICIAN OR A PRIMARY CARE PRACTITIONER.

4. MEDICATIONS THAT ARE MEDICALLY NECESSARY AND ORDERED ON PRESCRIPTION BY A PHYSICIAN, A PRIMARY CARE PRACTITIONER OR A DENTIST LICENSED PURSUANT TO TITLE 32, CHAPTER 11.

5. MEDICAL SUPPLIES, EQUIPMENT AND PROSTHETIC DEVICES.

6. TREATMENT OF MEDICAL CONDITIONS OF THE EYE INCLUDING ONE EYE EXAMINATION EACH YEAR FOR PRESCRIPTIVE LENSES AND THE PROVISION OF ONE SET OF PRESCRIPTIVE LENSES EACH YEAR FOR MEMBERS.

7. MEDICALLY NECESSARY DENTAL SERVICES.

8. WELL CHILD, IMMUNIZATIONS AND PREVENTION SERVICES.

9. FAMILY PLANNING SERVICES THAT DO NOT INCLUDE ABORTION OR ABORTION COUNSELING. IF A CONTRACTOR ELECTS NOT TO PROVIDE FAMILY PLANNING SERVICES, THIS ELECTION DOES NOT DISQUALIFY THE CONTRACTOR FROM DELIVERING ALL OTHER COVERED HEALTH AND MEDICAL SERVICES UNDER THIS ARTICLE. IN THAT EVENT, THE ADMINISTRATION MAY CONTRACT DIRECTLY WITH ANOTHER CONTRACTOR, INCLUDING AN OUTPATIENT SURGICAL CENTER OR A NONCONTRACTING PROVIDER, TO DELIVER FAMILY PLANNING SERVICES TO A MEMBER WHO IS ENROLLED WITH A CONTRACTOR WHO ELECTS NOT TO PROVIDE FAMILY PLANNING SERVICES.

10. PODIATRY SERVICES THAT ARE PERFORMED BY A PODIATRIST LICENSED PURSUANT TO TITLE 32, CHAPTER 7 AND THAT ARE ORDERED BY A PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER.

11. MEDICALLY NECESSARY PANCREAS, HEART, LIVER, KIDNEY, CORNEA, LUNG AND HEART-LUNG TRANSPLANTS AND AUTOLOGOUS AND ALLOGENEIC BONE MARROW TRANSPLANTS AND IMMUNOSUPPRESSANT MEDICATIONS FOR THESE TRANSPLANTS ORDERED ON PRESCRIPTION BY A PHYSICIAN LICENSED PURSUANT TO TITLE 32, CHAPTER 13 OR 17.

12. MEDICALLY NECESSARY EMERGENCY TRANSPORTATION.

13. INPATIENT AND OUTPATIENT BEHAVIORAL HEALTH SERVICES. INPATIENT BEHAVIORAL HEALTH SERVICES ARE LIMITED TO NOT MORE THAN THIRTY DAYS FOR EACH TWELVE MONTH PERIOD FROM THE DATE OF INITIAL ENROLLMENT OR THE REDETERMINATION OF ELIGIBILITY. OUTPATIENT BEHAVIORAL SERVICES ARE LIMITED TO NOT MORE THAN THIRTY VISITS FOR EACH TWELVE MONTH PERIOD FROM THE DATE OF INITIAL ENROLLMENT OR THE REDETERMINATION OF ELIGIBILITY.

B. THE ADMINISTRATION SHALL PAY NONCONTRACTING PROVIDERS ONLY FOR HEALTH AND MEDICAL SERVICES AS PRESCRIBED IN SUBSECTION A OF THIS SECTION.

C. TO THE EXTENT POSSIBLE AND PRACTICABLE, THE ADMINISTRATION AND CONTRACTORS SHALL PROVIDE FOR THE PRIOR APPROVAL OF MEDICALLY NECESSARY SERVICES PROVIDED PURSUANT TO THIS ARTICLE.

D. THE DIRECTOR SHALL MAKE AVAILABLE HOME HEALTH SERVICES IN LIEU OF HOSPITALIZATION PURSUANT TO CONTRACTS AWARDED UNDER THIS ARTICLE.

E. EXCEPT FOR MEMBERS WHO ARE EIGHTEEN YEARS OF AGE AND WHO ARE NOT SERIOUSLY MENTALLY ILL, BEHAVIORAL HEALTH SERVICES SHALL BE PROVIDED TO MEMBERS THROUGH THE ADMINISTRATION'S INTERGOVERNMENTAL AGREEMENT WITH THE DIVISION OF BEHAVIORAL HEALTH IN THE DEPARTMENT OF HEALTH SERVICES. THE DIVISION OF BEHAVIORAL HEALTH IN THE DEPARTMENT OF HEALTH SERVICES SHALL USE ITS ESTABLISHED DIAGNOSTIC AND EVALUATION PROGRAM FOR REFERRALS OF CHILDREN WHO ARE NOT ALREADY ENROLLED PURSUANT TO THIS ARTICLE AND WHO MAY BE IN NEED OF BEHAVIORAL HEALTH SERVICES. IN ADDITION TO AN EVALUATION, THE DIVISION OF BEHAVIORAL HEALTH SHALL ALSO IDENTIFY CHILDREN WHO MAY BE ELIGIBLE UNDER SECTION 36-2901, PARAGRAPH 4, SUBDIVISION (b) OR SECTION 36-2931, PARAGRAPH 5 AND SHALL REFER THE CHILDREN TO THE APPROPRIATE AGENCY RESPONSIBLE FOR MAKING THE FINAL ELIGIBILITY DETERMINATION. MEMBERS WHO ARE EIGHTEEN YEARS

OF AGE AND WHO ARE NOT SERIOUSLY MENTALLY ILL SHALL BE REFERRED TO THE CONTRACTORS FOR BEHAVIORAL HEALTH SERVICES.

F. THE DIRECTOR SHALL ADOPT RULES FOR THE PROVISION OF TRANSPORTATION SERVICES FOR MEMBERS. PRIOR AUTHORIZATION IS NOT REQUIRED FOR MEDICALLY NECESSARY AMBULANCE TRANSPORTATION SERVICES RENDERED TO MEMBERS INITIATED BY DIALING TELEPHONE NUMBER 911 OR OTHER DESIGNATED EMERGENCY RESPONSE SYSTEMS.

G. THE DIRECTOR MAY ADOPT RULES TO ALLOW THE ADMINISTRATION TO USE A SECOND OPINION PROCEDURE UNDER WHICH SURGERY MAY NOT BE ELIGIBLE FOR COVERAGE PURSUANT TO THIS ARTICLE WITHOUT DOCUMENTATION AS TO NEED BY AT LEAST TWO PHYSICIANS OR PRIMARY CARE PRACTITIONERS.

H. ALL HEALTH AND MEDICAL SERVICES PROVIDED UNDER THIS ARTICLE SHALL BE PROVIDED IN THE COUNTY OF RESIDENCE OF THE MEMBER, EXCEPT:

1. EMERGENCY SERVICES AND SPECIALTY SERVICES.

2. THE DIRECTOR MAY PERMIT THE DELIVERY OF HEALTH AND MEDICAL SERVICES IN OTHER THAN THE COUNTY OF RESIDENCE IN THIS STATE OR IN AN ADJOINING STATE IF IT IS DETERMINED THAT MEDICAL PRACTICE PATTERNS JUSTIFY THE DELIVERY OF SERVICES IN OTHER THAN THE COUNTY OF RESIDENCE OR A NET REDUCTION IN TRANSPORTATION COSTS CAN REASONABLY BE EXPECTED. NOTWITHSTANDING SECTION 36-2981, PARAGRAPH 7 OR 12, IF SERVICES ARE PROCURED FROM A PHYSICIAN OR PRIMARY CARE PRACTITIONER IN AN ADJOINING STATE, THE PHYSICIAN OR PRIMARY CARE PRACTITIONER SHALL BE LICENSED TO PRACTICE IN THAT STATE PURSUANT TO LICENSING STATUTES IN THAT STATE THAT ARE SIMILAR TO TITLE 32, CHAPTER 13, 15, 17 OR 25.

I. COVERED OUTPATIENT SERVICES SHALL BE SUBCONTRACTED BY A PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER TO OTHER LICENSED HEALTH CARE PROVIDERS TO THE EXTENT PRACTICABLE FOR PURPOSES OF MAKING HEALTH CARE SERVICES AVAILABLE TO UNDERSERVED AREAS, REDUCING COSTS OF PROVIDING MEDICAL CARE AND REDUCING TRANSPORTATION COSTS.

J. THE DIRECTOR SHALL ADOPT RULES THAT PRESCRIBE THE COORDINATION OF MEDICAL CARE FOR MEMBERS AND THAT INCLUDE A MECHANISM TO TRANSFER MEMBERS AND MEDICAL RECORDS AND INITIATE MEDICAL CARE.

K. THE DIRECTOR SHALL ADOPT RULES FOR THE REIMBURSEMENT OF SPECIALTY SERVICES PROVIDED TO THE MEMBER IF AUTHORIZED BY THE MEMBER'S PRIMARY CARE PHYSICIAN OR PRIMARY CARE PRACTITIONER.

36-2990. Quality of health care monitoring standard; development; adoption; use; additional monitoring; costs

A. THE ADMINISTRATION SHALL DEVELOP STANDARDS OF CARE THAT EACH CONTRACTOR SHALL USE TO MONITOR THE QUALITY OF HEALTH CARE RECEIVED BY MEMBERS.

B. THE DIRECTOR SHALL PERIODICALLY DETERMINE WHETHER EACH CONTRACTOR HAS PROPERLY ADOPTED AND IMPLEMENTED STANDARDS TO ENSURE THE QUALITY OF HEALTH CARE. IF THE DIRECTOR DETERMINES THAT A CONTRACTOR IS OUT OF COMPLIANCE, THE DIRECTOR SHALL UNDERTAKE ADDITIONAL EFFORTS TO MONITOR AND

ASSESS THE QUALITY OF HEALTH CARE PROVIDED BY THAT CONTRACTOR FOR THE PERIOD OF TIME THAT THE DIRECTOR DEEMS NECESSARY. THE DIRECTOR SHALL DETERMINE THE COST INCURRED IN UNDERTAKING THESE SPECIAL EFFORTS AND SHALL DEDUCT THAT AMOUNT FROM ANY PAYMENT OWED TO THE CONTRACTOR.

36-2991. Fraud; penalties; enforcement; violation; classification

A. A PERSON SHALL NOT PROVIDE OR CAUSE TO BE PROVIDED FALSE OR FRAUDULENT INFORMATION ON AN APPLICATION FOR ELIGIBILITY PURSUANT TO THIS ARTICLE.

B. A PERSON WHO VIOLATES SUBSECTION A OF THIS SECTION, WHO IS DETERMINED ELIGIBLE FOR SERVICES PURSUANT TO THIS ARTICLE AND WHO WOULD HAVE BEEN DETERMINED INELIGIBLE IF THE PERSON HAD PROVIDED TRUE AND CORRECT INFORMATION IS SUBJECT, IN ADDITION TO ANY OTHER PENALTIES THAT MAY BE PRESCRIBED BY FEDERAL OR STATE LAW, TO A CIVIL PENALTY OF NOT MORE THAN THE AMOUNT INCURRED BY THE SYSTEM, INCLUDING CAPITATION PAYMENTS MADE ON BEHALF OF THE PERSON. IN ADDITION, THE PERSON'S ELIGIBILITY MAY BE DISCONTINUED IN ACCORDANCE WITH RULES ADOPTED BY THE DIRECTOR.

C. IN ADDITION TO THE REQUIREMENTS OF STATE LAW, ANY APPLICABLE FRAUD AND ABUSE CONTROLS THAT ARE ENACTED UNDER FEDERAL LAW APPLY TO PERSONS WHO ARE ELIGIBLE FOR SERVICES UNDER THIS ARTICLE AND TO CONTRACTORS AND NONCONTRACTING PROVIDERS WHO PROVIDE SERVICES UNDER THIS ARTICLE.

D. THE DIRECTOR SHALL MAKE THE DETERMINATION TO ASSESS A CIVIL PENALTY AND IS RESPONSIBLE FOR COLLECTION OF THE PENALTY. THE DIRECTOR MAY ADOPT RULES THAT PRESCRIBE PROCEDURES FOR THE DETERMINATION AND COLLECTION OF CIVIL PENALTIES. THE DIRECTOR MAY COMPROMISE CIVIL PENALTIES IMPOSED UNDER THIS SECTION IN ACCORDANCE WITH CRITERIA ESTABLISHED IN RULES.

E. THE DIRECTOR SHALL ADOPT RULES PROVIDING FOR THE APPEAL OF A DECISION BY A PERSON ADVERSELY AFFECTED BY A DETERMINATION MADE BY THE DIRECTOR UNDER THIS SECTION. THE DIRECTOR'S FINAL DECISION IS SUBJECT TO JUDICIAL REVIEW PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6.

F. AMOUNTS PAID BY THE STATE AND RECOVERED UNDER THIS SECTION SHALL BE DEPOSITED IN THE STATE GENERAL FUND, AND ANY APPLICABLE FEDERAL SHARE SHALL BE RETURNED TO THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

G. IF A CIVIL PENALTY IMPOSED PURSUANT TO SUBSECTION D OF THIS SECTION IS NOT PAID, THE STATE MAY FILE AN ACTION TO COLLECT THE CIVIL PENALTY IN THE SUPERIOR COURT IN MARICOPA COUNTY. MATTERS THAT WERE RAISED OR COULD HAVE BEEN RAISED IN A HEARING BEFORE THE DIRECTOR OR IN AN APPEAL PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6 MAY NOT BE RAISED AS A DEFENSE TO THE CIVIL ACTION. AN ACTION BROUGHT PURSUANT TO THIS SUBSECTION SHALL BE INITIATED WITHIN SIX YEARS AFTER THE DATE THE CLAIM IS PRESENTED.

H. A PERSON WHO KNOWINGLY AIDS OR ABETS ANOTHER PERSON PURSUANT TO SECTION 13-301, 13-302 OR 13-303 IN THE COMMISSION OF AN OFFENSE UNDER THIS SECTION OR SECTION 13-3713 IS GUILTY OF A CLASS 5 FELONY.

36-2992. Duty to report fraud or abuse; immunity; unprofessional conduct

A. ALL CONTRACTORS AND NONCONTRACTING PROVIDERS SHALL ADVISE THE DIRECTOR OR THE DIRECTOR'S DESIGNEE IMMEDIATELY IN A WRITTEN REPORT OF ANY CASES OF SUSPECTED FRAUD OR ABUSE. THE DIRECTOR SHALL REVIEW THE REPORT AND CONDUCT A PRELIMINARY INVESTIGATION TO DETERMINE IF THERE IS A SUFFICIENT BASIS TO WARRANT A FULL INVESTIGATION. IF THE FINDINGS OF A PRELIMINARY INVESTIGATION GIVE THE DIRECTOR REASON TO BELIEVE THAT AN INCIDENT OF FRAUD OR ABUSE HAS OCCURRED, THE MATTER SHALL BE REFERRED TO THE ATTORNEY GENERAL.

B. ANY PERSON MAKING A COMPLAINT OR FURNISHING A REPORT, INFORMATION OR RECORDS IN GOOD FAITH PURSUANT TO THIS SECTION IS IMMUNE FROM ANY CIVIL LIABILITY BY REASON OF THAT ACTION UNLESS THAT PERSON HAS BEEN CHARGED WITH OR IS SUSPECTED OF THE REPORTED FRAUD OR ABUSE.

C. ANY HEALTH CARE PROVIDER WHO FAILS TO REPORT PURSUANT TO THIS SECTION COMMITS AN ACT OF UNPROFESSIONAL CONDUCT AND IS SUBJECT TO DISCIPLINARY ACTION BY THE PROVIDER'S LICENSING BOARD OR DEPARTMENT.

36-2993. Prohibited acts; penalties

A. A PERSON SHALL NOT PRESENT OR CAUSE TO BE PRESENTED TO THIS STATE OR TO A CONTRACTOR:

1. A CLAIM FOR A MEDICAL SERVICE OR ANY OTHER ITEM THAT THE PERSON KNOWS OR HAS REASON TO KNOW WAS NOT PROVIDED AS CLAIMED.

2. A CLAIM FOR A MEDICAL SERVICE OR ANY OTHER ITEM THAT THE PERSON KNOWS OR HAS REASON TO KNOW IS FALSE OR FRAUDULENT.

3. A CLAIM FOR PAYMENT THAT THE PERSON KNOWS OR HAS REASON TO KNOW MAY NOT BE MADE BY THE ADMINISTRATION BECAUSE:

(a) THE PERSON WAS TERMINATED OR SUSPENDED FROM PARTICIPATION IN THE PROGRAM ON THE DATE FOR WHICH THE CLAIM IS BEING MADE.

(b) THE ITEM OR SERVICE CLAIMED IS SUBSTANTIALLY IN EXCESS OF THE NEEDS OF THE INDIVIDUAL OR OF A QUALITY THAT FAILS TO MEET PROFESSIONALLY RECOGNIZED STANDARDS OF HEALTH CARE.

(c) THE PERSON WAS NOT A MEMBER ON THE DATE FOR WHICH THE CLAIM IS BEING MADE.

4. A CLAIM FOR A SERVICE OR AN ITEM BY A PERSON WHO KNOWS OR HAS REASON TO KNOW THAT THE INDIVIDUAL WHO FURNISHED OR SUPERVISED THE FURNISHING OF THE SERVICE:

(a) WAS NOT LICENSED AS A PHYSICIAN OR ANOTHER HEALTH CARE PROFESSIONAL REQUIRING STATE LICENSURE.

(b) OBTAINED THE INDIVIDUAL'S LICENSE THROUGH A MISREPRESENTATION OF MATERIAL FACT.

(c) REPRESENTED TO THE MEMBER AT THE TIME THE SERVICE WAS FURNISHED THAT THE PHYSICIAN WAS CERTIFIED IN A MEDICAL SPECIALTY BY A MEDICAL SPECIALTY BOARD IF THE INDIVIDUAL WAS NOT CERTIFIED.

5. A REQUEST FOR PAYMENT THAT THE PERSON KNOWS OR HAS REASON TO KNOW IS IN VIOLATION OF AN AGREEMENT BETWEEN THE PERSON AND THIS STATE OR THE ADMINISTRATION.

B. A PERSON WHO VIOLATES THIS SECTION IS SUBJECT, IN ADDITION TO ANY OTHER PENALTIES THAT MAY BE PRESCRIBED BY LAW, TO A CIVIL PENALTY OF NOT MORE THAN TWO THOUSAND DOLLARS FOR EACH ITEM OR SERVICE CLAIMED AND IS SUBJECT TO AN ASSESSMENT OF NOT MORE THAN TWICE THE AMOUNT CLAIMED FOR EACH ITEM OR SERVICE.

C. THE DIRECTOR OR THE DIRECTOR'S DESIGNEE SHALL MAKE THE DETERMINATION TO ASSESS CIVIL PENALTIES AND IS RESPONSIBLE FOR THE COLLECTION OF PENALTY AND ASSESSMENT AMOUNTS. THE DIRECTOR SHALL ADOPT RULES THAT PRESCRIBE PROCEDURES FOR THE DETERMINATION AND COLLECTION OF CIVIL PENALTIES AND ASSESSMENTS. CIVIL PENALTIES AND ASSESSMENTS IMPOSED UNDER THIS SECTION MAY BE COMPROMISED BY THE DIRECTOR OR THE DESIGNEE IN ACCORDANCE WITH CRITERIA ESTABLISHED IN RULES. THE DIRECTOR OR THE DIRECTOR'S DESIGNEE MAY MAKE THIS DETERMINATION IN THE SAME PROCEEDING TO EXCLUDE THE PERSON FROM PARTICIPATION IN THE PROGRAM.

D. A PERSON ADVERSELY AFFECTED BY A DETERMINATION OF THE DIRECTOR OR THE DIRECTOR'S DESIGNEE UNDER THIS SECTION MAY APPEAL THAT DECISION IN ACCORDANCE WITH PROVIDER GRIEVANCE PROVISIONS PRESCRIBED BY RULE. THE FINAL DECISION IS SUBJECT TO JUDICIAL REVIEW PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6.

E. THE ADMINISTRATION SHALL TRANSMIT MONIES COLLECTED PURSUANT TO THIS SECTION TO THE STATE TREASURER FOR DEPOSIT IN THE STATE GENERAL FUND. THE AMOUNT OF THE PENALTY OR ASSESSMENT MAY BE DEDUCTED FROM ANY AMOUNT THEN OR LATER OWING BY THE ADMINISTRATION OR THIS STATE TO THE PERSON AGAINST WHOM THE PENALTY OR ASSESSMENT HAS BEEN IMPOSED.

F. IF A CIVIL PENALTY OR ASSESSMENT IMPOSED PURSUANT TO THIS SECTION IS NOT PAID, THIS STATE OR THE ADMINISTRATION SHALL FILE AN ACTION TO COLLECT THE CIVIL PENALTY OR ASSESSMENT IN THE SUPERIOR COURT IN MARICOPA COUNTY. MATTERS THAT WERE RAISED OR COULD HAVE BEEN RAISED IN A HEARING BEFORE THE DIRECTOR OR IN AN APPEAL PURSUANT TO TITLE 12, CHAPTER 7, ARTICLE 6 MAY NOT BE RAISED AS A DEFENSE TO THE CIVIL ACTION. AN ACTION BROUGHT PURSUANT TO THIS SUBSECTION SHALL BE INITIATED WITHIN SIX YEARS AFTER THE DATE THE CLAIM WAS PRESENTED.

36-2994. Monthly financial report

A. THE DIRECTOR SHALL INCLUDE IN THE MONTHLY REPORT SUBMITTED TO THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES PURSUANT TO SECTION 36-2920 THE FOLLOWING INFORMATION ABOUT THE PROGRAM:

1. THE ACTUAL YEAR TO DATE EXPENDITURES AND PROJECTED ANNUAL EXPENDITURES.

2. THE ACTUAL MEMBER MONTHS.

3. MONIES RECOVERED MONTHLY FROM THIRD PARTY PAYORS.

4. THE AMOUNT AND ORIGIN OF ANY DONATION OR GRANT FROM A PRIVATE ENTITY AND THE IMPACT ON THE IMPLEMENTATION OF THE PROGRAM.

B. THE REPORT SHALL BE SUBMITTED ON OR BEFORE THE TWENTY-FIFTH DAY OF THE FOLLOWING MONTH.

C. THE DIRECTOR SHALL PROVIDE A COPY OF THE MONTHLY REPORT TO THE CHAIRMEN OF THE HOUSE OF REPRESENTATIVES AND SENATE STANDING COMMITTEES ON APPROPRIATIONS AND HEALTH.

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

A. THE CHILDREN'S HEALTH INSURANCE PROGRAM FUND IS ESTABLISHED. THE ADMINISTRATION SHALL ADMINISTER THE FUND AND SHALL USE FUND MONIES TO PAY ADMINISTRATIVE AND PROGRAM COSTS ASSOCIATED WITH THE OPERATION OF THE PROGRAM ESTABLISHED BY THIS ARTICLE.

B. SEPARATE ACCOUNTING SHALL BE MADE FOR EACH SOURCE OF MONIES RECEIVED PURSUANT TO SUBSECTION C OF THIS SECTION FOR EXPENSES AND INCOME ACTIVITY ASSOCIATED WITH THE PROGRAM ESTABLISHED PURSUANT TO THIS ARTICLE.

C. MONIES IN THE FUND ARE COMPRISED OF:

1. FEDERAL MONIES AVAILABLE TO THIS STATE FOR THE OPERATION OF THE PROGRAM.

2. TOBACCO TAX MONIES APPROPRIATED AS STATE MATCHING MONIES.

3. GIFTS, DONATIONS AND GRANTS FROM ANY SOURCE.

4. INTEREST PAID ON MONIES DEPOSITED IN THE FUND.

5. THIRD PARTY LIABILITY RECOVERIES.

D. IF A GIFT, A DONATION OR A GRANT OF OVER TEN THOUSAND DOLLARS RECEIVED FROM ANY PRIVATE SOURCE CONTAINS A CONDITION, THE ADMINISTRATION SHALL FIRST MEET WITH THE JOINT LEGISLATIVE STUDY COMMITTEE ON THE INTEGRATION OF HEALTH CARE SERVICES TO REVIEW THE CONDITION BEFORE IT SPENDS THAT GIFT, DONATION OR GRANT.

E. ALL MONIES IN THE FUND OTHER THAN MONIES APPROPRIATED BY THIS STATE DO NOT LAPSE.

F. MONIES APPROPRIATED FROM THE MEDICALLY NEEDY ACCOUNT OF THE TOBACCO TAX AND HEALTH CARE FUND PURSUANT TO SECTION 36-2921 ARE EXEMPT FROM SECTION 35-190 RELATING TO LAPSING OF APPROPRIATIONS. NOTWITHSTANDING SECTION 35-191, SUBSECTION B, THE PERIOD FOR ADMINISTRATIVE ADJUSTMENTS EXTENDS FOR ONLY SIX MONTHS FOR APPROPRIATIONS MADE FOR ADMINISTRATION COVERED SERVICES.

G. NOTWITHSTANDING SECTIONS 35-190 AND 35-191, ALL APPROVED CLAIMS FOR SYSTEM COVERED SERVICES PRESENTED AFTER THE END OF THE FISCAL YEAR IN WHICH THEY WERE INCURRED SHALL BE PAID EITHER IN ACCORDANCE WITH THIS SECTION OR IN THE CURRENT FISCAL YEAR WITH THE MONIES AVAILABLE IN THE FUNDS ESTABLISHED BY THIS SECTION.

H. CLAIMS FOR COVERED SERVICES THAT ARE DETERMINED TO BE VALID BY THE DIRECTOR AND THE GRIEVANCE AND APPEAL PROCEDURE SHALL BE PAID FROM THE CHILDREN'S HEALTH INSURANCE PROGRAM FUND.

I. ALL PAYMENTS FOR CLAIMS FROM THE CHILDREN'S HEALTH INSURANCE PROGRAM FUND SHALL BE ACCOUNTED FOR BY THE ADMINISTRATION BY THE FISCAL YEAR IN WHICH THE CLAIMS WERE INCURRED, REGARDLESS OF THE FISCAL YEAR IN WHICH THE PAYMENTS WERE MADE.

J. NOTWITHSTANDING ANY OTHER LAW, COUNTY OWNED OR CONTRACTED PROVIDERS ARE SUBJECT TO ALL CLAIMS PROCESSING AND PAYMENT REQUIREMENTS OR LIMITATIONS OF THIS CHAPTER THAT ARE APPLICABLE TO NONCOUNTY PROVIDERS.

Sec. 6. Laws 1997, chapter 186, section 6 is amended to read:

Sec. 6. Reporting requirements

A. Beginning on April 1, 1998, the director of the Arizona health care cost containment system administration shall report semiannually to the premium sharing demonstration project oversight committee on the implementation and operation of the premium sharing demonstration project. The administration shall submit the report to the governor, the president of the senate and the speaker of the house of representatives. The director of the administration shall include in the report recommendations on shifting premium sharing demonstration project enrollees who have incomes that are less than one hundred per cent of the federal poverty guidelines as published annually by the United States department of health and human services into the new plan, when the federal waiver for eligibility based on one hundred per cent of the federal poverty level is approved by the health care financing administration.

B. Beginning on April 1, 1998, the Arizona legislative council shall submit a report semiannually to the premium sharing demonstration project oversight committee. The report shall contain the following information regarding the demonstration project:

1. An analysis of client satisfaction.
2. Program enrollment information.
3. The average annual income of the enrollee.
4. The annual medical service expenditure.
5. The total monies collected from enrollees.
6. Information necessary to analyze and evaluate the project's effectiveness or impact.
7. A review of the actual medical costs incurred and the premiums charged.

C. On or before January 1, ~~1999~~ 2000, the premium sharing demonstration project oversight committee shall submit a report to the governor, the speaker of the house of representatives and the president of the senate containing its findings regarding the overall success of the demonstration project and recommending its continuation or discontinuation.

Sec. 7. Laws 1997, chapter 186, section 8 is amended to read:

Sec. 8. Delayed repeal

Sections 3 through 7 of this act are repealed from and after September 30, ~~2000~~ 2001.

Sec. 8. Joint legislative study committee on the integration of health care services

A. The joint legislative study committee on the integration of health care services is established consisting of five members of the house of representatives appointed by the speaker of the house of representatives and five members of the senate appointed by the president of the senate. Not more than three members of the house of representatives or senate may represent the same political party.

B. The committee shall meet on the call of either cochairperson.

C. The committee shall:

1. Determine the feasibility of integrating health care services offered pursuant to title 36, chapter 29, article 4, Arizona Revised Statutes, as added by this act, Laws 1997, chapter 186, sections 3 through 8 and proposition 203, as passed by the voters in the 1996 general election, and for those who are classified as medically indigent pursuant to section 11-297, Arizona Revised Statutes, and for those classified as medically needy pursuant to section 36-2905, Arizona Revised Statutes.

2. Examine the benefits of and determine the fiscal impact of integrating the programs identified in paragraph 1.

3. Study the impact on the eligibility requirements of each program identified in paragraph 1.

4. Study proposals to maximize health insurance coverage for families through the use of existing federal, state and local resources in order to receive the highest benefit from investment of those resources.

5. Study the covered health and medical services to be provided under section 36-2989, Arizona Revised Statutes, as added by this act, and compare these services with the health and medical service benefit packages allowed under the federal and state children's health insurance program legislation including the benefit package currently offered to state employees and their dependents.

6. Review other state children's health insurance program proposals.

7. Examine the use of vouchers, tax credits and the use of private health insurance for the program including coverage provided to the parent or legal guardian.

8. Determine the coverage of children under the program who are covered under a health care insurance plan, including employer sponsored health care coverage.

D. The committee shall report its findings and recommendations to the governor, the speaker of the house of representatives, the president of the senate, the secretary of state and the director of the department of library,

archives and public records on or before December 15, 1999 and shall submit a preliminary report on or before December 15, 1998.

Sec. 9. Annual report

Beginning on January 1, 2000, the Arizona health care cost containment system administration shall annually report the following information relating to the children's health insurance program established pursuant to title 36, chapter 29, article 4, Arizona Revised Statutes, as added by this act, to the governor, president of the senate, speaker of the house of representatives, secretary of state and director of the department of library, archives and public records:

1. The number of children served by the program.

2. The state and federal expenditures for the program for the previous fiscal year.

3. A comparison of the expenditures for the previous fiscal year with the expected federal funding for the next fiscal year.

4. Whether the federal funding for the next fiscal year will be sufficient to provide services at the current percentage of the federal poverty level or whether an enrollment cap may be needed.

5. Any recommendations for changes to the program.

Sec. 10. Direct services; qualifying community health centers; hospitals; eligibility screening

A child who receives services pursuant to section 36-2907.05, section 36-2907.06, subsection A or section 36-2907.08, subsection A, Arizona Revised Statutes, shall be screened for potential eligibility by the qualifying community health center or hospital that contracts with the department of health services pursuant to section 36-2907.06 or section 36-2907.08, Arizona Revised Statutes. If it appears that the child may be eligible, the qualifying community health center or hospital may provide services and shall refer the child for an eligibility determination by the Arizona health care cost containment system administration.

Sec. 11. Exemption from rule making; procurement code

A. The Arizona health care cost containment system administration and the department of health services are exempt from the rule making requirements of title 41, chapter 6, Arizona Revised Statutes, for one year after the effective date of this act to implement this act. The administration and the department shall hold hearings to give the public an opportunity to comment on the proposed rules. The administration and the department shall hold at least one of these hearings in a county with a population of less than five hundred thousand persons according to the most recent United States decennial census.

B. The department of health services is exempt from the provisions of title 41, chapter 23, Arizona Revised Statutes, relating to the procurement code, for the purpose of procuring contracts with qualifying health centers pursuant to section 36-2907.06, subsection G, Arizona Revised Statutes, or hospitals pursuant to section 36-2907.08, subsection H, Arizona Revised Statutes.

Sec. 12. Intent

It is the intent of the legislature that the Arizona health care cost containment system administration submit a state plan requesting approval from the federal health care financing administration to implement a title XXI children's health care program that will provide health insurance coverage for uninsured, low income children who are under nineteen years of age. Subject to an appropriation by the legislature, tobacco tax monies will be used as the state matching monies. The program will operate within the funding allocated by the legislature, and a cap may be imposed on enrollment if it appears the program will exceed the available funding. If federal monies become unavailable, the program is repealed and services will be terminated.

Sec. 13. Additional employees; authorization

The Arizona health care cost containment system administration is authorized to hire up to fifty-nine additional full-time equivalent employees to perform eligibility determinations and other requirements of this act.

Sec. 14. Conditional effective date

This act is effective from and after September 30, 1997 but only if the Arizona health care cost containment system administration's application for a title XXI state children's health insurance program is approved by the federal health care financing administration. If the federal health care financing administration does not approve this act as of October 1, 1998, this act is effective on the date that agency notifies the administration of its approval. The administration shall notify the director of the Arizona legislative council of the date of this notification.

Sec. 15. Delayed repeal

Section 8 of this act, relating to the joint legislative study committee on the integration of health care services, is repealed from and after December 31, 2001.

Sec. 16. Conditional repeal

This act is repealed on the date the Arizona health care cost containment system administration determines that federal monies are not available for the program pursuant to section 36-2984, Arizona Revised Statutes, as added by this act. The director of the administration shall notify the director of the Arizona legislative council of this date. The legislature shall submit legislation to restore any statutory sections affected by this conditional repeal.

Sec. 17. Appropriation

The sum of $38,400,000 is appropriated from the children's health insurance program fund established pursuant to section 36-2995, Arizona Revised Statutes, as added by this act, to the Arizona health care cost containment system for fiscal year 1998-1999 for the purpose of implementing the children's health insurance program established pursuant to title 36, chapter 29, article 4, Arizona Revised Statutes, as added by this act. All

monies remaining unexpended and unencumbered on October 1, 1999 revert to the children's health insurance program fund.

Sec. 18. Reimbursement for contractors

Before the implementation of the children's health insurance program authorized in title 36, chapter 29, article 4, Arizona Revised Statutes, as added by this act, the Arizona health care cost containment system shall develop actuarially sound rates that shall be used to reimburse the contractors as defined in section 36-2981, Arizona Revised Statutes, as added by this act.

Sec. 19. Medical savings accounts; direct service contracts

A. Within one hundred twenty days after the approval of the title XXI state plan submitted to the federal health care financing administration, the Arizona health care cost containment system administration shall submit a medical savings account amendment to the joint legislative study committee on the integration of health care services. The committee shall review the amendment and provide input on the amendment. Once the joint legislative study committee on the integration of health care services reviews the amendment, the Arizona health care cost containment system administration shall submit the amendment to the federal health care financing administration requesting approval to offer medical savings accounts as an option to the services that are provided to eligible children under title 36, chapter 29, article 4, Arizona Revised Statutes, as added by this act.

B. On or before July 1, 1999, the Arizona health care cost containment system administration shall submit a direct service contracts amendment to the title XXI state plan to the joint legislative study committee on the integration of health care services. The study committee shall review the amendment and provide input on the amendment. Once the study committee reviews the amendment, the Arizona health care cost containment system administration shall submit the amendment to the federal health care financing administration to secure title XXI funding to reimburse qualifying health centers and hospitals that contract with the department of health services pursuant to sections 36-2907.06 and 36-2907.08, Arizona Revised Statutes.

C. On or before July 1, 2000, the Arizona health care cost containment system administration shall submit a direct service contracts amendment for waiver authorization to spend more than ten per cent of the monies for administration, outreach and direct services to the joint legislative study committee on the integration on health care services. The study committee shall review the amendment and provide input on the amendment. Once the study committee reviews the amendment, the Arizona health care cost containment system administration shall submit the amendment to the federal health care financing administration requesting waiver authorization to offer services through direct service contracts as an option to the services that

are provided to eligible children under title 36, chapter 29, article 4, Arizona Revised Statutes, as added by this act.

Sec. 20. Qualifying plans

A. A qualifying plan, as defined in section 36-2981, Arizona Revised Statutes, as added by this act, may elect to participate in the children's health insurance program established pursuant to title 36, chapter 29, article 4, Arizona Revised Statutes, as added by this act, subject to all requirements established in that article and in accordance with section 36-2989, subsection A, Arizona Revised Statutes, as added by this act.

B. The director of the Arizona health care cost containment system shall establish the terms and conditions that shall be used to exercise the option to participate.

Sec. 21. Tobacco lawsuit; use of settlement or compromise

A reasonable portion of any monies that this state receives from a judgement, settlement or compromise of any action or claim against tobacco companies, related parties, less litigation related expenses, shall be used to maintain existing proven health care programs.

Sec. 22. Appropriations; purpose; exemption

A. The sum of $5,000,000 is appropriated from the tobacco tax and health care fund medically needy account to the department of health services for fiscal year 1998-1999 for grants to contracting qualifying health centers pursuant to section 36-2907.06, subsection G, Arizona Revised Statutes.

B. The sum of $3,000,000 is appropriated from the tobacco tax and health care fund medically needy account to the department of health services for fiscal year 1998-1999 for grants to contracting hospitals pursuant to section 36-2907.08, subsection H, Arizona Revised Statutes.

C. The appropriations made in subsections A and B of this section shall be used for medical and health care services to children who are under nineteen years of age and have income at or below one hundred fifty per cent of the federal poverty level.

D. The appropriations made in subsections A and B of this section are exempt from the provisions of section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations.

Sec. 23. Direct service contracts; reporting

The director of the department of health services shall provide to the legislature the following information for services provided pursuant to sections 36-2907.06 and 36-2907.08, Arizona Revised Statutes:

1. The number of members served.

2. The number of encounters and the average cost for each encounter.

3. The number of services and the average cost for each service.

4. The actual year to date expenditures and projected annual expenditures.