REFERENCE TITLE: AHCCCS; hospital reimbursement

State of Arizona
Senate
Forty-eighth Legislature
Second Regular Session
2008

SB 1376

Introduced by
Senators O'Halleran: Allen

AN ACT

AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 36-2902.03 AND 36-2904.01; AMENDING SECTIONS 36-2903, 36-2903.01, 36-2904, 36-2912 AND 36-2986, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Title 36, chapter 29, article 1, Arizona Revised Statutes, is amended by adding section 36-2902.03, to read:

36-2902.03. Hospital reimbursement advisory council; membership; compensation; duties; report

A. THE HOSPITAL REIMBURSEMENT ADVISORY COUNCIL IS ESTABLISHED CONSISTING OF THE FOLLOWING MEMBERS:

1. THE DIRECTOR OR THE DIRECTOR'S DESIGNEE, WHO SHALL SERVE AS A NONVOTING MEMBER AND WHOSE PRESENCE IS NOT COUNTED TO DETERMINE THE PRESENCE OF A QUORUM.

2. SIX REPRESENTATIVES OF HOSPITALS IN THIS STATE WHO ARE APPOINTED BY THE DIRECTOR FROM A LIST SUBMITTED BY A NONPROFIT TRADE ORGANIZATION REPRESENTING HOSPITALS IN THIS STATE. FROM THIS LIST THE DIRECTOR SHALL APPOINT:

(a) ONE REPRESENTATIVE OF THE HOSPITAL THAT HAD THE GREATEST NUMBER OF SYSTEM PATIENT DAYS IN THE PRECEDING FISCAL YEAR AND THAT IS LOCATED IN A COUNTY WITH A POPULATION OF ONE MILLION OR MORE PERSONS.

(b) ONE REPRESENTATIVE OF THE HOSPITAL THAT HAD THE GREATEST NUMBER OF SYSTEM PATIENT DAYS IN THE PRECEDING FISCAL YEAR AND THAT IS LOCATED IN A COUNTY WITH A POPULATION OF LESS THAN ONE MILLION PERSONS BUT FIVE HUNDRED THOUSAND OR MORE PERSONS.

(c) ONE REPRESENTATIVE OF THE HOSPITAL THAT HAS MORE THAN ONE HUNDRED LICENSED BEDS AND THAT HAD THE HIGHEST RATIO OF SYSTEM PATIENT DAYS TO THE TOTAL NUMBER OF ALL PATIENT DAYS IN THE PRECEDING FISCAL YEAR.

(d) ONE REPRESENTATIVE OF THE HOSPITAL THAT HAD THE GREATEST NUMBER OF SYSTEM PATIENT DAYS DURING THE PRECEDING FISCAL YEAR AND THAT IS LOCATED IN A COUNTY WITH A POPULATION OF LESS THAN FIVE HUNDRED THOUSAND PERSONS.

(e) ONE REPRESENTATIVE OF EITHER A HOSPITAL THAT HAS ONE HUNDRED OR FEWER LICENSED BEDS AND THAT IS LOCATED IN A COUNTY WITH A POPULATION OF LESS THAN FIVE HUNDRED THOUSAND PERSONS OR A HOSPITAL THAT IS LICENSED AS A CRITICAL ACCESS HOSPITAL.

(f) ONE REPRESENTATIVE OF THE HOSPITAL THAT SPECIALIZES IN PEDIATRIC SERVICES AND THAT HAD THE GREATEST NUMBER OF SYSTEM PATIENT DAYS IN THE PRECEDING FISCAL YEAR.

3. SIX MEMBERS WHO REPRESENT INDIVIDUAL CONTRACTORS, AT LEAST ONE OF WHOM PROVIDES HEALTH CARE SERVICES TO MEMBERS IN A COUNTY WITH FEWER THAN FIVE HUNDRED THOUSAND PERSONS. THE DIRECTOR SHALL APPOINT THESE MEMBERS.

4. ONE MEMBER WHO IS AN ECONOMIST WITH EXPERTISE IN HEALTH CARE ECONOMICS AND PUBLIC AND PRIVATE HOSPITAL REIMBURSEMENT AND WHO IS FAMILIAR WITH THE HEALTH CARE MARKET IN THIS STATE. THE DIRECTOR SHALL APPOINT THIS MEMBER.

B. COUNCIL MEMBERS APPOINTED PURSUANT TO PARAGRAPHS 2 THROUGH 4 SHALL SERVE STAGGERED THREE-YEAR TERMS ENDING JUNE 30.

C. COUNCIL MEMBERS ARE NOT ELIGIBLE TO RECEIVE COMPENSATION BUT PUBLIC MEMBERS ARE ELIGIBLE FOR REIMBURSEMENT OF EXPENSES PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 2.

D. ON OR BEFORE SEPTEMBER 1, 2009, AND AT LEAST EVERY THREE YEARS THEREAFTER, THE COUNCIL SHALL EVALUATE THE INPATIENT AND OUTPATIENT HOSPITAL REIMBURSEMENT SYSTEM ESTABLISHED PURSUANT TO THIS ARTICLE AND ISSUES AFFECTING THE DELIVERY, AVAILABILITY AND COST OF HOSPITAL SERVICES IN THIS STATE. THE COUNCIL SHALL ENGAGE A CONSULTANT OR CONSULTANTS TO PERFORM EVALUATIONS PURSUANT TO THIS SUBSECTION AS NECESSARY. THE EVALUATION SHALL INCLUDE:

1. AN ANALYSIS OF THE RELATIONSHIP BETWEEN THE INPATIENT AND OUTPATIENT REIMBURSEMENT RATES AND PAYMENTS PROVIDED PURSUANT TO THIS ARTICLE, THE ACTUAL COSTS HOSPITALS INCUR IN TREATING PATIENTS ENROLLED PURSUANT TO THIS ARTICLE AND THE ADEQUACY OF THE RATES AND PAYMENTS TO COVER THOSE COSTS.

2. AN ANALYSIS OF CHANGES IN MEDICAL PRACTICE PATTERNS, TECHNOLOGY, WORKFORCE SUPPLY, POPULATION GROWTH, HOSPITAL UNCOMPENSATED CARE AND OTHER CHANGES IN THE HEALTH CARE MARKET AFFECTING THE COST AND DELIVERY OF HOSPITAL SERVICES IN THIS STATE.

3. AN ANALYSIS OF THE AVAILABILITY OF HEALTH CARE SERVICES TO MEMBERS AND MEMBERS' ACCESS TO HEALTH CARE SERVICES PROVIDED PURSUANT TO THIS ARTICLE.

4. THE EFFECT OF PAYMENT POLICIES ESTABLISHED PURSUANT TO THIS ARTICLE ON THE DELIVERY, AVAILABILITY AND COST OF HEALTH CARE SERVICES BOTH PROVIDED PURSUANT TO THIS ARTICLE AND PROVIDED OTHER THAN PURSUANT TO THIS ARTICLE, INCLUDING THE COST AND AVAILABILITY OF COMMERCIAL HEALTH INSURANCE IN THIS STATE.

E. ON OR BEFORE SEPTEMBER 1 OF EACH YEAR THAT AN EVALUATION IS REQUIRED PURSUANT TO SUBSECTION D, THE COUNCIL SHALL SUBMIT A REPORT OF ITS FINDINGS AND RECOMMENDATIONS TO THE GOVERNOR, THE PRESIDENT OF THE SENATE, THE SPEAKER OF THE HOUSE OF REPRESENTATIVES, THE CHAIRPERSON OF THE JOINT LEGISLATIVE BUDGET COMMITTEE AND THE CHAIRPERSONS OF THE HOUSE AND SENATE HEALTH COMMITTEES. THE COUNCIL SHALL PROVIDE A COPY OF EACH REPORT TO THE SECRETARY OF STATE AND THE DIRECTOR OF THE ARIZONA STATE LIBRARY, ARCHIVES AND PUBLIC RECORDS.

F. THE COUNCIL SHALL MEET AT LEAST TWICE EACH YEAR TO REVIEW ISSUES RELATED TO THE RATES AND PAYMENTS FOR, AS WELL AS THE DELIVERY, AVAILABILITY AND COST OF, HOSPITAL SERVICES PROVIDED PURSUANT TO THIS ARTICLE AND MAKE RECOMMENDATIONS TO THE DIRECTOR AS NECESSARY.

G. AT ITS FIRST MEETING EACH YEAR, THE COUNCIL SHALL ELECT A CHAIRPERSON FROM ITS VOTING MEMBERS.

Sec. 2. Section 36-2903, Arizona Revised Statutes, is amended to read:

36-2903. Arizona health care cost containment system; administrator; powers and duties of director and administrator; exemption from attorney general representation; definition

A. The Arizona health care cost containment system is established consisting of contracts with contractors for the provision of hospitalization and medical care coverage to members. Except as specifically required by federal law and by section 36-2909, the system is only responsible for providing care on or after the date that the person has been determined eligible for the system, and is only responsible for reimbursing the cost of care rendered on or after the date that the person was determined eligible for the system.

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

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

2. Contract administration and oversight of contractors, including certification instead of licensure for title XVIII and title XIX purposes.

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

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

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

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

7. Development and management of a contractor payment system.

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

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

10. Coordination of benefits provided under this article to any member. The administrator 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.

11. Development of a health education and information program.

12. Development and management of an enrollment system.

13. Establishment and maintenance of a claims resolution procedure to ensure that ninety per cent of the clean claims SUBMITTED BY HOSPITALS AND NINETY PER CENT OF THE CLEAN CLAIMS FROM PHYSICIANS AND OTHER PROVIDERS shall be paid within thirty days of receipt, ~~and~~ THAT ninety-nine per cent of the remaining clean claims SUBMITTED BY HOSPITALS AND NINETY-NINE PER CENT OF THE REMAINING CLEAN CLAIMS FROM PHYSICIANS AND OTHER PROVIDERS shall be paid within ninety days of receipt AND THAT THE TIMELY PAYMENT STANDARDS PRESCRIBED PURSUANT TO SECTION 36-2904.01 ARE SATISFIED. For the purposes of this paragraph, "clean claims" has the same meaning ~~as~~ prescribed in section ~~36-2904, subsection G~~ 36-2904.01, SUBSECTION Q.

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

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

16. Establishment of an employee recognition fund.

17. Establishment of an eligibility process to determine whether a medicare low income subsidy is available to persons who want to apply for a subsidy as authorized by title XVIII.

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

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

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

F. Except for reinsurance obtained by contractors, the administrator shall coordinate benefits provided under this article to any eligible person

who is covered by workers' compensation, disability insurance, a hospital and medical service corporation, a health care services organization, an accountable health plan or any other health or medical or disability insurance plan, including coverage made available to persons defined as eligible by section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e), or who receives payments for accident-related injuries, so that any costs for hospitalization and medical care paid by the system are recovered from any other available third party payors. The administrator 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 system shall act as payor of last resort for persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2974 or section 36-2981, paragraph 6 unless specifically prohibited by federal law. By operation of law, eligible persons assign to the system and a county rights to all types of medical benefits to which the person is entitled, including first party medical benefits under automobile insurance policies based on the order of priorities established pursuant to section 36-2915. The state has a right to subrogation against any other person or firm to enforce the assignment of medical benefits. ~~The provisions of~~ This subsection ~~are~~ IS controlling over the provisions of any insurance policy that provides benefits to an eligible person if the policy is inconsistent with ~~the provisions of~~ this subsection.

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

H. 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 administrator and the director subject to subsection I of this section and that such records be maintained by the contractor for five years. The director shall also require that these records be made available by a contractor on request of the secretary of the United States department of health and human services, or its successor agency.

I. 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 such information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other provision of law, such rules shall be designed to provide for the exchange of necessary information among the counties, the administration and the department of economic security for the purposes of eligibility determination under this article. Notwithstanding any law to the contrary, a member's medical record shall be released without the member's consent in situations or suspected cases of fraud or abuse relating to the system to an officer of the state's certified Arizona health care cost

containment system fraud control unit who has submitted a written request for the medical record.

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

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

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

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

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

M. As a condition of the contract with any contractor, the director shall require contract terms as necessary in the judgment of the director to ensure adequate performance and compliance with all applicable federal laws by the contractor of the provisions of each contract executed pursuant to this chapter. Contract provisions required by the director shall include at a minimum 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 that have posted other security, equal to or greater than that required by the system, with a state agency for the performance of health service contracts if funds would be available from such security for the system on default by the contractor. The director may also adopt rules for the withholding or forfeiture of payments to be made to a contractor by the system for the failure of the contractor to comply with a provision of the contractor's contract with the system or with the adopted rules. 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 accomplish the orderly transition of those members to other system 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 and provides 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.

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

O. Notwithstanding subsection F of this section, if the administration determines that according to federal guidelines it is more cost-effective for a person defined as eligible under section 36-2901, paragraph 6, subdivision (a) to be enrolled in a group health insurance plan in which the person is entitled to be enrolled, the administration may pay all of that person's premiums, deductibles, coinsurance and other cost sharing obligations for services covered under section 36-2907. The person shall apply for enrollment in the group health insurance plan as a condition of eligibility under section 36-2901, paragraph 6, subdivision (a).

P. The total amount of state monies that may be spent in any fiscal year by the administration for health care shall not exceed the amount appropriated or authorized by section 35-173 for all health care purposes. 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.

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

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

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

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

4. The administration, after collaboration with the department of health services regarding quality improvement activities, may prohibit the contractors and program contractors from receiving certain test results if the administration determines that a serious potential exists that the results may be used for purposes other than those intended for the quality improvement activities. The department of health services shall consult with

the clinical laboratory licensure advisory committee established by section 36-465 before providing recommendations to the administration on certain test results and quality improvement activities.

5. The administration shall provide contracted laboratories and the department of health services with an annual report listing the quality improvement activities that will require laboratory data. The report shall be updated and distributed to the contracting laboratories and the department of health services when laboratory data is needed for new quality improvement activities.

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

R. For the purposes of this section, "quality improvement activities" means those requirements, including health care outcome studies specified in federal law or required by the centers for medicare and medicaid services or the administration, to improve health care outcomes.

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

36-2903.01. Additional powers and duties; report

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

B. The director shall:

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

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

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

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

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

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

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

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

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

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

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

4. By rule establish a procedure and time frames for the intake of grievances and requests for hearings, for the continuation of benefits and services during the appeal process and for a grievance process at the contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and 41-1092.05, the administration shall develop rules to establish the procedure and time frame for the informal resolution of grievances and appeals. A grievance that is not related to a claim for payment of system covered services shall be filed in writing with and received by the administration or the prepaid capitated provider or program contractor not later than sixty days after the date of the adverse action, decision or policy implementation being grieved. A grievance that is related to a claim for payment of system covered services must be filed in writing and received by the administration or the prepaid capitated provider or program contractor within twelve months after the date of service, within twelve months after the date that eligibility is posted or within sixty days after the date of the denial of a timely claim submission, whichever is later. A grievance for the denial of a claim for reimbursement of services may contest the validity of any adverse action, decision, policy implementation or rule that related to or resulted in the full or partial denial of the claim. A policy implementation may be subject to a grievance procedure, but it may not be appealed for a hearing. The administration is not required to participate in a mandatory

settlement conference if it is not a real party in interest. In any proceeding before the administration, including a grievance or hearing, persons may represent themselves or be represented by a duly authorized agent who is not charging a fee. A legal entity may be represented by an officer, partner or employee who is specifically authorized by the legal entity to represent it in the particular proceeding.

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

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

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

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

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

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

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

4. Notwithstanding any other law, require persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2931, paragraph 5

and section 36-2981, paragraph 6 to be financially responsible for any cost sharing requirements established in a state plan or a section 1115 waiver and approved by the centers for medicare and medicaid services. Cost sharing requirements may include copayments, coinsurance, deductibles, enrollment fees and monthly premiums for enrolled members, including households with children enrolled in the Arizona long-term care system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. For inpatient hospital stays, the administration shall use a prospective tiered per diem methodology, using hospital peer groups if analysis shows that cost differences can be attributed to independently definable features that hospitals within a peer group share. In peer grouping the administration may consider such factors as length of stay differences and labor market variations. If there are no cost differences, the administration shall implement a stop loss-stop gain or similar mechanism. Any stop loss-stop gain or similar mechanism shall ensure that the tiered per diem rates assigned to a hospital do not represent less than ninety per cent of its 1990 base year costs or more than one hundred ten per cent of its 1990 base year costs, adjusted by an audit factor, during the period of March 1, 1993 through September 30, 1994. The tiered per diem rates set for hospitals shall represent no less than eighty-seven and one-half per cent or more than one hundred twelve and one-half per cent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1994 through September 30, 1995 and no less than eighty-five per cent or more than one hundred fifteen per cent of its 1990 base year costs, adjusted by an audit factor, from October 1, 1995 through September 30, 1996. For the periods after September 30, 1996 no stop loss-stop gain or similar mechanisms shall be in effect. An adjustment in the stop loss-stop gain percentage may be made to ensure that total payments do not increase as a result of this provision. If peer groups are used the administration shall establish initial peer group designations for each hospital before implementation of the per diem system. The administration may also use a negotiated rate methodology. The tiered per diem methodology may include separate consideration for specialty hospitals that limit their provision of services

to specific patient populations, such as rehabilitative patients or children. The initial per diem rates shall be based on hospital claims and encounter data for dates of service November 1, 1990 through October 31, 1991 and processed through May of 1992.

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

3. Through June 30, 2004, for outpatient hospital services, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to the covered charges. Beginning on July 1, 2004 through June 30, 2005, the administration shall reimburse a hospital by applying a hospital specific outpatient cost-to-charge ratio to covered charges. If the hospital increases its charges for outpatient services filed with the Arizona department of health services pursuant to chapter 4, article 3 of this title, by more than 4.7 per cent for dates of service effective on or after July 1, 2004, the hospital specific cost-to-charge ratio will be reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7 per cent, the effective date of the increased charges will be the effective date of the adjusted Arizona health care cost containment system cost-to-charge ratio. The administration shall develop the methodology for a capped fee-for-service schedule and a statewide cost-to-charge ratio. Any covered outpatient service not included in the capped fee-for-service schedule shall be reimbursed by applying the statewide cost-to-charge ratio that is based on the services not included in the capped fee-for-service schedule. Beginning on July 1, 2005, the administration shall reimburse clean claims with dates of service on or after July 1, 2005, based on the capped fee-for-service schedule or the statewide cost-to-charge ratio established pursuant to this paragraph. The administration may make additional adjustments to the outpatient hospital rates established pursuant to this section based on other factors, including the number of beds in the hospital, specialty services available to patients and the geographic location of the hospital.

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

(a) An admission face sheet.

(b) An itemized statement.

(c) An admission history and physical.

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

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

(f) Operative reports, if applicable.

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

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

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

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

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

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

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

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

8. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the prospective payment of inpatient hospital capital related costs. The capital payment shall include hospital specific and statewide average amounts. For tiered per diem rates beginning on October 1, 1999, the capital related cost component is frozen at

the blended rate of forty per cent of the hospital specific capital cost and sixty per cent of the statewide average capital cost in effect as of January 1, 1999 and as further adjusted by the calculation of tier rates for maternity and nursery as prescribed by law. The administration shall adjust the capital related cost component by the data resources incorporated market basket index for prospective payment system hospitals.

9. For graduate medical education programs:

(a) Beginning September 30, 1997, the administration shall establish a separate graduate medical education program to reimburse hospitals that had graduate medical education programs that were approved by the administration as of October 1, 1999. The administration shall separately account for monies for the graduate medical education program based on the total reimbursement for graduate medical education reimbursed to hospitals by the system in federal fiscal year 1995-1996 pursuant to the tiered per diem methodology specified in this section. The graduate medical education program reimbursement shall be adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement. Subject to legislative appropriation, on an annual basis, each qualified hospital shall receive a single payment from the graduate medical education program that is equal to the same percentage of graduate medical education reimbursement that was paid by the system in federal fiscal year 1995-1996. Any reimbursement for graduate medical education made by the administration shall not be subject to future settlements or appeals by the hospitals to the administration. The monies available under this subdivision shall not exceed the fiscal year 2005-2006 appropriation adjusted annually by the increase or decrease in the index published by the global insight hospital market basket index for prospective hospital reimbursement, except for monies distributed for expansions pursuant to subdivision (b) of this paragraph.

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

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

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

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

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

(ii) For a portion of additional indirect graduate medical education costs for programs that are located in a county with a population of less than five hundred thousand persons at the time the residency position was created or for a residency position that includes a rotation in a county with a population of less than five hundred thousand persons at the time the residency position was established. These programs must be approved by the administration.

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

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

(f) Beginning July 1, 2007, local, county and tribal governments may provide monies in addition to any state general fund monies appropriated for graduate medical education in order to qualify for additional matching federal monies for programs or positions in a specific locality or at a specific institution. These programs and positions must be approved by the administration. The administration shall report to the president of the senate, the speaker of the house of representatives and the director of the joint legislative budget committee on or before July 1 of each year on the amount of money contributed and number of residency positions funded by local, county and tribal governments, including the amount of federal matching monies used.

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

(h) For the purposes of this paragraph, "graduate medical education program" means a program, including an approved fellowship, that prepares a physician for the independent practice of medicine by providing didactic and

clinical education in a medical discipline to a medical student who has completed a recognized undergraduate medical education program.

10. The prospective tiered per diem payment methodology for inpatient hospital services shall include a mechanism for the payment of claims with extraordinary operating costs per day. For tiered per diem rates effective beginning on October 1, 1999, outlier cost thresholds are frozen at the levels in effect on January 1, 1999 and adjusted annually by the administration by the global insight hospital market basket index for prospective payment system hospitals. Beginning with dates of service on or after October 1, 2007, the administration shall phase in the use of the most recent statewide urban and statewide rural average medicare cost-to-charge ratios or centers for medicare and medicaid services approved cost-to-charge ratios to qualify and pay extraordinary operating costs. Cost-to-charge ratios shall be updated annually. Routine maternity charges are not eligible for outlier reimbursement. The administration shall complete full implementation of the phase-in on or before October 1, 2009.

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

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

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

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

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

2. The percentage of third party payments that is collected by a contractor or noncontracting provider and that the contractor or noncontracting provider may keep and the percentage of such payments that the

contractor or noncontracting provider may be required to pay to the administration. Contractors and noncontracting providers must pay to the administration one hundred per cent of all third party payments that are collected and that duplicate administration fee-for-service payments. A contractor that contracts with the administration pursuant to section 36-2904, subsection A may be entitled to retain a percentage of third party payments if the payments collected and retained by a contractor are reflected in reduced capitation rates. A contractor may be required to pay the administration a percentage of third party payments that are collected by a contractor and that are not reflected in reduced capitation rates.

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

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

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

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

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

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

3. If the administration determines that a provider that has a contract with a contractor or noncontracting provider has billed a member for charges that were paid or should have been paid by the administration, the administration shall send written notification by certified mail or other service with proof of delivery to the provider that has a contract with a contractor or noncontracting provider stating that this billing is in violation of federal and state law. If, twenty-one days or more after receiving the notification, a provider that has a contract with a contractor or noncontracting provider knowingly continues billing a member for charges that were paid or should have been paid by the system, the administration may

assess a civil penalty in an amount equal to three times the amount of the billing and reduce payment to the provider that has a contract with a contractor or noncontracting provider accordingly. Receipt of delivery signed by the addressee or the addressee's employee is prima facie evidence of knowledge. Civil penalties collected pursuant to this subsection shall be deposited in the state general fund. Section 36-2918, subsections C, D and F, relating to the imposition, collection and enforcement of civil penalties, apply to civil penalties imposed pursuant to this paragraph.

M. The administration may conduct postpayment review of all claims paid by the administration and may recoup any monies erroneously paid. The director may adopt rules that specify procedures for conducting postpayment review. A contractor may conduct a postpayment review of all claims paid by the contractor and may recoup monies that are erroneously paid, PROVIDED THAT, EXCEPT IN CASES OF FRAUD, A CONTRACTOR SHALL NOT ADJUST OR REQUEST RECOUPMENT OF ANY PAYMENT MORE THAN TWELVE MONTHS AFTER THE CLAIM WAS ORIGINALLY PAID. IF THE CONTRACTOR AND THE HOSPITAL AGREE BY CONTRACT ON A LENGTH OF TIME TO ADJUST OR REQUEST ADJUSTMENT OF THE PAYMENT OF A CLAIM, THE CONTRACTOR AND HOSPITAL MUST EACH HAVE THE SAME LENGTH OF TIME TO ADJUST OR REQUEST THE ADJUSTMENT. EXCEPT AS PROVIDED IN SECTION 36-2904.01, SUBSECTION E, PARAGRAPH 2 AND SUBJECT TO ANY PERIOD OF APPEAL, IF A CLAIM IS ADJUSTED NEITHER THE CONTRACTOR NOR THE HOSPITAL OWES INTEREST ON THE OVERPAYMENT OR UNDERPAYMENT RESULTING FROM THE ADJUSTMENT IF THE ADJUSTED PAYMENT IS MADE OR RECOUPMENT IS TAKEN WITHIN THIRTY DAYS AFTER THE DATE OF THE CLAIM ADJUSTMENT.

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

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

P. Notwithstanding any other law, on federal approval the administration may make disproportionate share payments to private hospitals, county operated hospitals, including hospitals owned or leased by a special health care district, and state operated institutions for mental disease beginning October 1, 1991 in accordance with federal law and subject to legislative appropriation. If at any time the administration receives written notification from federal authorities of any change or difference in the actual or estimated amount of federal funds available for disproportionate share payments from the amount reflected in the legislative appropriation for such purposes, the administration shall provide written notification of such change or difference to the president and the minority leader of the senate, the speaker and the minority leader of the house of representatives, the director of the joint legislative budget committee, the legislative committee of reference and any hospital trade association within this state, within three working days not including weekends after receipt of

the notice of the change or difference. In calculating disproportionate share payments as prescribed in this section, the administration may use either a methodology based on claims and encounter data that is submitted to the administration from contractors or a methodology based on data that is reported to the administration by private hospitals and state operated institutions for mental disease. The selected methodology applies to all private hospitals and state operated institutions for mental disease qualifying for disproportionate share payments.

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

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

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

Sec. 4. Section 36-2904, Arizona Revised Statutes, is amended to read:

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

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

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

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

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

1. Pay noncontracting providers for health and medical services, other than hospital services, on a capped fee-for-service basis for members and persons who are determined eligible. However, the state shall not pay any

amount for services that exceeds a maximum amount set forth in a capped fee-for-service schedule adopted by the administration.

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

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

C. Payments to contractors shall be made monthly or quarterly and may be subject to contract provisions requiring the retention of a specified percentage of the payment by the director, a reserve fund or 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 funds withheld from contractors shall be distributed to contractors 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 fund.

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

E. For a member defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a), item (v) the director shall enroll the member with an available contractor located in the geographic area of the member's residence. The member may select a primary care physician or primary care practitioner from among the primary care physicians or primary care practitioners participating in the contract in which the member is enrolled. The system shall only provide reimbursement for health or medical 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. The director shall establish requirements as to the

minimum time period that a member is assigned to specific contractors in the system.

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

G. The administration shall not pay claims for system covered services that are initially ~~submitted~~ RECEIVED more than six months after the date of the service for which payment is claimed or after the date that eligibility is posted OR THREE MONTHS AFTER A PRIMARY PAYOR INITIALLY DENIES OR PAYS A CLAIM, whichever date is later, or that are ~~submitted~~ RECEIVED as clean claims more than twelve months after the date of service for which payment is claimed or after the date that eligibility is posted OR FIFTEEN MONTHS AFTER A PRIMARY PAYOR INITIALLY DENIES OR PAYS A CLAIM, whichever date is later, except for claims submitted for reinsurance pursuant to section 36-2906, subsection C, paragraph 6. The administration shall not pay claims for system covered services that are ~~submitted~~ RECEIVED by contractors for reinsurance after the time period specified in the contract. The director ~~may~~ SHALL adopt rules ~~or~~ AND require contractual provisions that prescribe requirements and time limits for submittal of and payment for those claims PURSUANT TO SECTION 36-2904.01. Notwithstanding any other provision of this article, if a claim that gives rise to a contractor's claim for reinsurance or deferred liability is the subject of an administrative grievance or appeal proceeding or other legal action, the contractor shall have at least sixty days after an ultimate decision is rendered to submit a claim for reinsurance or deferred liability. Contractors that contract with the administration pursuant to subsection A of this section shall not pay claims for system covered services that are initially ~~submitted~~ RECEIVED more than six months after the date of the service for which payment is claimed or after the date that eligibility is posted OR THREE MONTHS AFTER A PRIMARY PAYOR INITIALLY DENIES OR PAYS A CLAIM, whichever date is later, or that are ~~submitted~~ RECEIVED as clean claims more than twelve months after the date of the service for which payment is claimed or after the date that eligibility is posted OR THREE MONTHS AFTER A PRIMARY PAYOR INITIALLY DENIES OR PAYS A CLAIM, whichever date is later. For the purposes of this subsection~~:~~ "CLEAN CLAIMS", "DATE OF SERVICE" AND "RECEIVED" HAVE THE SAME MEANINGS PRESCRIBED IN SECTION 36-2904.01.

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

~~under investigation for fraud or abuse or claims under review for medical necessity.~~

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

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

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

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

1. The director shall require any contractor to reimburse hospitals for services provided under this article based on reimbursement levels that do not in the aggregate exceed those established pursuant to section 36-2903.01, NOT INCLUDING ANY PENALTY OR INTEREST PAYMENTS THAT ARE REQUIRED PURSUANT TO SECTION 36-2904.01, SUBSECTION E, and under terms on which the contractor and the hospital agree. However, a hospital and a contractor may agree on a different payment methodology than the methodology prescribed by the director pursuant to section 36-2903.01. The director by rule shall prescribe:

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

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

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

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

~~(i) An admission face sheet.~~

~~(ii) An itemized statement.~~

~~(iii) An admission history and physical.~~

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

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

~~(vi) Operative reports, if applicable.~~

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

(c) THAT PAYMENTS TO A HOSPITAL FROM A CONTRACTOR WILL BE MADE PURSUANT TO THE TIMELY PAY PROVISIONS OF SECTION 36-2904.01.

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

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

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

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

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

(e) THAT IF A CONTRACTOR ENGAGES IN PAYMENT PRACTICES IN VIOLATION OF SECTION 36-2904.01, IT IS SUBJECT TO THE PENALTIES PRESCRIBED IN THAT SECTION.

2. IF A CONTRACTOR AND A HOSPITAL DO NOT AGREE ON REIMBURSEMENT LEVELS AND TERMS AS REQUIRED BY THIS SUBSECTION, THE REIMBURSEMENT LEVELS ESTABLISHED PURSUANT TO SECTION 36-2903.01 AND THE TIMELY PAY PROVISIONS ESTABLISHED PURSUANT TO SECTION 36-2904.01 APPLY.

~~2.~~ 3. In any county having a population of five hundred thousand or fewer persons, a hospital that executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services

pursuant to this article shall offer a subcontract to any other provider providing services to that portion of the county and to any other person that plans to become a provider in that portion of the county. If a hospital executes a subcontract other than a capitation contract with a provider for the provision of hospital and medical services pursuant to this article, the hospital shall adopt uniform criteria to govern the reimbursement levels paid by all providers with whom the hospital executes a subcontract.

J. If there is an insufficient number of, or an inadequate member capacity in, contracts awarded to contractors, the director, in order to deliver covered services to members enrolled or expected to be enrolled in the system within a county, may negotiate and award, without bid, a contract with a health care services organization holding a certificate of authority pursuant to title 20, chapter 4, article 9. The director shall require a health care services organization contracting under this subsection to comply with section 36-2906.01. The term of the contract shall not extend beyond the next bid and contract award process as provided in section 36-2906 and shall be no greater than capitation rates paid to contractors in the same county or counties pursuant to section 36-2906. Contracts awarded pursuant to this subsection are exempt from the requirements of title 41, chapter 23.

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

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

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

N. The director shall prepare a report that represents a statistically valid sample and that indicates the number of children age two by contractor who received the immunizations recommended by the national centers for

disease control and prevention while enrolled as members. The report shall indicate each type of immunization and the number and percentage of enrolled children in the sample age two who received each type of immunization. The report shall be done by contract year and shall be delivered to the governor, the president of the senate and the speaker of the house of representatives no later than April 1, 2004 and every second year thereafter.

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

O. THE ADMINISTRATION SHALL IMPLEMENT AN ELECTRONIC CLAIMS SUBMISSION SYSTEM AND SHALL REQUIRE ANY CONTRACTOR TO BE ABLE TO RECEIVE ELECTRONIC CLAIMS FROM HOSPITALS.

Sec. 5. Title 36, chapter 29, article 1, Arizona Revised Statutes, is amended by adding section 36-2904.01, to read:

36-2904.01. Claims; timely payment; civil penalties; definitions

A. EXCEPT AS PROVIDED IN SUBSECTION B OF THIS SECTION, NOT LATER THAN THIRTY DAYS AFTER A CLAIM IS RECEIVED BY THE CONTRACTOR THE CONTRACTOR SHALL DETERMINE IF THE CLAIM IS PAYABLE. IF THE CONTRACTOR DETERMINES THAT THE ENTIRE CLAIM IS PAYABLE, THE CONTRACTOR SHALL PAY THE AMOUNT OWED NOT LATER THAN THIRTY DAYS AFTER A CLAIM IS RECEIVED BY THE CONTRACTOR. IF THE CONTRACTOR DETERMINES THAT A PORTION OF THE CLAIM IS PAYABLE, THE CONTRACTOR SHALL PAY THE PORTION OF THE AMOUNT OWED THAT IS NOT IN DISPUTE AND NOTIFY THE HOSPITAL THROUGH A REMITTANCE DOCUMENT THE SPECIFIC REASON THE REMAINING PORTION OF THE AMOUNT OWED WILL NOT BE PAID NOT LATER THAN THIRTY DAYS AFTER A CLAIM IS RECEIVED BY THE CONTRACTOR. IF THE CONTRACTOR DETERMINES THAT THE CLAIM IS NOT PAYABLE, THE CONTRACTOR SHALL NOTIFY THE HOSPITAL THROUGH A REMITTANCE DOCUMENT OF THE SPECIFIC REASON THE AMOUNT OWED WILL NOT BE PAID NOT LATER THAN THIRTY DAYS AFTER A CLAIM IS RECEIVED BY THE CONTRACTOR.

B. IF AFTER RECEIVING A CLEAN CLAIM A CONTRACTOR NEEDS ADDITIONAL INFORMATION FROM THE BILLING HOSPITAL TO DETERMINE IF A CLAIM IS PAYABLE, THE CONTRACTOR, NOT LATER THAN THE THIRTIETH DAY AFTER THE CONTRACTOR RECEIVES A CLAIM, SHALL REQUEST IN WRITING THAT THE HOSPITAL PROVIDE THE NECESSARY ADDITIONAL INFORMATION. THE REQUEST FOR ADDITIONAL INFORMATION MUST DESCRIBE WITH SPECIFICITY THE CLINICAL INFORMATION REQUESTED, MUST REQUEST ONLY INFORMATION THE CONTRACTOR CAN DEMONSTRATE IS RELEVANT AND NECESSARY TO THE PAYMENT DETERMINATION OF THE SPECIFIC CLAIM AND MAY NOT REQUEST INFORMATION ALREADY AVAILABLE TO THE CONTRACTOR. A HOSPITAL IS NOT REQUIRED TO PROVIDE ADDITIONAL INFORMATION THAT IS NOT CONTAINED IN, OR IS NOT IN THE PROCESS OF BEING INCORPORATED INTO, THE PATIENT'S MEDICAL OR BILLING RECORD MAINTAINED BY THE HOSPITAL. A HOSPITAL IS NOT REQUIRED TO PROVIDE ADDITIONAL INFORMATION IN ANY NONELECTRONIC FORMAT IF THE HOSPITAL PROVIDES THE CONTRACTOR WITH ACCESS TO THE HOSPITAL'S ELECTRONIC MEDICAL OR BILLING RECORDS IN ACCORDANCE WITH THE TERMS OF AN INFORMATION ACCESS AGREEMENT

BETWEEN THE HOSPITAL AND THE CONTRACTOR. A CONTRACTOR THAT REQUESTS ADDITIONAL INFORMATION UNDER THIS SUBSECTION SHALL DETERMINE ON OR BEFORE THE FIFTEENTH CALENDAR DAY AFTER RECEIVING THE ADDITIONAL INFORMATION WHETHER THE CLAIM IS PAYABLE AND EITHER PAY THE CLAIM OR NOTIFY THE HOSPITAL IN WRITING WHY THE CLAIM WILL NOT BE PAID. IF A CONTRACTOR REQUESTS ADDITIONAL INFORMATION FROM A PERSON OR ENTITY OTHER THAN THE HOSPITAL THAT SUBMITTED THE CLAIM, THE CONTRACTOR SHALL PROVIDE TO THE HOSPITAL THAT SUBMITTED THE CLAIM WRITTEN NOTICE CONTAINING THE NAME OF THE PERSON OR ENTITY. THE CONTRACTOR MAY NOT WITHHOLD PAYMENT PENDING RECEIPT OF ANY ADDITIONAL INFORMATION REQUESTED UNDER THIS SUBSECTION. IF ON RECEIVING ADDITIONAL INFORMATION REQUESTED UNDER THIS SUBSECTION THE CONTRACTOR DETERMINES THAT THERE WAS AN ERROR IN PAYMENT OF THE CLAIM, THE CONTRACTOR MAY RECOVER ANY OVERPAYMENT PURSUANT TO SECTION 36-2903.01, SUBSECTION M. A CONTRACTOR MAY NOT MAKE MORE THAN ONE REQUEST FOR ADDITIONAL INFORMATION UNDER THIS SUBSECTION IN CONNECTION WITH A CLAIM. IF A CONTRACTOR HAS RECEIVED THE ADDITIONAL INFORMATION REQUESTED IN CONNECTION WITH A CLAIM, A HOSPITAL IS NOT REQUIRED TO PROVIDE THIS ADDITIONAL INFORMATION A SECOND TIME IF THE CONTRACTOR REPORTS THAT THE ADDITIONAL INFORMATION IS LOST, REGARDLESS OF THE FAULT OF THE CONTRACTOR IN THAT LOSS, IF THE HOSPITAL HAS DOCUMENTATION DEMONSTRATING THAT THE INFORMATION WAS SENT PREVIOUSLY. IF SUCH ADDITIONAL INFORMATION IS REPORTED LOST BY THE CONTRACTOR, THE ADDITIONAL INFORMATION IS PRESUMED TO HAVE BEEN FAVORABLE TO THE CLAIM SUBMITTED BY THE HOSPITAL.

C. A CLAIM IS CONSIDERED TO HAVE BEEN PAID ON THE DATE PAYMENT IS RECEIVED BY THE HOSPITAL.

D. A CONTRACTOR ON WRITTEN REQUEST OF A HOSPITAL SHALL PROVIDE THE HOSPITAL WITH COPIES OF ALL APPLICABLE UTILIZATION REVIEW POLICIES, ALL CLAIM PROCESSING POLICIES OR PROCEDURES AND ALL OTHER INFORMATION USED BY CONTRACTOR IN PROCESSING SPECIFIC CLAIMS FOR PAYMENT. THIS INFORMATION SHALL:

1. USE NATIONALLY RECOGNIZED AND GENERALLY ACCEPTED CURRENT PROCEDURAL TERMINOLOGY CODES, NOTES AND GUIDELINES, INCLUDING ALL RELEVANT MODIFIERS.

2. BE CONSISTENT WITH NATIONALLY RECOGNIZED AND GENERALLY ACCEPTED BUNDLING EDITS AND LOGIC.

3. INCLUDE A LEVEL OF DETAIL SUFFICIENT TO ENABLE A REASONABLE PERSON WITH SUFFICIENT TRAINING, EXPERIENCE AND COMPETENCE IN CLAIMS PROCESSING TO DETERMINE WHETHER THE CONTRACTOR PAID THE FULL AMOUNT OWED.

4. BE CONSISTENT WITH THE TERMS OF THE CONTRACTOR'S PREPAID CAPITATED CONTRACT WITH THE ADMINISTRATION, THE ADMINISTRATION'S POLICIES AND PROCEDURES THAT APPLY TO CONTRACTORS AND THE CONTRACTOR'S POLICIES AND PROCEDURES SUBMITTED TO AND APPROVED BY THE ADMINISTRATION.

E. IF A CLEAN CLAIM IS PAYABLE BUT THE CONTRACTOR DOES NOT PAY THE FULL AMOUNT OWED WITHIN THIRTY DAYS AFTER THE CLAIM IS RECEIVED, THE CONTRACTOR SHALL PAY A CIVIL PENALTY AS FOLLOWS:

1. IF THE CONTRACTOR PAYS THE FULL AMOUNT OWED AND MAKES THE PAYMENT AFTER THE THIRTIETH DAY AND ON OR BEFORE THE SIXTIETH DAY FOLLOWING THE DATE

THE CLAIM WAS RECEIVED, THE CONTRACTOR SHALL PAY THE HOSPITAL THE AMOUNT OWED, PLUS A PENALTY OF TEN PER CENT OF THE AMOUNT OWED. IF THE CONTRACTOR MAKES THE PAYMENT AFTER THE SIXTIETH DAY AND ON OR BEFORE THE NINETIETH DAY FOLLOWING THE DATE THE CLAIM WAS RECEIVED, THE CONTRACTOR SHALL PAY THE HOSPITAL THE AMOUNT OWED, PLUS A PENALTY OF TWENTY-FIVE PER CENT OF THE AMOUNT OWED. IF THE CONTRACTOR MAKES THE PAYMENT AFTER THE NINETIETH DAY AND ON OR BEFORE THE ONE HUNDRED TWENTIETH DAY FOLLOWING THE DATE THE CLAIM WAS RECEIVED, THE CONTRACTOR SHALL PAY THE HOSPITAL THE AMOUNT OWED, PLUS A PENALTY OF FIFTY PER CENT OF THE AMOUNT OWED.

2. IF THE CONTRACTOR PAYS ONLY A PORTION OF THE AMOUNT OWED AND MAKES THE BALANCE OF THE PAYMENT AFTER THE THIRTIETH DAY AND ON OR BEFORE THE SIXTIETH DAY FOLLOWING THE DATE THE CLAIM WAS RECEIVED, THE CONTRACTOR SHALL PAY THE HOSPITAL A PENALTY OF TEN PER CENT OF THE AMOUNT OWED THAT WAS NOT TIMELY PAID. IF THE CONTRACTOR MAKES THE BALANCE OF THE PAYMENT AFTER THE SIXTIETH DAY AND ON OR BEFORE THE NINETIETH DAY AFTER THE DATE THE CLAIM WAS RECEIVED, THE CONTRACTOR SHALL PAY THE HOSPITAL A PENALTY OF TWENTY-FIVE PER CENT OF THE AMOUNT OWED THAT WAS NOT TIMELY PAID. IF THE CONTRACTOR MAKES THE BALANCE OF THE PAYMENT AFTER THE NINETIETH DAY AND ON OR BEFORE THE ONE HUNDRED TWENTIETH DAY AFTER THE DATE THE CLAIM WAS RECEIVED, THE CONTRACTOR SHALL PAY THE HOSPITAL A PENALTY OF FIFTY PER CENT OF THE AMOUNT OWED THAT WAS NOT TIMELY PAID.

3. IF THE CONTRACTOR PAYS THE AMOUNT OWED OR THE BALANCE OF THE AMOUNT OWED ON A CLAIM AFTER THE ONE HUNDRED TWENTIETH DAY AFTER THE DATE THE CLAIM WAS RECEIVED, THE CONTRACTOR SHALL PAY THE PENALTY ON THE BALANCE OF THE AMOUNT OWED OF FIFTY PER CENT AND EIGHTEEN PER CENT ANNUAL INTEREST ON THE BALANCE OF THE AMOUNT OWED. INTEREST ACCRUES BEGINNING ON THE DATE THE CONTRACTOR WAS REQUIRED TO PAY THE AMOUNT OWED AND ENDING ON THE DATE THE FULL AMOUNT OWED AND THE PENALTY ARE PAID IN FULL.

F. A CONTRACTOR IS NOT LIABLE FOR A PENALTY UNDER SUBSECTION E OF THIS SECTION IF THE FAILURE TO PAY THE CLAIM IS A RESULT OF A CATASTROPHIC EVENT THAT SUBSTANTIALLY INTERFERES WITH THE NORMAL BUSINESS OPERATIONS OF THE CONTRACTOR.

G. SUBSECTION E OF THIS SECTION DOES NOT RELIEVE THE CONTRACTOR OF THE OBLIGATION TO PAY THE REMAINING UNPAID AMOUNT OWED THE HOSPITAL.

H. A CONTRACTOR THAT PAYS A PENALTY PURSUANT TO SUBSECTION E OF THIS SECTION SHALL CLEARLY INDICATE ON THE EXPLANATION OF PAYMENT STATEMENT THE AMOUNT OF THE PAYMENT THAT IS THE AMOUNT OWED AND THE AMOUNT THAT IS PAID AS A PENALTY.

I. THE TIMELY PAY REQUIREMENTS AND THE TIME FRAMES PRESCRIBED IN SUBSECTION E OF THIS SECTION ARE NOT STAYED OR INTERRUPTED BY ANY ADMINISTRATIVE GRIEVANCE, APPEAL PROCEEDING OR OTHER LEGAL ACTION CHALLENGING A CONTRACTOR'S DETERMINATION TO NOT PAY A CLAIM.

J. IN ADDITION TO ANY OTHER PENALTY OR REMEDY AUTHORIZED BY THIS SECTION OR ANOTHER LAW OF THIS STATE, THE DIRECTOR MAY IMPOSE ADDITIONAL ADMINISTRATIVE PENALTIES ON ANY CONTRACTOR THAT VIOLATES THE TIMELY PAYMENT

STANDARDS PRESCRIBED IN THIS SECTION OR SECTION 36-2903, SUBSECTION B, PARAGRAPH 13. FOR EACH DAY AN ADMINISTRATIVE PENALTY IS IMPOSED UNDER THIS SUBSECTION, THE PENALTY MAY NOT EXCEED ONE THOUSAND DOLLARS FOR EACH CLAIM THAT REMAINS UNPAID IN VIOLATION OF SUBSECTION A OF THIS SECTION.

K. IN DETERMINING WHETHER A CONTRACTOR HAS PROCESSED CLAIMS IN COMPLIANCE WITH THE AGGREGATE CLAIM PAYMENT STANDARDS PRESCRIBED IN SECTION 36-2903, SUBSECTION B, PARAGRAPH 13, THE DIRECTOR SHALL COMPUTE THE COMPLIANCE PERCENTAGE FOR HOSPITAL CLAIMS SEPARATE FROM PHYSICIAN AND OTHER PROVIDER CLAIMS AND APPLY THE AGGREGATE CLAIM PAYMENT STANDARDS TO EACH GROUP SEPARATELY.

L. IF A CONTRACTOR VIOLATES THE AGGREGATE CLAIM PAYMENT STANDARDS PRESCRIBED IN SECTION 36-2903, SUBSECTION B, PARAGRAPH 13 FOR EITHER HOSPITAL CLAIMS OR PHYSICIAN AND OTHER PROVIDER CLAIMS FOR MORE THAN TWO CONSECUTIVE MONTHLY REPORTING PERIODS, OR FOR THREE MONTHLY REPORTING PERIODS OUT OF FIVE, THE DIRECTOR SHALL NOT PERMIT THE ENROLLMENT OF ANY NEW ENROLLEES INTO THE PREPAID CAPITATED PLAN OF THAT CONTRACTOR UNTIL THE DIRECTOR DETERMINES THAT THE CONTRACTOR HAS SATISFIED THE AGGREGATE CLAIM PAYMENT STANDARDS PRESCRIBED IN SECTION 36-2903, SUBSECTION B, PARAGRAPH 13 FOR TWO CONSECUTIVE MONTHLY REPORTING PERIODS.

M. WITHIN THIRTY DAYS AFTER THE DETERMINATION OF EACH CONTRACTOR'S COMPLIANCE WITH THE AGGREGATE CLAIM PAYMENT STANDARDS PURSUANT TO SECTION 36-2903, SUBSECTION B, PARAGRAPH 13, THE DIRECTOR SHALL PUBLISH THE COMPLIANCE RESULTS FOR EACH CONTRACTOR FOR EACH CATEGORY OF PROVIDER.

N. A CONTRACTOR SHALL ACCOUNT FOR ANY INTEREST OR PENALTY PAID PURSUANT TO THIS SECTION AS AN ADMINISTRATIVE EXPENSE.

O. AN OTHERWISE CLEAN CLAIM THAT IS SUBMITTED BY A HOSPITAL AND THAT INCLUDES ADDITIONAL FIELDS, DATA ELEMENTS OR ATTACHMENTS OR OTHER INFORMATION NOT REQUIRED UNDER THIS SECTION IS CONSIDERED TO BE A CLEAN CLAIM FOR THE PURPOSES OF THIS SECTION.

P. A CLAIM SUBMITTED USING THE FORM OR FORMAT DESIGNATED PURSUANT TO SUBSECTION Q, PARAGRAPH 2, SUBDIVISION (a) OR (b) OF THIS SECTION THAT IS MISSING OR CONTAINS ERRONEOUS DATA ELEMENTS THAT ARE NOT NECESSARY TO DETERMINE WHETHER THE CLAIM IS PROPERLY PAYABLE IS CONSIDERED A CLEAN CLAIM FOR PURPOSES OF THIS SECTION IF THE CLAIM ALSO COMPLIES WITH ALL ENCOUNTER EDITS PRESCRIBED BY THE ADMINISTRATION.

Q. FOR THE PURPOSES OF THIS SECTION:

1. "AMOUNT OWED" MEANS THE AMOUNT PAYABLE BY A CONTRACTOR UNDER THE TERMS OF AN AGREEMENT BETWEEN THE CONTRACTOR AND THE HOSPITAL UNDER SECTION 36-2904, SUBSECTION I, PARAGRAPH 1 OR THE AMOUNT PAYABLE BY A CONTRACTOR TO A NONCONTRACTED HOSPITAL UNDER THE TERMS OF SECTION 36-2904, SUBSECTION I, PARAGRAPH 1, SUBDIVISION (c).

2. "CLEAN CLAIM" MEANS:

(a) THAT THE HOSPITAL SUBMITS THE CLAIM USING THE CENTERS FOR MEDICARE AND MEDICAID SERVICES FORM UB-04, OR A SUCCESSOR FORM, DESIGNATED BY THE FEDERAL MEDICARE PROGRAM FOR THE SUBMISSION OF HOSPITAL CLAIMS.

(b) IF IT IS AN ELECTRONIC CLAIM, THAT THE HOSPITAL SUBMITS THE CLAIM USING THE INSTITUTIONAL 837 (ASC X12N 837) FORMAT OR A SUCCESSOR FORMAT DESIGNATED FOR THE ELECTRONIC SUBMISSION OF CLAIMS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT.

(c) THAT THE CLAIM CONFORMS TO ANY RULES ADOPTED BY THE DIRECTOR THAT SPECIFY THE INFORMATION THAT MUST BE ENTERED INTO THE APPROPRIATE FIELDS ON THE APPLICABLE CLAIM FORM FOR A CLAIM TO BE A CLEAN CLAIM, PROVIDED THAT THE DIRECTOR MAY NOT REQUIRE ANY DATA ELEMENT FOR AN ELECTRONIC CLAIM THAT IS NOT REQUIRED IN AN ELECTRONIC TRANSACTION SET NEEDED TO COMPLY WITH FEDERAL LAW.

(d) THAT THE CLAIM CONFORMS TO ANY CONTRACTUAL AGREEMENT BETWEEN A CONTRACTOR AND A HOSPITAL TO USE FEWER DATA ELEMENTS THAN ARE REQUIRED IN AN ELECTRONIC TRANSACTION SET NEEDED TO COMPLY WITH FEDERAL LAW.

3. "DATE OF SERVICE" FOR A HOSPITAL INPATIENT MEANS THE DATE OF DISCHARGE OF THE PATIENT.

4. "RECEIVED" MEANS THE LATER OF THE FOLLOWING DATES:

(a) IF MAILED, THE FIFTH DAY AFTER THE POSTMARK ON THE CLAIM'S ENVELOPE.

(b) IF MAILED USING OVERNIGHT SERVICES OR RETURN RECEIPT REQUESTED, ON THE DATE THE DELIVERY RECEIPT IS SIGNED.

(c) IF SUBMITTED ELECTRONICALLY, THE DATE OF THE ELECTRONIC VERIFICATION OF RECEIPT BY THE ADMINISTRATION OR CONTRACTOR.

(d) IF FAXED, THE DATE OF THE TRANSMISSION ACKNOWLEDGMENT.

(e) IF HAND DELIVERED, THE DATE THE DELIVERY RECEIPT IS SIGNED.

Sec. 6. Section 36-2912, Arizona Revised Statutes, is amended to read:

36-2912. Healthcare group coverage; program requirements for small businesses and public employers; related requirements; definitions

A. The administration shall administer a healthcare group program to allow willing contractors to deliver health care services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). In the absence of a willing contractor, the administration may contract directly with any health care provider or entity. The administration may enter into a contract with another entity to provide administrative functions for the healthcare group program.

B. Employers with one eligible employee or up to an average of fifty eligible employees under section 36-2901, paragraph 6, subdivision (d):

1. May contract with the administration to be the exclusive health benefit plan if the employer has five or fewer eligible employees and enrolls one hundred per cent of these employees into the health benefit plan.

2. May contract with the administration for coverage available pursuant to this section if the employer has six or more eligible employees and enrolls eighty per cent of these employees into the healthcare group program.

3. Shall have a minimum of one and a maximum of fifty eligible employees at the effective date of their first contract with the administration.

C. The administration shall not enroll an employer group in healthcare group sooner than one hundred eighty days after the date that the employer's health insurance coverage under an accountable health plan is discontinued. Enrollment in healthcare group is effective on the first day of the month after the one hundred eighty day period. This subsection does not apply to an employer group if the employer's accountable health plan discontinues offering the health plan of which the employer is a member.

D. Employees with proof of other existing health care coverage who elect not to participate in the healthcare group program shall not be considered when determining the percentage of enrollment requirements under subsection B of this section if either:

1. Group health coverage is provided through a spouse, parent or legal guardian, or insured through individual insurance or another employer.

2. Medical assistance is provided by a government subsidized health care program.

3. Medical assistance is provided pursuant to section 36-2982, subsection I.

E. An employer shall not offer coverage made available pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally designated plan.

F. An employee or dependent defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may participate in healthcare group on a voluntary basis only.

G. Notwithstanding subsection B, paragraph 2 of this section, the administration shall adopt rules to allow a business that offers healthcare group coverage pursuant to this section to continue coverage if it expands its employment to include more than fifty employees.

H. The administration shall provide eligible employees with disclosure information about the health benefit plan.

I. The director shall:

1. Require that any contractor that provides covered services to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (a) provide separate audited reports on the assets, liabilities and financial status of any corporate activity involving providing coverage pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

2. Beginning on July 1, 2005, require that a contractor, the administration or an accountable health plan negotiate reimbursement rates and not use the administration's reimbursement rates established pursuant to section 36-2903.01, subsection H~~,~~ as a default reimbursement rate if a contract does not exist between a contractor and a provider.

3. Use monies from the healthcare group fund established by section 36-2912.01 for the administration's costs of operating the healthcare group program.

4. Ensure that the contractors are required to meet contract terms as are necessary in the judgment of the director to ensure adequate performance by the contractor. Contract provisions shall include, at a minimum, 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 that have posted other security, equal to or greater than that required for the healthcare group program, with the administration or the department of insurance for the performance of health service contracts if funds would be available to the administration from the other security on the contractor's default. In waiving, or approving waivers of, any requirements established pursuant to this section, the director shall ensure that the administration has taken into account all the obligations to which a contractor's security is associated. The director may also adopt rules that provide for the withholding or forfeiture of payments to be made to a contractor for the failure of the contractor to comply with provisions of its contract or with provisions of adopted rules.

5. Adopt rules.

6. Provide reinsurance to the contractors for clean claims based on thresholds established by the administration. For the purposes of this paragraph, "clean claims" has the same meaning prescribed in section ~~36-2904~~ 36-2904.01.

J. With respect to services provided by contractors to persons defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e), a contractor is the payor of last resort and has the same lien or subrogation rights as those held by health care services organizations licensed pursuant to title 20, chapter 4, article 9.

K. The administration shall offer a health benefit plan on a guaranteed issuance basis to small employers as required by this section. All small employers qualify for this guaranteed offer of coverage. The administration shall provide a health benefit plan to each small employer without regard to health status-related factors if the small employer agrees to make the premium payments and to satisfy any other reasonable provisions of the plan and contract. The administration shall offer to all small employers the available health benefit plan and shall accept any small employer that applies and meets the eligibility requirements. In addition to the requirements prescribed in this section, for any offering of any health benefit plan to a small employer, as part of the administration's solicitation and sales materials, the administration shall make a reasonable disclosure to the employer of the availability of the information described in this subsection and, on request of the employer, shall provide that information to the employer. The administration shall provide information concerning the following:

1. Provisions of coverage relating to the following, if applicable:

(a) The administration's right to establish premiums and to change premium rates and the factors that may affect changes in premium rates.

(b) Renewability of coverage.

(c) Any preexisting condition exclusion.

(d) The geographic areas served by the contractor.

2. The benefits and premiums available under all health benefit plans for which the employer is qualified.

L. The administration shall describe the information required by subsection K of this section in language that is understandable by the average small employer and with a level of detail that is sufficient to reasonably inform a small employer of the employer's rights and obligations under the health benefit plan. This requirement is satisfied if the administration provides the following information:

1. An outline of coverage that describes the benefits in summary form.

2. The rate or rating schedule that applies to the product, preexisting condition exclusion or affiliation period.

3. The minimum employer contribution and group participation rules that apply to any particular type of coverage.

4. In the case of a network plan, a map or listing of the areas served.

M. A contractor is not required to disclose any information that is proprietary and protected trade secret information under applicable law.

N. At least sixty days before the date of expiration of a health benefit plan, the administration shall provide a written notice to the employer of the terms for renewal of the plan.

O. The administration may increase or decrease premiums based on actuarial reviews of the projected and actual costs of providing health care benefits to eligible members. Before changing premiums, the administration must give sixty days' written notice to the employer. The administration may cap the amount of the change.

P. The administration may consider age, sex, income and community rating when it establishes premiums for the healthcare group program.

Q. Except as provided in subsection R of this section, a health benefit plan may not deny, limit or condition the coverage or benefits based on a person's health status-related factors or a lack of evidence of insurability.

R. A health benefit plan shall not exclude coverage for preexisting conditions, except that:

1. A health benefit plan may exclude coverage for preexisting conditions for a period of not more than twelve months or, in the case of a late enrollee, eighteen months. The exclusion of coverage does not apply to services that are furnished to newborns who were otherwise covered from the time of their birth or to persons who satisfy the portability requirements under this section.

2. The contractor shall reduce the period of any applicable preexisting condition exclusion by the aggregate of the periods of creditable coverage that apply to the individual.

S. The contractor shall calculate creditable coverage according to the following:

1. The contractor shall give an individual credit for each portion of each month the individual was covered by creditable coverage.

2. The contractor shall not count a period of creditable coverage for an individual enrolled in a health benefit plan if after the period of coverage and before the enrollment date there were sixty-three consecutive days during which the individual was not covered under any creditable coverage.

3. The contractor shall give credit in the calculation of creditable coverage for any period that an individual is in a waiting period for any health coverage.

T. The contractor shall not count a period of creditable coverage with respect to enrollment of an individual if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered under any creditable coverage. The contractor shall not include in the determination of the period of continuous coverage described in this section any period that an individual is in a waiting period for health insurance coverage offered by a health care insurer or is in a waiting period for benefits under a health benefit plan offered by a contractor. In determining the extent to which an individual has satisfied any portion of any applicable preexisting condition period, the contractor shall count a period of creditable coverage without regard to the specific benefits covered during that period. A contractor shall not impose any preexisting condition exclusion in the case of an individual who is covered under creditable coverage thirty-one days after the individual's date of birth. A contractor shall not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before age eighteen and who is covered under creditable coverage thirty-one days after the adoption or placement for adoption.

U. The written certification provided by the administration must include:

1. The period of creditable coverage of the individual under the contractor and any applicable coverage under a COBRA continuation provision.

2. Any applicable waiting period or affiliation period imposed on an individual for any coverage under the health plan.

V. The administration shall issue and accept a written certification of the period of creditable coverage of the individual that contains at least the following information:

1. The date that the certificate is issued.

2. The name of the individual or dependent for whom the certificate applies and any other information that is necessary to allow the issuer

providing the coverage specified in the certificate to identify the individual, including the individual's identification number under the policy and the name of the policyholder if the certificate is for or includes a dependent.

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

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

5. One of the following:

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

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

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

W. The administration shall provide any certification pursuant to this section within thirty days after the event that triggered the issuance of the certification. Periods of creditable coverage for an individual are established by presentation of the certifications in this section.

X. The healthcare group program shall comply with all applicable federal requirements.

Y. Healthcare group may pay a commission to an insurance producer. To receive a commission, the producer must certify that to the best of the producer’s knowledge the employer group has not had insurance in the one hundred eighty days before applying to healthcare group. For the purposes of this subsection, "commission" means a one time payment on the initial enrollment of an employer.

Z. On or before June 15 and November 15 of each year, the director shall submit a report to the joint legislative budget committee regarding the number and type of businesses participating in healthcare group and that includes updated information on healthcare group marketing activities. The director, within thirty days of implementation, shall notify the joint legislative budget committee of any changes in healthcare group benefits or cost sharing arrangements.

AA. For the purposes of this section:

1. "Accountable health plan" has the same meaning prescribed in section 20-2301.

2. "COBRA continuation provision" means:

(a) Section 4980B, except subsection (f)(1) as it relates to pediatric vaccines, of the internal revenue code of 1986.

(b) Title I, subtitle B, part 6, except section 609, of the employee retirement income security act of 1974.

(c) Title XXII of the public health service act.

(d) Any similar provision of the law of this state or any other state.

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

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

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

(c) A health benefits plan, as defined in section 20-2301, issued by a health plan.

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

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

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

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

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

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

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

(k) A health benefit plan pursuant to section 5(e) of the peace corps act (22 United States Code section 2504(e)).

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

(m) A policy or contract issued by a health care insurer or the administration to a member of a bona fide association.

4. "Eligible employee" means a person who is one of the following:

(a) Eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

(b) A person who works for an employer for a minimum of twenty hours per week or who is self-employed for at least twenty hours per week.

(c) An employee who elects coverage pursuant to section 36-2982, subsection I. The restriction prohibiting employees employed by public agencies prescribed in section 36-2982, subsection I does not apply to this subdivision.

(d) A person who meets all of the eligibility requirements, who is eligible for a federal health coverage tax credit pursuant to section 35 of the internal revenue code of 1986 and who applies for health care coverage

through the healthcare group program. The requirement that a person be employed with a small business that elects healthcare group coverage does not apply to this eligibility group.

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

6. "Health benefit plan" means coverage offered by the administration for the healthcare group program pursuant to this section.

7. "Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in a health plan including:

(a) Health status.

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

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

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

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

8. "Hospital" means a health care institution licensed as a hospital pursuant to chapter 4, article 2 of this title.

9. "Late enrollee" means an employee or dependent who requests enrollment in a health benefit plan after the initial enrollment period that is provided under the terms of the health benefit plan if the initial enrollment period is at least thirty-one days. Coverage for a late enrollee begins on the date the person becomes a dependent if a request for enrollment is received within thirty-one days after the person becomes a dependent. An employee or dependent shall not be considered a late enrollee if:

(a) The person:

(i) At the time of the initial enrollment period was covered under a public or private health insurance policy or any other health benefit plan.

(ii) Lost coverage under a public or private health insurance policy or any other health benefit plan due to the employee's termination of employment or eligibility, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, legal separation or divorce or the termination of employer contributions toward the coverage.

(iii) Requests enrollment within thirty-one days after the termination of creditable coverage that is provided under a COBRA continuation provision.

(iv) Requests enrollment within thirty-one days after the date of marriage.

(b) The person is employed by an employer that offers multiple health benefit plans and the person elects a different plan during an open enrollment period.

(c) The person becomes a dependent of an eligible person through marriage, birth, adoption or placement for adoption and requests enrollment no later than thirty-one days after becoming a dependent.

10. "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under a health benefit plan issued by a contractor. Preexisting condition does not include a genetic condition in the absence of a diagnosis of the condition related to the genetic information.

11. "Preexisting condition limitation" or "preexisting condition exclusion" means a limitation or exclusion of benefits for a preexisting condition under a health benefit plan offered by a contractor.

12. "Small employer" means an employer who employs at least one but not more than fifty eligible employees on a typical business day during any one calendar year.

13. "Waiting period" means the period that must pass before a potential participant or eligible employee in a health benefit plan offered by a health plan is eligible to be covered for benefits as determined by the individual's employer.

Sec. 7. Section 36-2986, Arizona Revised Statutes, is amended to read:

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 to implement this article, including 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, enrollment and redetermination 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 G~~ 36-2904.01.

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

12. Requiring contractors to submit encounter data in a form specified by the director.

13. Assessing civil penalties for improper billing as prescribed in section 36-2903.01, subsection L.

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 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 and the time frames specified 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 and shall coordinate benefits pursuant to section 36-2903, subsection F and be a payor of last resort for persons who are eligible pursuant to this article.

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

Sec. 8. Initial terms of members of the hospital reimbursement advisory council

A. Notwithstanding section 36-2902.03, Arizona Revised Statutes, as added by this act, the initial terms of members of the hospital reimbursement advisory council are:

1. Four terms ending June 30, 2009.

2. Four terms ending June 30, 2010.

3. Five terms ending June 30, 2011.

B. The governor shall make all subsequent appointments as prescribed by statute.