[Ariz. Rev. Stat. §§ 36-2981 through 36-2998.]

§§ 36-2981 through 36-2998: Arizona Health Care Cost Containment System Administration -- Children's Health Insurance Program

§ 36-2981. Definitions.

In this article, unless the context otherwise requires:

1. "Administration" means the Arizona health care cost containment system administration.

2. "Contractor" means a health plan that contracts with the administration for the provision of hospitalization and medical care to members according to the provisions of this article or a qualifying plan.

3. "Director" means the director of the administration.

4. "Federal poverty level" means the federal poverty level guidelines published annually by the United States department of health and human services.

5. "Health plan" means an entity that contracts with the administration for services provided pursuant to article 1 of this chapter.

6. "Member" means a person who is eligible for and enrolled in the program, who is under nineteen years of age and whose gross household income meets the following requirements:

(a) Beginning on November 1, 1998 through September 30, 1999, has income at or below one hundred fifty per cent of the federal poverty level.

(b) Beginning on October 1, 1999 and for each fiscal year thereafter, has income at or below two hundred per cent of the federal poverty level.

7. "Noncontracting provider" means an entity that provides hospital or medical care but does not have a contract or subcontract with the administration.

8. "Physician" means a person licensed pursuant to title 32, chapter 13 or 17.

9. "Prepaid capitated" means a method of payment by which a contractor delivers health care services for the duration of a contract to a specified number of members based on a fixed rate per member, per month without regard to the number of members who receive care or the amount of health care services provided to a member.

10. "Primary care physician" means a physician who is a family practitioner, general practitioner, pediatrician, general internist, obstetrician or gynecologist.

11. "Primary care practitioner" means a nurse practitioner who is certified pursuant to title 32, chapter 15 or a physician assistant who is licensed pursuant to title 32, chapter 25 and who is acting within the respective scope of practice of those chapters.

12. "Program" means the children's health insurance program.

13. "Qualifying plan" means a contractor that contracts with the state pursuant to section 38-651 to provide health and accident insurance for state employees and that provides services to members pursuant to section 36-2989, subsection A.

14. "Special health care district" means a special health care district organized pursuant to title 48, chapter 31.

15. "Tribal facility" means a facility that is operated by an Indian tribe and that is authorized to provide services pursuant to Public Law 93-638, as amended.

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

A. The children's health insurance program is established for children who are eligible pursuant to section 36-2981, paragraph 6. The administration shall administer the program. All covered services shall be provided by health plans that have contracts with the administration pursuant to section 36-2906, by a qualifying plan or by either tribal facilities or the Indian health service for Native Americans who are eligible for the program and who elect to receive services through the Indian health service or a tribal facility.

B. This article does not create a legal entitlement for any applicant or member who is eligible for the program.

C. The director shall take all steps necessary to implement the administrative structure for the program and to begin delivering services to persons within sixty days after approval of the state plan by the United States department of health and human services.

D. The administration shall perform eligibility determinations for persons applying for eligibility and annual redeterminations for continued eligibility pursuant to this article.

E. The administration shall adopt rules for the collection of copayments from members whose income does not exceed one hundred fifty percent of the federal poverty level and for the collection of copayments and premiums from members whose income exceeds one hundred fifty percent of the federal poverty level. The director shall adopt rules for disenrolling a member if the member does not pay the premium required pursuant to this section. The director shall adopt rules to prescribe the circumstances under which the administration shall grant a hardship exemption to the disenrollment requirements of this subsection for a member who is no longer able to pay the premium.

F. Before enrollment, a member, or if the member is a minor, that member's parent or legal guardian, shall select an available health plan in the member's geographic service area or a qualifying health plan offered in the county, and may select a primary care physician or primary care practitioner from among the available physicians and practitioners participating with the contractor in which the member is enrolled. The contractors shall only reimburse costs of services or related services provided by or under referral from a primary care physician or primary care practitioner participating in the contract in which the member is enrolled, except for emergency services that shall be reimbursed pursuant to section 36-2987. The director shall establish requirements as to the minimum time period that a member is assigned to specific contractors.

G. Eligibility for the program is creditable coverage as defined in section 20-1379.

H. Notwithstanding section 36-2983, the administration may purchase for a member employer-sponsored group health insurance with state and federal monies available pursuant to this article, subject to any restrictions imposed by the centers for medicare and medicaid services. This subsection does not apply to members who are eligible for health benefits coverage under a state health benefits plan based on a family member's employment with a public agency in this state.

§ 36-2983. Eligibility for the program.

A. The administration shall establish a streamlined eligibility process for applicants to the program and shall issue a certificate of eligibility at the time eligibility for the program is determined. Eligibility shall be based on gross household income for a member as defined in section 36-2981. The administration shall not apply a resource test in the eligibility determination or redetermination process.

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

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

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

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

F. In determining the eligibility for all qualified aliens pursuant to this article, the income and resources of a person who executed an affidavit of support pursuant to section 213A of the immigration and nationality act on behalf of the qualified alien and the income and resources of the spouse, if any, of the sponsoring

individual shall be counted at the time of application and for the redetermination of eligibility for the duration of the attribution period as specified in federal law.

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

1. Eligible for title XIX or other federally operated or financed health care insurance programs, except the Indian health service.

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

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

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

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

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

§ 36-2984. Repealed by Laws 2002, Ch. 329, § 15.

§ 36-2985. Notice of program suspension; spending limit.

A. If the director determines that federal and state monies appropriated for the program are insufficient, the administration shall immediately notify the governor, the president of the senate and the speaker of the house of representatives and may stop processing all new applications.

B. The total amount of state monies that the administration may spend in any fiscal year for health care provided under this article shall not exceed the amount appropriated or authorized by section 35-173.

C. This article does not impose a duty on an officer, agent or employee of this state to discharge a responsibility or create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.

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

A. The director has full operational authority to adopt rules or to use the appropriate rules adopted for article 1 of this chapter 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 percent of the clean claims are paid within thirty days after receipt and ninety-nine percent 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.

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 K.

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 has a disability.

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 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.

§ 36-2987. Reimbursement for the program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. To the extent possible, the administration shall use contractors that have a contract with the administration pursuant to article 1 of this chapter or qualifying plans to provide services to members who qualify for the program.

B. The administration has full authority to amend existing contracts awarded pursuant to article 1 of this chapter.

C. As determined by the director, reinsurance may be provided against expenses in excess of a specified amount on behalf of any member for covered emergency services, inpatient services or outpatient services in the same manner as reinsurance provided under article 1 of this chapter. Subject to the approval of the director, reinsurance may be obtained against expenses in excess of a specified amount on behalf of any member.

D. Notwithstanding any other law, the administration may procure, provide or coordinate covered services by interagency agreement with authorized agencies of this state for distinct groups of members, including persons eligible for children's rehabilitative services through the department of economic security and members eligible for comprehensive medical and dental benefits through the department of child safety.

E. After contracts are awarded pursuant to this section, the director may negotiate with any successful bidder for the expansion or contraction of services or service areas.

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

G. The director may negotiate at any time with a hospital on behalf of a contractor for inpatient hospital services and outpatient hospital services provided pursuant to the requirements specified in section 36-2904.

H. A contractor may require that subcontracting providers or noncontracting providers be paid for covered services, other than hospital services, according to the capped fee-for-service schedule adopted by the administration or at lower rates as may be negotiated by the contractor.

I. A school district may perform outreach and information activities that relate to this article, with permission of the school principal and school district. The administration and contractors may collaborate with entities such as community based organizations, faith based organizations, schools and school districts for outreach and information activities related to this article. Outreach and information activities shall not include delivery of services, screening activities, eligibility determination or enrollment related to this article. Outreach and information activities include promotion of health care coverage, participation in school events and distribution of applications and materials to pupils and their families. Outreach and information activities performed by the administration, contractors or a school district shall not reduce or interfere with classroom instruction time.

J. The administration is exempt from the procurement code pursuant to section 41-2501.

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

A. Except as provided in this section, health and medical services prescribed in section 36-2907 are covered services and include:

1. Inpatient hospital services that are ordinarily furnished by a hospital for the care and treatment of inpatients, that are medically necessary and that are provided under the direction of a physician or a primary care practitioner. For the purposes of this paragraph, inpatient hospital services exclude services in an institution for tuberculosis or mental diseases unless authorized by federal law.

2. Outpatient health services that are medically necessary and ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. For the purposes of this paragraph,

"outpatient health services" includes services provided by or under the direction of a physician or a primary care practitioner.

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

4. Medications that are medically necessary and ordered on prescription by a physician, a primary care practitioner or a dentist licensed pursuant to title 32, chapter 11.

5. Medical supplies, equipment and prosthetic devices.

6. Treatment of medical conditions of the eye, including eye examinations for prescriptive lenses and the provision of prescriptive lenses for members.

7. Medically necessary dental services.

8. Well child services, immunizations and prevention services.

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

10. Podiatry services that are performed by a podiatrist licensed pursuant to title 32, chapter 7 and that are ordered by a primary care physician or primary care practitioner.

11. Medically necessary pancreas, heart, liver, kidney, cornea, lung and heart-lung transplants and autologous and allogeneic bone marrow transplants and immunosuppressant medications for these transplants ordered on prescription by a physician licensed pursuant to title 32, chapter 13 or 17.

12. Medically necessary emergency and nonemergency transportation.

13. Inpatient and outpatient behavioral health services that are the same as the least restrictive health benefits coverage plan for behavioral health services that are offered through a health care services organization for state employees under section 38-651.

14. Hospice care.

B. The administration shall pay noncontracting providers only for health and medical services as prescribed in subsection A of this section.

C. To the extent possible and practicable, the administration and contractors shall provide for the prior approval of medically necessary services provided pursuant to this article.

D. The director shall make available home health services in lieu of hospitalization pursuant to contracts awarded under this article.

E. Behavioral health services shall be provided to members through the administration's contractors. The administration acting through regional behavioral health authorities as defined in section 36-3401 shall use its established diagnostic and evaluation program for referrals of children who are not already enrolled pursuant to this article and who may be in need of behavioral health services. In addition to an evaluation, the administration acting through regional behavioral health authorities as defined in section 36-3401 shall also identify children who may be eligible under section 36-2901, paragraph 6, subdivision (a) or section 36-2931, paragraph 5 and shall refer the children to the appropriate agency responsible for making the final eligibility determination.

F. The director shall adopt rules for the provision of transportation services for members. Prior authorization is not required for medically necessary ambulance transportation services rendered to members initiated by dialing telephone number 911 or other designated emergency response systems.

G. The director may adopt rules to allow the administration to use a second opinion procedure under which surgery may not be eligible for coverage pursuant to this article without documentation as to need by at least two physicians or primary care practitioners.

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

1. Emergency services and specialty services.

2. The director may permit the delivery of health and medical services in other than the geographic service area in this state or in an adjoining state if it is determined that medical practice patterns justify the delivery of services or a net reduction in transportation costs can reasonably be expected. Notwithstanding section 36-2981, paragraph 8 or 11, if services are procured from a physician or primary care practitioner in an adjoining state, the physician or primary care practitioner shall be licensed to practice in that state pursuant to licensing statutes in that state that are similar to title 32, chapter 13, 15, 17 or 25.

I. Covered outpatient services shall be subcontracted by a primary care physician or primary care practitioner to other licensed health care providers to the extent practicable for purposes of making health care services available to underserved areas, reducing costs of providing medical care and reducing transportation costs.

J. The director shall adopt rules that prescribe the coordination of medical care for members and that include a mechanism to transfer members and medical records and initiate medical care.

K. The director shall adopt rules for the reimbursement of specialty services provided to the member if authorized by the member's primary care physician or primary care practitioner.

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

A. The administration shall develop standards of care that each contractor shall use to monitor the quality of health care received by members.

B. The director shall periodically determine whether each contractor has properly adopted and implemented standards to ensure the quality of health care. If the director determines that a contractor is out of compliance, the director shall undertake additional efforts to monitor and assess the quality of health care provided by that contractor for the period of time that the director deems necessary. The director shall determine the cost incurred in undertaking these special efforts and shall deduct that amount from any payment owed to the contractor.

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

A. A person shall not provide or cause to be provided false or fraudulent information on an application for eligibility pursuant to this article.

B. A person who violates subsection A of this section, who is determined eligible for services pursuant to this article and who would have been determined ineligible if the person had provided true and correct information is subject, in addition to any other penalties that may be prescribed by federal or state law, to a civil penalty of not more than the amount incurred by the system, including capitation payments made on behalf of the person. In addition, the person's eligibility may be discontinued in accordance with rules adopted by the director.

C. In addition to the requirements of state law, any applicable fraud and abuse controls that are enacted under federal law apply to persons who are eligible for services under this article and to contractors and noncontracting providers who provide services under this article.

D. The director shall make the determination to assess a civil penalty and is responsible for collection of the penalty. The director may adopt rules that prescribe procedures for the determination and collection of civil penalties. The director may compromise civil penalties imposed under this section in accordance with criteria established in rules.

E. The director shall adopt rules providing for the appeal of a decision by a person adversely affected by a determination made by the director under this section. The director's final decision is subject to judicial review pursuant to title 12, chapter 7, article 6.

F. Amounts paid by the state and recovered under this section shall be deposited in the state general fund, and any applicable federal share shall be returned to the United States department of health and human services.

G. If a civil penalty imposed pursuant to subsection D of this section is not paid, the state may file an action to collect the civil penalty in the superior court in Maricopa county. Matters that were raised or could have been

raised in a hearing before the director or in an appeal pursuant to title 12, chapter 7, article 6 may not be raised as a defense to the civil action. An action brought pursuant to this subsection shall be initiated within six years after the date the claim is presented.

H. A person who knowingly aids or abets another person pursuant to section 13-301, 13-302 or 13-303 in the commission of an offense under this section or section 13-3713 is guilty of a class 5 felony.

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

A. All contractors and noncontracting providers shall advise the director or the director's designee immediately in a written report of any cases of suspected fraud or abuse. The director shall review the report and conduct a preliminary investigation to determine if there is a sufficient basis to warrant a full investigation. If the findings of a preliminary investigation give the director reason to believe that an incident of fraud or abuse has occurred, the matter shall be referred to the attorney general.

B. Any person making a complaint or furnishing a report, information or records in good faith pursuant to this section is immune from any civil liability by reason of that action unless that person has been charged with or is suspected of the reported fraud or abuse.

C. Any health care provider who fails to report pursuant to this section commits an act of unprofessional conduct and is subject to disciplinary action by the provider's licensing board or department.

§ 36-2993. Prohibited acts; penalties.

A. A person shall not present or cause to be presented to this state or to a contractor:

1. A claim for a medical service or any other item that the person knows or has reason to know was not provided as claimed.

2. A claim for a medical service or any other item that the person knows or has reason to know is false or fraudulent.

3. A claim for payment that the person knows or has reason to know may not be made by the administration because:

(a) The person was terminated or suspended from participation in the program on the date for which the claim is being made.

(b) The item or service claimed is substantially in excess of the needs of the individual or of a quality that fails to meet professionally recognized standards of health care.

(c) The person was not a member on the date for which the claim is being made.

4. A claim for a service or an item by a person who knows or has reason to know that the individual who furnished or supervised the furnishing of the service:

(a) Was not licensed as a physician or another health care professional requiring state licensure.

(b) Obtained the individual's license through a misrepresentation of material fact.

(c) Represented to the member at the time the service was furnished that the physician was certified in a medical specialty by a medical specialty board if the individual was not certified.

5. A request for payment that the person knows or has reason to know is in violation of an agreement between the person and this state or the administration.

B. A person who violates this section is subject, in addition to any other penalties that may be prescribed by law, to a civil penalty of not more than two thousand dollars for each item or service claimed and is subject to an assessment of not more than twice the amount claimed for each item or service.

C. The director or the director's designee shall make the determination to assess civil penalties and is responsible for the collection of penalty and assessment amounts. The director shall adopt rules that prescribe procedures for the determination and collection of civil penalties and assessments. Civil penalties and assessments imposed under this section may be compromised by the director or the designee in accordance with criteria established in rules. The director or the director's designee may make this determination in the same proceeding to exclude the person from participation in the program.

D. A person adversely affected by a determination of the director or the director's designee under this section may appeal that decision in accordance with provider grievance provisions prescribed by rule. The final decision is subject to judicial review pursuant to title 12, chapter 7, article 6.

E. The administration shall deposit, pursuant to sections 35-146 and 35-147, monies collected pursuant to this section in the state general fund. The amount of the penalty or assessment may be deducted from any amount then or later owing by the administration or this state to the person against whom the penalty or assessment has been imposed.

F. If a civil penalty or assessment imposed pursuant to this section is not paid, this state or the administration shall file an action to collect the civil penalty or assessment in the superior court in Maricopa county. Matters that were raised or could have been raised in a hearing before the director or in an appeal pursuant to title 12, chapter 7, article 6 may not be raised as a defense to the civil action. An action brought pursuant to this subsection shall be initiated within six years after the date the claim was presented.

§ 36-2994. Monthly financial report.

A. The director shall include in the monthly report submitted to the president of the senate and the speaker of the house of representatives pursuant to section 36-2920 the following information about the program:

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

2. The actual member months.

3. Monies recovered monthly from third party payors.

4. The amount and origin of any donation or grant from a private entity and the impact on the implementation of the program.

B. The report shall be submitted on or before the twenty-fifth day of the following month.

C. The director shall provide a copy of the monthly report to the chairmen of the house of representatives and senate standing committees on appropriations and health.

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

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

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

C. Monies in the fund are comprised of:

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

2. Tobacco tax and state general fund monies appropriated as state matching monies.

3. Gifts, donations and grants from any source.

4. Interest paid on monies deposited in the fund.

5. Third party liability recoveries.

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

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

F. Monies appropriated from the medically needy account of the tobacco tax and health care fund are exempt from section 35-190 relating to lapsing of appropriations. Notwithstanding section 35-191, subsection B, the

period for administrative adjustments extends for only six months for appropriations made for administration covered services.

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

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

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

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

§ 36–2996. Repealed by Laws 2003, Ch. 104, § 21.

§ 36–2997. Repealed by Laws 2001, Ch. 344, § 86, eff. Oct. 1, 2001.

§ 36-2998. Qualifying plans.

A. A qualifying plan, as defined in section 36-2981, may elect to participate in the children's health insurance program established pursuant to this article, subject to all requirements established in this article and in accordance with section 36-2989.

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