House Engrossed

FILED
MICHELE REAGAN
SECRETARY OF STATE

State of Arizona
House of Representatives
Fifty-second Legislature
First Regular Session
2015

CHAPTER 264

HOUSE BILL 2373

AN ACT

AMENDING SECTION 36-2907, 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. Section 36-2907, Arizona Revised Statutes, is amended to read:

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

A. Subject to the limitations and exclusions specified in this section, contractors shall provide the following medically necessary health and medical services:

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

2. Outpatient health services that are ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient health services include 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 ordered on prescription by a physician or a dentist licensed pursuant to title 32, chapter 11. Persons who are dually eligible for title XVIII and title XIX services must obtain available medications through a medicare licensed or certified medicare advantage prescription drug plan, a medicare prescription drug plan or any other entity authorized by medicare to provide a medicare part D prescription drug benefit.

5. Medical supplies, durable medical equipment, insulin pumps and prosthetic devices ordered by a physician or a primary care practitioner. Suppliers of durable medical equipment shall provide the administration with complete information about the identity of each person who has an ownership or controlling interest in their business and shall comply with federal bonding requirements in a manner prescribed by the administration.

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

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

8. 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 chapter. 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 the contractor that elects not to provide family planning services.

9. Podiatry services ordered by a primary care physician or primary care practitioner.

10. Nonexperimental transplants approved for title XIX reimbursement.

11. Ambulance and nonambulance transportation, except as provided in subsection G of this section.

12. Hospice care.

13. ORTHOTICS, IF ALL OF THE FOLLOWING APPLY:

(a) THE USE OF THE ORTHOTIC IS MEDICALLY NECESSARY AS THE PREFERRED TREATMENT OPTION CONSISTENT WITH MEDICARE GUIDELINES.

(b) THE ORTHOTIC IS LESS EXPENSIVE THAN ALL OTHER TREATMENT OPTIONS OR SURGICAL PROCEDURES TO TREAT THE SAME DIAGNOSED CONDITION.

(c) THE ORTHOTIC IS ORDERED BY A PHYSICIAN OR PRIMARY CARE PRACTITIONER.

B. The limitations and exclusions for health and medical services provided under this section are as follows:

1. Circumcision of newborn males is not a covered health and medical service.

2. For eligible persons who are at least twenty-one years of age:

(a) Outpatient health services do not include occupational therapy or speech therapy.

(b) Prosthetic devices do not include hearing aids, dentures, bone anchored hearing aids or cochlear implants. Prosthetic devices, except prosthetic implants, may be limited to twelve thousand five hundred dollars per contract year.

(c) Percussive vests and orthotics are not covered health and medical services.

(d) Durable medical equipment is limited to items covered by medicare.

(e) Podiatry services do not include services performed by a podiatrist.

(f) Nonexperimental transplants do not include pancreas only transplants.

(g) Bariatric surgery procedures, including laparoscopic and open gastric bypass and restrictive procedures, are not covered health and medical services.

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

D. The director shall adopt rules necessary to limit, to the extent possible, the scope, duration and amount of services, including maximum limitations for inpatient services that are consistent with federal regulations under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)). To the extent possible and

practicable, these rules shall provide for the prior approval of medically necessary services provided pursuant to this chapter.

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

F. The director shall adopt rules for the coverage of behavioral health services for persons who are eligible under section 36-2901, paragraph 6, subdivision (a). The administration shall contract with the department of health services for the delivery of all medically necessary behavioral health services to persons who are eligible under rules adopted pursuant to this subsection. The division of behavioral health in the department of health services shall establish a diagnostic and evaluation program to which other state agencies shall refer children who are not already enrolled pursuant to this chapter and who may be in need of behavioral health services. In addition to an evaluation, the division of behavioral health shall also identify children who may be eligible under section 36-2901, paragraph 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.

G. The director shall adopt rules for the provision of transportation services and rules providing for copayment by members for transportation for other than emergency purposes. Subject to approval by the centers for medicare and medicaid services, nonemergency medical transportation shall not be provided except for stretcher vans and ambulance transportation. Prior authorization is required for transportation by stretcher van and for medically necessary ambulance transportation initiated pursuant to a physician's direction. Prior authorization is not required for medically necessary ambulance transportation services rendered to members or eligible persons initiated by dialing telephone number 911 or other designated emergency response systems.

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

I. If the director does not receive bids within the amounts budgeted or if at any time the amount remaining in the Arizona health care cost containment system fund is insufficient to pay for full contract services for the remainder of the contract term, the administration, on notification to

system contractors at least thirty days in advance, may modify the list of services required under subsection A of this section for persons defined as eligible other than those persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). The director may also suspend services or may limit categories of expense for services defined as optional pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) for persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not apply to the continuity of care for persons already receiving these services.

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

K. 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 provided pursuant to section 36-2908.

2. That 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 the director determines that medical practice patterns justify the delivery of services or a net reduction in transportation costs can reasonably be expected. Notwithstanding the definition of physician as prescribed in section 36-2901, 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 similar to title 32, chapter 13, 15, 17 or 25 and shall complete a provider agreement for this state.

L. 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 including, but not limited to, making health care services available to underserved areas, reducing costs of providing medical care and reducing transportation costs.

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

N. For the purposes of this section, "ambulance" has the same meaning prescribed in section 36-2201.

Sec. 2. <u>Conditional repeal; notice</u>

A. Laws 2013, first special session, chapter 10, section 40 is repealed on the earlier of:

1. The approval of services authorized by section 36-2907, subsection A, paragraph 13, Arizona Revised Statutes, as added by this act, by the centers for medicare and medicaid services.

2. The date specified in Laws 2013, first special session, chapter 10, section 40.

B. The executive director of the Arizona health care cost containment system administration shall notify in writing the director of the Arizona legislative council of the date the centers for medicare and medicaid services approves the application for services authorized by section 36-2907, subsection A, paragraph 13, Arizona Revised Statutes, as added by this act.

Sec. 3. AHCCCS; application for approval of services

A. The Arizona health care cost containment system administration shall submit to the centers for medicare and medicaid services an application for approval of services authorized by section 36-2907, subsection A, paragraph 13, Arizona Revised Statutes, as added by this act, no later than thirty days after the effective date of this act. The Arizona health care cost containment system administration shall request that authorization to provide the services authorized by section 36-2907, subsection A, paragraph 13, Arizona Revised Statutes, as added by this act, be approved as soon as practicable, including providing the services in the current contract year.

B. The Arizona health care cost containment system administration may not limit a contractor's ability to approve services authorized by section 36-2907, subsection A, paragraph 13, Arizona Revised Statutes, as added by this act.

C. Arizona health care cost containment system contractors shall determine whether an orthotic ordered by a physician or a primary care practitioner is medically necessary as the preferred treatment option consistent with medicare guidelines and that the orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition pursuant to section 36-2907, subsection A, paragraph 13, Arizona Revised Statutes, as added by this act.

APPROVED BY THE GOVERNOR APRIL 10, 2015.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 13, 2015.

Passed the House March 4, 2015

by the following vote: 60 Ayes,

0 Nays, 0 Not Voting

Speaker of the House

☐ Pro Tempore

Chief Clerk of the House

Passed the Senate April 2, 2015

by the following vote: 28 Ayes,

1 Nays, 1 Not Voting

President of the Senate

Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill received by the Governor this

6th day of April, 2015

at 9:13 o'clock A. M.

Secretary to the Governor

Approved this 10th day of

April

at 4:42 o'clock P M.

Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill received by the Secretary of State

this 13 day of April, 2015

at 8:30 o'clock A M.

Secretary of State

H.B. 2373