CHAPTER 17

HOUSE BILL 2244

AN ACT

AMENDING SECTIONS 36-2907 AND 36-2939, ARIZONA REVISED STATUTES; RELATING TO THE PROVISION OF TRIBAL HEALTHCARE DENTAL SERVICES.

(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, including occupational therapy.

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

10. Nonexperimental transplants approved for title XIX
reimbursement.

11. DENTAL SERVICES AS FOLLOWS:
   (a) EXCEPT AS PROVIDED IN SUBDIVISION (b) OF THIS PARAGRAPH, for
   persons who are at least twenty-one years of age, emergency dental care
   and extractions in an annual amount of not more than one thousand dollars
   $1,000 per member.
   (b) SUBJECT TO APPROVAL BY THE CENTERS FOR MEDICARE AND MEDICAID
   SERVICES, FOR PERSONS TREATED AT AN INDIAN HEALTH SERVICE OR TRIBAL
   FACILITY, ADULT DENTAL SERVICES THAT ARE ELIGIBLE FOR A FEDERAL MEDICAL
   ASSISTANCE PERCENTAGE OF ONE HUNDRED PERCENT AND THAT ARE IN EXCESS OF THE
   LIMIT PRESCRIBED IN SUBDIVISION (a) OF THIS PARAGRAPH.

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

13. Hospice care.

14. 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 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 $12,500 per contract year.
   (c) Percussive vests are not covered health and medical services.
   (d) Durable medical equipment is limited to items covered by
medicare.
   (e) Nonexperimental transplants do not include pancreas-only
transplants.
(f) 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 acting through the regional behavioral health authorities 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 administration acting through regional behavioral health authorities 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 PROVIDING 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. 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. L. 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 AND medical records and the initiation of INITIATING medical care.

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

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

36-2939. Long-term care system services
A. The following services shall be provided by the program contractors to members who are determined to need institutional services pursuant to this article:
1. Nursing facility services other than services in an institution for tuberculosis or mental disease.
2. Notwithstanding any other law, behavioral health services if these services are not duplicative of long-term care services provided as of January 30, 1993 under this subsection and are authorized by the program contractor through the long-term care case management system. If the administration is the program contractor, the administration may authorize these services.
3. Hospice services. For the purposes of this paragraph, "hospice" means a program of palliative and supportive care for terminally ill members and their families or caregivers.
4. Case management services as provided in section 36-2938.
5. Health and medical services as provided in section 36-2907.
6. Dental services AS FOLLOWS:
   (a) EXCEPT AS PROVIDED IN SUBDIVISION (b) OF THIS PARAGRAPH, in an annual amount of not more than one thousand dollars $1,000 per member.
   (b) SUBJECT TO APPROVAL BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, FOR PERSONS TREATED AT AN INDIAN HEALTH SERVICE OR TRIBAL FACILITY, ADULT DENTAL SERVICES THAT ARE ELIGIBLE FOR A FEDERAL MEDICAL ASSISTANCE PERCENTAGE OF ONE HUNDRED PERCENT AND THAT ARE IN EXCESS OF THE LIMIT PRESCRIBED IN SUBDIVISION (a) OF THIS PARAGRAPH.
B. In addition to the services prescribed in subsection A of this section, the department, as a program contractor, shall provide the following services if appropriate to members who have a developmental disability as defined in section 36-551 and who are determined to need institutional services pursuant to this article:
1. Intermediate care facility services for a member who has a developmental disability as defined in section 36-551. For purposes of this article, a facility shall meet all federally approved standards and may only include the Arizona training program facilities, a state owned
and operated service center, state owned or operated community residential
settings and private facilities that contract with the department.

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

(a) Home health, which means the provision of nursing services,
skilled home health aide 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 a physician's orders and in accordance with federal
law. Physical therapy, occupational therapy, or speech and audiology
services provided by a home health agency may be provided in accordance
with federal law. Home health agencies shall comply with federal bonding
requirements in a manner prescribed by the administration.

(b) Skilled home health aide, which means a home health service
ordered by a physician on the member's plan of care and provided by a
licensed nursing assistant under the supervision of a registered nurse
pursuant to subsection G of this section.

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

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

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

(f) Day care for persons with developmental disabilities, which
means a service that provides planned care supervision and activities,
personal care, activities of daily living skills training and habilitation
services in a group setting during a portion of a continuous
twenty-four-hour period.

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

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

(i) Transportation, which means a service that provides or assists
in obtaining transportation for the member.
(j) Other services or licensed or certified settings approved by
the director.

C. In addition to services prescribed in subsection A of this
section, home and community based services may be provided in a member's
home, in an adult foster care home as prescribed in section 36-401, in an
assisted living home or assisted living center as defined in section
36-401 or in a level one or level two behavioral health alternative
residential facility approved by the director by program contractors to
all members who do not have a developmental disability as defined in
section 36-551 and are determined to need institutional services pursuant
to this article. Members residing in an assisted living center must be
provided the choice of single occupancy. The director may also approve
other licensed residential facilities as appropriate on a case-by-case
basis for traumatic brain injured members. Home and community based
services may include the following:

1. Home health, which 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 a physician's orders
and in accordance with federal law. Physical therapy, occupational
therapy, or speech and audiology services provided by a home health agency
may be provided in accordance with federal law. Home health agencies
shall comply with federal bonding requirements in a manner prescribed by
the administration.

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

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

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

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

6. Habilitation, which means the provision of physical therapy,
occupational therapy, speech or audiology services or training in
independent living, special developmental skills, sensory-motor
development, behavior intervention, and orientation and mobility in
accordance with federal law.
7. Respite care, which means a service that provides short-term care and supervision available on a twenty-four-hour basis.

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

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

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

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

E. Notwithstanding subsections A, B, C, F and G of this section, a service may not be provided that does not qualify for federal monies available under title XIX of the social security act or the section 1115 waiver.

F. In addition to services provided pursuant to subsections A, B and C of this section, the director may implement a demonstration project to provide home and community based services to special populations, including persons with disabilities who are eighteen years of age or younger, are medically fragile, reside at home and would be eligible for supplemental security income for the aged, blind or disabled or the state supplemental payment program, except for the amount of their parent's income or resources. In implementing this project, the director may provide for parental contributions for the care of their child.

G. In addition to services provided pursuant to subsections A, B, C and F of this section, the director shall implement a program under which skilled home health aide services may be provided to members who have developmental disabilities, who are under eighteen years of age and who are eligible to receive continuous skilled nursing or skilled nursing respite care services pursuant to chapter 5.1, article 1 of this title by a parent, guardian or family member who is a licensed nursing assistant employed by a medicare-certified home health agency service provider. The director shall request any necessary approvals from the centers for medicare and medicaid services to implement this subsection and to qualify for federal monies available under title XIX of the social security act or the section 1115 waiver.
H. Subject to section 36-562, the administration by rule shall prescribe a deductible schedule for programs provided to members who are eligible pursuant to subsection B of this section, except that the administration shall implement a deductible based on family income. In determining deductible amounts and whether a family is required to have deductibles, the department shall use adjusted gross income. Families whose adjusted gross income is at least four hundred percent and less than or equal to five hundred percent of the federal poverty guidelines shall have a deductible of two percent of adjusted gross income. Families whose adjusted gross income is more than five hundred percent of adjusted gross income shall have a deductible of four percent of adjusted gross income. Only families whose children are under eighteen years of age and who are members who are eligible pursuant to subsection B of this section may be required to have a deductible for services. For the purposes of this subsection, "deductible" means an amount a family, whose children are under eighteen years of age and who are members who are eligible pursuant to subsection B of this section, pays for services, other than departmental case management and acute care services, before the department will pay for services other than departmental case management and acute care services.

Sec. 3. **AHCCCS; federal authorization; adult dental services**

The Arizona health care cost containment system administration shall seek federal authorization to reimburse the Indian health services and tribal facilities to cover the cost of adult dental services that are eligible for a federal medical assistance percentage of one hundred percent, that are in excess of the limits prescribed in sections 36-2907 and 36-2939, Arizona Revised Statutes, as amended by this act, and that are received through these entities.
