Senate Engrossed

2025-2026; health care

State of Arizona
Senate
Fifty-seventh Legislature
First Regular Session
2025

SENATE BILL 1741

AN ACT

REPEALING SECTION 36-145, ARIZONA REVISED STATUTES; AMENDING SECTIONS 36-694, 36-1802, 36-2907, 36-2939, 36-2981 AND 36-2989, ARIZONA REVISED STATUTES; AMENDING LAWS 2022, CHAPTER 330, SECTION 3; AMENDING LAWS 2023, CHAPTER 139, SECTION 4, AS AMENDED BY LAWS 2024, CHAPTER 215, SECTION 2; APPROPRIATING MONIES; RELATING TO HEALTH CARE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Repeal

Section 36-145, Arizona Revised Statutes, is repealed.

Sec. 2. Section 36-694, Arizona Revised Statutes, is amended to read:

36-694. Report of blood tests; newborn screening program; committee; fee; definitions

A. When a birth or stillbirth is reported, the attending physician or other person required to report the birth shall state on the certificate whether a blood test for syphilis was made on a specimen of blood taken from the woman who bore the child or from the umbilical cord at delivery, as required by section 36-693, and the approximate date when the specimen was taken.

B. When a birth is reported, the attending physician or person who is required to report the birth shall order or cause to be ordered tests for certain congenital disorders, including hearing disorders. The results of tests for these disorders must be reported to the department of health services. The department of health services shall specify in rule the disorders, the process for collecting and submitting specimens and the reporting requirements for test results.

C. When a hearing test is performed on a newborn, the initial hearing test results and any subsequent hearing test results must be reported to the department of health services as prescribed by department rules.

D. The director of the department of health services shall establish a newborn screening program within the department to ensure that the testing for congenital disorders and the reporting of hearing test results required by this section are conducted in an effective and efficient manner. The newborn screening program shall include all congenital disorders that are included on the recommended uniform screening panel adopted by the secretary of the United States department of health and human services for both core and secondary conditions. ~~Beginning January 1, 2022,~~ CONGENITAL disorders that are added to the core and secondary conditions list of the recommended uniform screening panel shall be added to this state's newborn screening panel within two years after their addition to the recommended uniform screening panel. The newborn screening program shall include an education program for the general public, the medical community, parents and professional groups. The director shall designate the state laboratory as the only testing facility for the program, except that the director may designate other laboratory testing facilities for conditions or tests added to the newborn screening program on or after July 24, 2014. If the director designates another laboratory testing facility for any condition or test, the director shall require the facility to follow all of the privacy and sample destruction time frames that are required of the state laboratory.

E. IN ADDITION TO THE CONGENITAL DISORDERS ADDED TO THIS STATE'S NEWBORN SCREENING PANEL PURSUANT TO SUBSECTION D OF THIS SECTION, THE DEPARTMENT SHALL ADD DUCHENNE MUSCULAR DYSTROPHY TO THIS STATE'S NEWBORN SCREENING PANEL.

~~E.~~ F. The newborn screening program shall establish and maintain a central database of newborns and infants who are tested for hearing loss and congenital disorders that includes information required in rule. Test results are confidential subject to the disclosure provisions of sections 12-2801 and 12-2802.

~~F.~~ G. If tests conducted pursuant to this section indicate that a newborn or infant may have a hearing loss or a congenital disorder, the screening program shall provide follow-up services to encourage the child's family to access evaluation services, specialty care and early intervention services.

~~G.~~ H. The director shall establish a committee to provide recommendations and advice to the department on at least an annual basis regarding newborn screening best practices and emerging trends.

~~H.~~ I. The director may establish by rule a fee that the department may collect for operating the newborn screening program, including contracting for the testing pursuant to this section. The director shall present any change to the fee for the newborn screening program to the joint legislative budget committee for review.

~~I.~~ J. Not later than sixty days after the department adjusts the newborn screening program fee established pursuant to subsection ~~H~~ I of this section:

1. Each health insurer that is subject to title 20 shall update its hospital rates that include newborn screening to reflect the increase.

2. For the Arizona health care cost containment system and contractors acting pursuant to chapter 29, article 1 of this title that are not subject to title 20, the Arizona health care cost containment system shall update its hospital rates that include newborn screening to reflect the increase.

~~J.~~ K. For the purposes of this section:

1. "Infant" means a child who is twenty-nine days of age to two years of age.

2. "Newborn" means a child who is not more than twenty-eight days of age.

Sec. 3. Section 36-1802, Arizona Revised Statutes, is amended to read:

36-1802. Arizona nurse education investment pilot program; fund; use of monies

A. The Arizona nurse education investment pilot program is established in the department to increase the capacity of nursing education programs in this state by fostering collaboration among this state's education and health care communities and the state and federal

governments. Subject to available monies, the program shall address this state's nursing shortage by increasing the number of all levels of nurses graduating from this state's nursing education programs by the end of fiscal year 2026-2027 from the number graduating in fiscal year 2021-2022. The department may use legislative appropriations, private donations, grants and federal monies to implement, support, promote and maintain the program or to supplant monies appropriated from the state general fund. The department shall use all other funding sources before using any state general fund monies appropriated for this purpose.

B. The Arizona nurse education investment pilot program fund is established consisting of legislative appropriations and monies provided by any federal agency, entity or program for nursing education and workforce expansion. The department shall administer the fund. Monies in the fund are continuously appropriated and exempt from the provisions of section 35-190 relating to lapsing of appropriations. Any monies remaining in the fund on ~~July 1, 2026~~ JUNE 30, 2027 revert to the state general fund.

C. The department shall allocate fund monies to the Arizona board of regents and community college districts based on the number of nursing students graduating in fiscal year 2021-2022 from eligible education programs offered or overseen by the Arizona board of regents and the community college districts. Eligible education programs include programs for nursing assistants, licensed practical nurses, registered nurses and advanced practice nurses.

D. Monies allocated from the Arizona nurse education investment pilot program fund shall be used by the Arizona board of regents and the community college districts:

1. To pay for salaries, benefits, training and related expenses and operational costs necessary to increase the number of qualified nursing education faculty members teaching in nursing degree and certificate programs that are operated or overseen by the Arizona board of regents or the community college districts. The monies may be spent only for additional nursing education faculty members based on the number of faculty members who provided this education on June 30, 2021.

2. To supplement and not supplant monies that are appropriated by the legislature for each of fiscal years 2022-2023 through ~~2024-2025~~ 2025-2026 based on the number of nursing education faculty members who ~~provide~~ PROVIDED this education and WHO were funded in fiscal year 2021-2022.

3. For capital expenses that are directly related to additional faculty and students, including student support services.

E. The Arizona board of regents shall establish a process, which may include a grant program, to annually distribute fund monies to the universities under its jurisdiction for use only as prescribed in this section.

F. The director shall award grants to community college districts for use only as prescribed in this section based on the recommendations from a statewide organization that represents community colleges. The department shall establish an application form, process and procedure by which monies may be granted. The grants prescribed by this subsection are subject to the availability of monies and shall be distributed in a manner designed to increase the number of nurse graduates or students completing certificate programs by increasing available faculty and teaching resources in a manner that:

1. Provides for the efficient use of available monies and shared resources.

2. Distributes monies throughout geographic areas of this state and to underrepresented populations in the nursing workforce in this state.

Sec. 4. Section 36-2907, Arizona Revised Statutes, is amended to read:

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

A. Subject to the limits 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 to care FOR and treat 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 who is 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 $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 exceed 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.

15. Subject to approval by the centers for medicare and medicaid services, medically necessary chiropractic services that are performed by a chiropractor who is licensed pursuant to title 32, chapter 8 and that are ordered by a primary care physician or primary care practitioner

pursuant to rules adopted by the administration. The primary care physician or primary care practitioner may initially order up to twenty visits annually that include treatment and may request authorization for additional chiropractic services in that same year if additional chiropractic services are medically necessary.

16. For up to ten program hours annually, diabetes outpatient self-management training services, as defined in 42 United States Code section 1395x, if prescribed by a primary care practitioner in either of the following circumstances:

(a) The member is initially diagnosed with diabetes.

(b) For a member who has previously been diagnosed with diabetes, either:

(i) A change occurs in the member's diagnosis, medical condition or treatment regimen.

(ii) The member is not meeting appropriate clinical outcomes.

17. PURSUANT TO THE TERMS AND CONDITIONS THAT ARE APPROVED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND SUBJECT TO AVAILABLE FUNDING, TRADITIONAL HEALING SERVICES, IF BOTH OF THE FOLLOWING APPLY:

(a) THE MEMBER QUALIFIES FOR SERVICES THROUGH THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY PURSUANT TO THE CONDITIONS OF PARTICIPATION OUTLINED IN 42 CODE OF FEDERAL REGULATIONS SECTION 136.12.

(b) THE TRADITIONAL HEALING SERVICE IS DELIVERED BY OR THROUGH THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY.

B. The limits 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 $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 limits 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 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. 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 allow 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 that are similar to title 32, chapter 13, 15, 17 or 25 and shall complete a provider agreement for this state.

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.

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 transferring patients and medical records and initiating medical care.

M. PURSUANT TO THE TERMS AND CONDITIONS THAT ARE APPROVED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND SUBJECT TO AVAILABLE FUNDING, THE DIRECTOR SHALL IMPLEMENT LIMITED BENEFIT COVERAGE PRERELEASE SERVICES TO ELIGIBLE INCARCERATED INDIVIDUALS AND COMMITTED YOUTH FOR UP TO NINETY DAYS IMMEDIATELY BEFORE THE INDIVIDUALS' OR COMMITTED YOUTH'S

EXPECTED DATE OF RELEASE FROM A PRISON, JAIL, SECURE CARE FACILITY OR TRIBAL CORRECTIONAL FACILITY.

~~M.~~ N. Notwithstanding section 36-2901.08, monies from the hospital assessment fund established by section 36-2901.09 may not be used to provide ANY OF THE FOLLOWING:

1. Chiropractic services as prescribed in subsection A, paragraph 15 of this section.

~~N. Notwithstanding section 36-2901.08, monies from the hospital assessment fund established by section 36-2901.09 may not be used to provide~~

2. Diabetes outpatient self-management training services as prescribed in subsection A, paragraph 16 of this section.

O. For the purposes of this section: ~~,~~

1. "Ambulance" has the same meaning prescribed in section 36-2201.

2. "TRIBAL FACILITY" HAS THE SAME MEANING PRESCRIBED IN SECTION 36-2981.

Sec. 5. Section 36-2939, Arizona Revised Statutes, is amended to read:

36-2939. Long-term care system services; definitions

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 $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.

7. PURSUANT TO THE TERMS AND CONDITIONS THAT ARE APPROVED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND SUBJECT TO AVAILABLE FUNDING, TRADITIONAL HEALING SERVICES IF BOTH OF THE FOLLOWING APPLY:

(a) THE MEMBER QUALIFIES FOR SERVICES THROUGH THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY PURSUANT TO THE CONDITIONS OF PARTICIPATION OUTLINED IN 42 CODE OF FEDERAL REGULATIONS SECTION 136.12.

(b) THE TRADITIONAL HEALING SERVICE IS DELIVERED BY OR THROUGH THE INDIAN HEALTH SERVICE OR A TRIBAL FACILITY.

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, licensed 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 or allowed practitioner'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) Licensed health aide services, which means a home health agency service provided pursuant to subsection G of this section that is ordered by a physician or an allowed practitioner on the member's plan of care and provided by a licensed health aide who is licensed pursuant to title 32, chapter 15.

(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 or allowed practitioner'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. Licensed health aide services, which means a home health agency service provided pursuant to subsection G of this section that is ordered by a physician or an allowed practitioner on the member's plan of care and provided by a licensed health aide who is licensed pursuant to title 32, chapter 15.

3. 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.

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

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

6. 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.

7. 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.

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

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

10. 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.

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

D. The amount of monies 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 allocating 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. Consistent with the services provided pursuant to subsections A, B, C and F of this section and subject to approval by the centers for medicare and medicaid services, the director shall implement a program under which licensed health aide services may be provided to members who are under twenty-one years of age, who are eligible pursuant to section 36-2934, including members with developmental disabilities as defined in chapter 5.1, article 1 of this title, and who require continuous skilled nursing or skilled nursing respite care services. The licensed health aide services may be provided only by a parent, guardian or family member who is a licensed health aide employed by a medicare-certified home health agency service provider. Not later than sixty days after the approval of the rules implementing section 32-1645, subsection C, 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. The reimbursement rate for services provided under this subsection shall reflect the special skills needed to meet the health care needs of these members and shall exceed the reimbursement rate for home health aide services.

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.

I. For the purposes of this section: ,

1. "Allowed practitioner" means a nurse practitioner who is certified pursuant to title 32, chapter 15, a clinical nurse specialist who is certified pursuant to title 32, chapter 15 or a physician assistant who is certified pursuant to title 32, chapter 25.

2. "TRIBAL FACILITY" HAS THE SAME MEANING PRESCRIBED IN SECTION 36-2981.

Sec. 6. Section 36-2981, Arizona Revised Statutes, is amended to read:

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 to provide hospitalization and medical care to members according to 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 October 1, 1999 through September 30, 2023, has income at or below two hundred percent of the federal poverty level.

(b) Beginning on October 1, 2023 and for each fiscal year thereafter, subject to the approval of the centers for medicare and medicaid services, has income at or below two hundred twenty-five percent 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 who is 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 OR TRIBAL ORGANIZATION and that is authorized to provide services pursuant to Public Law 93-638, as amended.

Sec. 7. Section 36-2989, Arizona Revised Statutes, is amended to read:

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.

L. PURSUANT TO THE TERMS AND CONDITIONS THAT ARE APPROVED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES AND SUBJECT TO AVAILABLE FUNDING, THE DIRECTOR SHALL IMPLEMENT LIMITED BENEFIT COVERAGE PRERELEASE SERVICES TO ELIGIBLE INCARCERATED INDIVIDUALS OR COMMITTED YOUTH FOR UP TO NINETY DAYS IMMEDIATELY BEFORE THE INDIVIDUALS' OR COMMITTED YOUTH'S EXPECTED DATE OF RELEASE FROM A PRISON, JAIL, SECURE CARE FACILITY OR TRIBAL CORRECTIONAL FACILITY.

Sec. 8. Laws 2022, chapter 330, section 3 is amended to read:

Sec. 3. Delayed repeal

A. ~~Title 36, chapter 16~~ SECTIONS 36-1803, 36-1804, 36-1805, 36-1806 AND 36-1807, Arizona Revised Statutes, ~~as added by this act, is~~ ARE repealed from and after December 31, 2026.

B. TITLE 36, CHAPTER 16, ARIZONA REVISED STATUTES, IS REPEALED FROM AND AFTER JUNE 30, 2027.

Sec. 9. Laws 2023, chapter 139, section 4, as amended by Laws 2024, chapter 215, section 2, is amended to read:

Sec. 4. Department of health services; collaborative care uptake fund; exemption; technical assistance grants; delayed repeal; transfer of monies; definitions

A. The collaborative care uptake fund is established in the department. The fund consists of monies appropriated by the legislature. Monies in the fund are continuously appropriated and are exempt from the provisions of section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations. The department may not use more than three percent of the monies deposited in the fund to administer the fund.

B. The department shall use the collaborative care uptake fund monies to award grants to primary care physicians who are in a medical practice with not more than fifty employees to meet the initial costs of establishing and delivering behavioral health integration services through the collaborative care model and for technical assistance grants pursuant to subsection D of this section.

C. A primary care physician who receives a grant under this section may use the grant monies:

1. To hire staff.

2. To identify and formalize contractual relationships with other health care practitioners, including health care practitioners who will function as psychiatric consultants and behavioral health care managers in providing behavioral health integration services through the collaborative care model.

3. To purchase or upgrade software and other resources needed to appropriately provide behavioral health integration services through the collaborative care model, including resources needed to establish a patient registry and implement measurement-based care.

4. For any other purposes the department prescribes as necessary to support the collaborative care model.

D. The department shall solicit proposals from and enter into grant agreements with eligible collaborative care technical assistance center applicants to provide technical assistance to primary care physicians on providing behavioral health integration services through the collaborative care model. Each collaborative care technical assistance center applicant must provide in the grant application information on how the collaborative care technical assistance center will meet the assistance requirements prescribed in subsection E of this section in order to be eligible for a grant.

E. A collaborative care technical assistance center that receives a grant under subsection D of this section shall provide technical assistance to primary care physicians and shall assist the primary care physicians with the following:

1. Developing financial models and budgets for program launch and sustainability based on practice size.

2. Developing staffing models for essential staff roles, including care managers and consulting psychiatrists.

3. Providing information technology expertise to assist with building the model requirements into electronic health records, including assistance with care manager tools, patient registry, ongoing patient monitoring and patient records.

4. Providing training support for all key staff and operational consultation to develop practice workflows.

5. Establishing methods to ensure the sharing of best practices and operational knowledge among primary care physicians who provide behavioral health integration services through the collaborative care model.

6. For any other purposes the department prescribes as necessary to support the collaborative care model.

F. From and after June 30, ~~2025~~ 2027, this section is repealed and any unexpended and unencumbered monies remaining in the collaborative care uptake fund established by this section are transferred to the state general fund.

G. For the purposes of this section:

1. "Collaborative care model" means the evidence-based, integrated behavioral health service delivery method that is described as the psychiatric collaborative care model in 81 Federal Register 80230, that includes a formal collaborative arrangement among a primary care team consisting of a primary care physician, a care manager and a psychiatric consultant and that includes the following elements:

(a) Care directed by the primary care team.

(b) Structured care management.

(c) Regular assessments of clinical status using developmentally appropriate, validated tools.

(d) Modification of treatment as appropriate.

2. "Collaborative care technical assistance center":

(a) Means a health care organization that can provide educational support and technical assistance related to the collaborative care model.

(b) Includes an academic medical center.

3. "Department" means the department of health services.

4. "Primary care physician" has the same meaning prescribed in section 36-2901, Arizona Revised Statutes.

Sec. 10. Department of administration; dialysis services; grant

The department of administration shall award in fiscal year 2025-2026 a onetime grant of $3,000,000 to an operator of a health care facility to construct an outpatient treatment center for dialysis services. To qualify for the grant, the health care facility at which the

outpatient treatment center for dialysis services will be constructed shall meet all of the following:

1. Operate pursuant to Public Law 93-638.

2. Operate as a critical access hospital as defined in 42 Code of Federal Regulations section 440.170(g) and pursuant to 42 Code of Federal Regulations part 485, subpart F.

3. Be located on unincorporated land within or on tribal land in a county in this state with a population of not more than seventy thousand persons.

4. Benefit tribal members in need of dialysis treatment.

5. Serve a patient population of at least ten thousand persons.

6. Be located at least thirty miles from the nearest outpatient treatment center that is licensed pursuant to title 36, chapter 4, Arizona Revised Statutes, to provide dialysis services.

Sec. 11. Department of administration; grant program; technology solution; hospital interoperability; reports; delayed repeal

A. Notwithstanding section 41-703.01, Arizona Revised Statutes, for fiscal years 2025-2026, 2026-2027 and 2027-2028, the department of administration shall administer a competitive grant program that provides an interoperability software technology solution to support the provision of acute care services in rural hospitals, health care providers and trauma centers by providing resources to further treatment and care coordination with a focus on reducing public and private health care costs and unnecessary transportation costs. The department of administration shall award the grant under this program not later than December 1, 2025.

B. The Arizona health care cost containment system shall work with the department of administration to supplement the grant monies by identifying and applying to receive federal matching monies.

C. For fiscal years 2025-2026, 2026-2027 and 2027-2028, the grant recipient shall provide to the department of administration a report that provides metrics and quantifies cost and time savings for using an interoperable software solution in health care that complies with the health insurance portability and accountability act privacy standards (45 Code of Federal Regulations part 160 and part 164, subpart E). On or before June 30 of each fiscal year, the department of administration in coordination with the Arizona health care cost containment system shall provide to the governor, the president of the senate, the speaker of the house of representatives, the chairpersons of the health and human services committees of the senate and the house of representatives and the directors of the joint legislative budget committee and the governor's office of strategic planning and budgeting a report on the allocation of grant funding and a compiled analysis of the reports provided by the grant recipient.

D. Monies appropriated for the purposes of this section do not affect the monies appropriated in fiscal year 2022-2023 for interoperability software technology solutions or any grant awarded to or contract with a grant recipient pursuant to section 41-703.01, Arizona Revised Statutes.

E. This section is repealed from and after December 31, 2028.

Sec. 12. ALTCS; county contributions; fiscal year 2025-2026

A. Notwithstanding section 11-292, Arizona Revised Statutes, county contributions for the Arizona long-term care system for fiscal year 2025-2026 are as follows:

1.	Apache	$ 707,000
2.	Cochise	$ 7,510,100
3.	Coconino	$ 2,122,700
4.	Gila	$ 3,173,800
5.	Graham	$ 2,339,400
6.	Greenlee	$ 66,900
7.	La Paz	$ 828,800
8.	Maricopa	$275,201,600
9.	Mohave	$ 10,438,200
10.	Navajo	$ 2,926,600
11.	Pima	$ 63,729,700
12.	Pinal	$ 17,094,300
13.	Santa Cruz	$ 2,949,900
14.	Yavapai	$ 7,808,600
15.	Yuma	$ 12,640,000

B. If the overall cost for the Arizona long-term care system exceeds the amount specified in the general appropriations act for fiscal year 2025-2026, the state treasurer shall collect from the counties the difference between the amount specified in subsection A of this section and the counties' share of the state's actual contribution. The counties' share of the state's contribution must comply with any federal maintenance of effort requirements. The director of the Arizona health care cost containment system administration shall notify the state treasurer of the counties' share of the state's contribution and report the amount to the director of the joint legislative budget committee. The state treasurer shall withhold from any other monies payable to a county from whatever state funding source is available an amount necessary to fulfill that county's requirement specified in this subsection. The state treasurer may not withhold distributions from the Arizona highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes. The state treasurer shall deposit the amounts withheld pursuant to this subsection and amounts paid pursuant to subsection A of this section in the long-term care system fund established by section 36-2913, Arizona Revised Statutes.

Sec. 13. AHCCCS; disproportionate share payments; fiscal year 2025-2026

A. Disproportionate share payments for fiscal year 2025-2026 made pursuant to section 36-2903.01, subsection O, Arizona Revised Statutes, include:

1. $28,474,900 for the Arizona state hospital. The Arizona state hospital shall provide a certified public expense form for the amount of qualifying disproportionate share hospital expenditures made on behalf of this state to the Arizona health care cost containment system administration on or before March 31, 2026. The administration shall assist the Arizona state hospital in determining the amount of qualifying disproportionate share hospital expenditures. Once the administration files a claim with the federal government and receives federal financial participation based on the amount certified by the Arizona state hospital, the administration shall deposit the entire amount of federal financial participation in the state general fund. If the certification provided is for an amount less than $28,474,900, the administration shall notify the governor, the president of the senate and the speaker of the house of representatives and shall deposit the entire amount of federal financial participation in the state general fund. The certified public expense form provided by the Arizona state hospital must contain both the total amount of qualifying disproportionate share hospital expenditures and the amount limited by section 1923(g) of the social security act.

2. $884,800 for private qualifying disproportionate share hospitals. The Arizona health care cost containment system administration shall make payments to hospitals consistent with this appropriation and the terms of the state plan, but payments are limited to those hospitals that either:

(a) Meet the mandatory definition of disproportionate share qualifying hospitals under section 1923 of the social security act.

(b) Are located in Yuma county and contain at least three hundred beds.

B. After the distributions made pursuant to subsection A of this section, the allocations of disproportionate share hospital payments made pursuant to section 36-2903.01, subsection P, Arizona Revised Statutes, shall be made available in the following order to qualifying private hospitals that are:

1. Located in a county with a population of less than four hundred thousand persons.

2. Located in a county with a population of at least four hundred thousand persons but less than nine hundred thousand persons.

3. Located in a county with a population of at least nine hundred thousand persons.

Sec. 14. AHCCCS transfer; counties; federal monies; fiscal year 2025-2026

On or before December 31, 2026, notwithstanding any other law, for fiscal year 2025-2026, the Arizona health care cost containment system administration shall transfer to the counties the portion, if any, as may be necessary to comply with section 10201(c)(6) of the patient protection and affordable care act (P.L. 111-148), regarding the counties' proportional share of this state's contribution.

Sec. 15. County acute care contributions; fiscal year 2025-2026; intent

A. Notwithstanding section 11-292, Arizona Revised Statutes, for fiscal year 2025-2026 for the provision of hospitalization and medical care, the counties shall contribute the following amounts:

1.	Apache	$ 268,800
2.	Cochise	$ 2,214,800
3.	Coconino	$ 742,900
4.	Gila	$ 1,413,200
5.	Graham	$ 536,200
6.	Greenlee	$ 190,700
7.	La Paz	$ 212,100
8.	Maricopa	$14,783,900
9.	Mohave	$ 1,237,700
10.	Navajo	$ 310,800
11.	Pima	$14,951,800
12.	Pinal	$ 2,715,600
13.	Santa Cruz	$ 482,800
14.	Yavapai	$ 1,427,800
15.	Yuma	$ 1,325,100

B. If a county does not provide funding as specified in subsection A of this section, the state treasurer shall subtract the amount owed by the county to the Arizona health care cost containment system fund and the long-term care system fund established by section 36-2913, Arizona Revised Statutes, from any payments required to be made by the state treasurer to that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona Revised Statutes, plus interest on that amount pursuant to section 44-1201, Arizona Revised Statutes, retroactive to the first day the funding was due. If the monies the state treasurer withholds are insufficient to meet that county's funding requirements as specified in subsection A of this section, the state treasurer shall withhold from any other monies payable to that county from whatever state funding source is available an amount necessary to fulfill that county's requirement. The state treasurer may not withhold distributions from the Arizona highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes.

C. Payment of an amount equal to one-twelfth of the total amount determined pursuant to subsection A of this section shall be made to the state treasurer on or before the fifth day of each month. On request from the director of the Arizona health care cost containment system administration, the state treasurer shall require that up to three months' payments be made in advance, if necessary.

D. The state treasurer shall deposit the amounts paid pursuant to subsection C of this section and amounts withheld pursuant to subsection B of this section in the Arizona health care cost containment system fund and the long-term care system fund established by section 36-2913, Arizona Revised Statutes.

E. If payments made pursuant to subsection C of this section exceed the amount required to meet the costs incurred by the Arizona health care cost containment system for the hospitalization and medical care of those persons defined as an eligible person pursuant to section 36-2901, paragraph 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of the Arizona health care cost containment system administration may instruct the state treasurer either to reduce remaining payments to be paid pursuant to this section by a specified amount or to provide to the counties specified amounts from the Arizona health care cost containment system fund and the long-term care system fund established by section 36-2913, Arizona Revised Statutes.

F. The legislature intends that the Maricopa county contribution pursuant to subsection A of this section be reduced in each subsequent year according to the changes in the GDP price deflator. For the purposes of this subsection, "GDP price deflator" has the same meaning prescribed in section 41-563, Arizona Revised Statutes.

Sec. 16. Proposition 204 administration; exclusion; county expenditure limitations

County contributions for the administrative costs of implementing sections 36-2901.01 and 36-2901.04, Arizona Revised Statutes, that are made pursuant to section 11-292, subsection O, Arizona Revised Statutes, are excluded from the county expenditure limitations.

Sec. 17. Competency restoration; exclusion; county expenditure limitations

County contributions made pursuant to section 13-4512, Arizona Revised Statutes, are excluded from the county expenditure limitations.

Sec. 18. AHCCCS; risk contingency rate setting

Notwithstanding any other law, for the contract year beginning October 1, 2025 and ending September 30, 2026, the Arizona health care cost containment system administration may continue the risk contingency rate setting for all managed care organizations and the funding for all managed care organizations administrative funding levels that were imposed for the contract year beginning October 1, 2010 and ending September 30, 2011.

Sec. 19. Arizona nurse education investment pilot program; fiscal year 2025-2026; use of monies

Notwithstanding section 36-1802, Arizona Revised Statutes, as amended by this act, the Arizona board of regents is excluded from the Arizona nurse education investment pilot program distributions in fiscal year 2025-2026.

Sec. 20. AHCCCS; complete care contracts; extension

A. On or before December 1, 2025, the director of the Arizona health care cost containment system shall offer one-year AHCCCS complete care contract extensions to all managed care entities with then-current AHCCCS complete care contracts beginning with the contract number YH19-0001, including those with regional behavioral health agreements. If accepted, the extensions shall be both:

1. Effective between October 1, 2027 and September 30, 2028.

2. Offered as otherwise provided by law, except that an extension may not be offered to any entity that will cause the Arizona health care cost containment system to lose any federal monies to which the Arizona health care cost containment system is otherwise entitled.

B. The director of the Arizona health care cost containment system may offer additional extensions of the contracts extended pursuant to subsection A of this section on determination by the Arizona department of administration that the contract extensions are in the best interest of this state.

Sec. 21. Legislative findings

A. The legislature finds that the amendments to the Arizona health care cost containment system's 1115 demonstration waiver that were approved by the centers for medicare and medicaid services for the following amendments are not subject to section 36-3302, Arizona Revised Statutes, as added by Laws 2025, chapter 93, section 2, because both amendments were submitted to and approved by the centers for medicare and medicaid services before the effective date of this statutory requirement:

1. Coverage of traditional health care practices.

2. Prerelease services under the reentry demonstration initiative.

B. The legislature further finds that if the Arizona health care cost containment system wished to submit demonstration waiver amendments for this or similar coverage on or after April 24, 2025, similar changes to the changes made in section 36-2907, Arizona Revised Statutes, as amended by this act, relating to traditional healing services and prerelease services would comply with the requirements of section 36-3302, Arizona Revised Statutes, as added by Laws 2025, chapter 93, section 2,.

Sec. 22. Legislative intent; implementation of program

The legislature intends that for fiscal year 2025-2026 the Arizona health care cost containment system administration implement a program within the available appropriation.

Sec. 23. Retroactivity

Laws 2023, chapter 139, section 4, as amended by Laws 2024, chapter 215, section 2 and this act, applies retroactively to from and after June 29, 2025.

Sec. 24. Applicability; notification

A. Section 36-694, Arizona Revised Statutes, as amended by this act, applies on the earlier of either of the following:

1. October 1, 2027.

2. Two years after the date Duchenne muscular dystrophy is added to the recommended uniform screening panel adopted by the secretary of the United States department of health and human services.