REFERENCE TITLE: traditional healing services; AHCCCS

State of Arizona
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SB 1776

Introduced by
Senators Gonzales: Alston, Bravo, Diaz, Hatathlie, Kuby, Miranda, Ortiz, Sears, Sundareshan

AN ACT

AMENDING SECTIONS 36-2907 AND 36-2939, 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; 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, AN URBAN INDIAN ORGANIZATION 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) Prosthetic devices do not include hearing aids, dentures or bone-anchored hearing aids. Prosthetic devices, except prosthetic implants, may be limited to $12,500 per contract year.

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

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

(d) Nonexperimental transplants do not include pancreas-only transplants.

(e) 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'~~ EACH INDIVIDUAL'S or committed youth's expected date of release from a prison, jail, secure care facility or tribal correctional facility.

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.

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

3. Speech therapy provided in an outpatient setting to eligible persons who are at least twenty-one years of age.

4. Cochlear implants to eligible persons who are at least twenty-one years of age.

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.

3. "URBAN INDIAN ORGANIZATION" MEANS AN URBAN INDIAN ORGANIZATION IN THIS STATE THAT RECEIVES INDIAN HEALTH SERVICES FUNDING PURSUANT TO 25 UNITED STATES CODE CHAPTER 18.

Sec. 2. 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, AN URBAN INDIAN ORGANIZATION 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.

3. "URBAN INDIAN ORGANIZATION" MEANS AN URBAN INDIAN ORGANIZATION IN THIS STATE THAT RECEIVES INDIAN HEALTH SERVICES FUNDING PURSUANT TO 25 UNITED STATES CODE CHAPTER 18.