Fifty-sixth Legislature
Second Regular Session

COMMITTEE ON HEALTH & HUMAN SERVICES

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2449

(Reference to printed bill)

Strike everything after the enacting clause and insert:

"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. MEDICATIONS THAT ARE PRESCRIBED TO ADDRESS A MENTAL DISORDER ARE NOT SUBJECT TO PRIOR AUTHORIZATION OR STEP-THERAPY PROTOCOLS, EXCEPT THAT THE ADMINISTRATION AND ITS CONTRACTORS MAY IMPOSE STEP THERAPY THAT REQUIRES THE MEMBER TO TRY NOT MORE THAN ONE PRESCRIPTION DRUG BEFORE RECEIVING COVERAGE FOR THE DRUG PRESCRIBED BY THE MEMBER'S PHYSICIAN OR PRIMARY CARE PROVIDER, FOR PERSONS WHO ARE AT LEAST EIGHTEEN YEARS OF AGE IF ALL OF THE FOLLOWING APPLY:

(a) THE MEDICATION IS PRESCRIBED TO PREVENT, ASSESS OR TREAT ANY OF THE FOLLOWING QUALIFYING MENTAL DISORDERS AS DETERMINED BY THE MEMBER'S HEALTH CARE PROVIDER:

(i) BIPOLAR DISORDER, INCLUDING HYPOMANIC, MANIC, DEPRESSIVE AND MIXED.

(ii) MAJOR DEPRESSIVE DISORDER, EITHER SINGLE-EPISODE OR RECURRENT.

(iii) OBSESSIVE-COMPULSIVE DISORDER.

(iv) PARANOID AND OTHER PSYCHOTIC DISORDERS.

(v) POSTPARTUM DEPRESSION.

(vi) POST-TRAUMATIC STRESS DISORDER.

(vii) SCHIZOAFFECTIVE DISORDERS, INCLUDING BIPOLAR OR DEPRESSIVE.

(viii) SCHIZOPHRENIA.

(b) THE PRESCRIBED MEDICATION IS EITHER ON THE SYSTEM'S APPROVED BEHAVIORAL HEALTH DRUG LIST OR IS CURRENTLY AVAILABLE UNDER THE MEDICAID DRUG REBATE PROGRAM.

(c) THE PRESCRIPTION DOES NOT EXCEED LABELED DOSAGES APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION.

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.

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

N. IN DEVELOPING A PREFERRED DRUG LIST FOR THE PURPOSES OF PRESCRIPTION DRUG COVERAGE, THE ADMINISTRATION SHALL ENSURE THAT THE PHARMACY AND THERAPEUTICS COMMITTEE REVIEWS ANY DRUG THAT IS NEWLY APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION FOR THE TREATMENT OF QUALIFYING MENTAL DISORDERS, AS PRESCRIBED IN SUBSECTION A, PARAGRAPH 4 OF THIS SECTION, AT THE FIRST MEETING OF THE PHARMACY AND THERAPEUTICS COMMITTEE FOLLOWING THE DATE OF THE DRUG'S APPROVAL. IF THERE IS NOT ADEQUATE TIME TO REVIEW THE NEWLY APPROVED DRUG, THE DRUG MAY BE REVIEWED AT THE SECOND MEETING OF THE PHARMACY AND THERAPEUTICS COMMITTEE FOLLOWING THE DATE OF THE DRUG'S APPROVAL.

0. For the purposes of this section: ;—

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

2. "STEP-THERAPY PROTOCOL" MEANS A PROTOCOL OR PROGRAM THAT ESTABLISHES THE SPECIFIC SEQUENCE IN WHICH PRESCRIPTION DRUGS THAT ARE FOR A SPECIFIED MEDICAL CONDITION AND THAT ARE MEDICALLY NECESSARY FOR A PARTICULAR PATIENT ARE COVERED BY THE STATE PLAN.

Sec. 2. Title 36, chapter 34, article 1, Arizona Revised Statutes, is amended by adding section 36-3410.01, to read:

36-3410.01. Prescription medications; mental disorders; prior authorization and step therapy not required; definition

A. MEDICATIONS THAT ARE PRESCRIBED TO ADDRESS A MENTAL DISORDER ARE NOT SUBJECT TO PRIOR AUTHORIZATION OR STEP-THERAPY PROTOCOLS, EXCEPT THAT THE ADMINISTRATION AND ITS CONTRACTORS MAY IMPOSE STEP THERAPY THAT REQUIRES THE MEMBER TO TRY NOT MORE THAN ONE PRESCRIPTION DRUG BEFORE RECEIVING COVERAGE FOR THE DRUG PRESCRIBED BY THE MEMBER'S PHYSICIAN OR PRIMARY CARE PROVIDER, FOR PERSONS WHO ARE AT LEAST EIGHTEEN YEARS OF AGE IF ALL OF THE FOLLOWING APPLY:

1. THE MEDICATION IS PRESCRIBED TO PREVENT, ASSESS OR TREAT ANY OF THE FOLLOWING QUALIFYING MENTAL DISORDERS AS DETERMINED BY THE PERSON'S HEALTH CARE PROVIDER:

(a) BIPOLAR DISORDER, INCLUDING HYPOMANIC, MANIC, DEPRESSIVE AND MIXED.

(b) MAJOR DEPRESSIVE DISORDER, EITHER SINGLE-EPISODE OR RECURRENT.

(c) OBSESSIVE-COMPULSIVE DISORDER.

(d) PARANOID AND OTHER PSYCHOTIC DISORDERS.

(e) POSTPARTUM DEPRESSION.

(f) POST-TRAUMATIC STRESS DISORDER.

(g) SCHIZOAFFECTIVE DISORDERS, INCLUDING BIPOLAR OR DEPRESSIVE.

(h) SCHIZOPHRENIA.

2. THE PRESCRIBED MEDICATION IS A COVERED BENEFIT.

3. THE PRESCRIPTION DOES NOT EXCEED LABELED DOSAGES APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION.

B. FOR THE PURPOSES OF THIS SECTION, "STEP-THERAPY PROTOCOL" MEANS A PROTOCOL OR PROGRAM THAT ESTABLISHES THE SPECIFIC SEQUENCE IN WHICH PRESCRIPTION DRUGS THAT ARE FOR A SPECIFIED MEDICAL CONDITION AND THAT ARE MEDICALLY NECESSARY FOR A PARTICULAR PATIENT ARE COVERED."

Amend title to conform

And, as so amended, it do pass

STEVE MONTENEGRO
CHAIRMAN

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