

REFERENCE TITLE: AHCCCS; ketamine infusion therapy

State of Arizona  
House of Representatives  
Fifty-sixth Legislature  
Second Regular Session  
2024

## **HB 2762**

Introduced by  
Representative Parker B

AN ACT

AMENDING SECTION 36-2907, ARIZONA REVISED STATUTES; RELATING THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Section 36-2907, Arizona Revised Statutes, is amended to  
3 read:

4 36-2907. Covered health and medical services; modifications;  
5 related delivery of service requirements; rules;  
6 definition

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

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

16 2. Outpatient health services that are ordinarily provided in  
17 hospitals, clinics, offices and other health care facilities by licensed  
18 health care providers. Outpatient health services include services  
19 provided by or under the direction of a physician or a primary care  
20 practitioner, including occupational therapy.

21 3. Other laboratory and X-ray services ordered by a physician or a  
22 primary care practitioner.

23 4. Medications that are ordered on prescription by a physician or a  
24 dentist who is licensed pursuant to title 32, chapter 11. Persons who are  
25 dually eligible for title XVIII and title XIX services must obtain  
26 available medications through a medicare licensed or certified medicare  
27 advantage prescription drug plan, a medicare prescription drug plan or any  
28 other entity authorized by medicare to provide a medicare part D  
29 prescription drug benefit.

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

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

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

42 8. Family planning services that do not include abortion or  
43 abortion counseling. If a contractor elects not to provide family  
44 planning services, this election does not disqualify the contractor from  
45 delivering all other covered health and medical services under this

1 chapter. In that event, the administration may contract directly with  
2 another contractor, including an outpatient surgical center or a  
3 noncontracting provider, to deliver family planning services to a member  
4 who is enrolled with the contractor that elects not to provide family  
5 planning services.

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

9 10. Nonexperimental transplants approved for title XIX  
10 reimbursement.

11 11. Dental services as follows:

12 (a) Except as provided in subdivision (b) of this paragraph, for  
13 persons who are at least twenty-one years of age, emergency dental care  
14 and extractions in an annual amount of not more than \$1,000 per member.

15 (b) Subject to approval by the centers for medicare and medicaid  
16 services, for persons treated at an Indian health service or tribal  
17 facility, adult dental services that are eligible for a federal medical  
18 assistance percentage of one hundred percent and that exceed the limit  
19 prescribed in subdivision (a) of this paragraph.

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

22 13. Hospice care.

23 14. Orthotics, if all of the following apply:

24 (a) The use of the orthotic is medically necessary as the preferred  
25 treatment option consistent with medicare guidelines.

26 (b) The orthotic is less expensive than all other treatment options  
27 or surgical procedures to treat the same diagnosed condition.

28 (c) The orthotic is ordered by a physician or primary care  
29 practitioner.

30 15. Subject to approval by the centers for medicare and medicaid  
31 services, medically necessary chiropractic services that are performed by  
32 a chiropractor who is licensed pursuant to title 32, chapter 8 and that  
33 are ordered by a primary care physician or primary care practitioner  
34 pursuant to rules adopted by the administration. The primary care  
35 physician or primary care practitioner may initially order up to twenty  
36 visits annually that include treatment and may request authorization for  
37 additional chiropractic services in that same year if additional  
38 chiropractic services are medically necessary.

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

43 (a) The member is initially diagnosed with diabetes.

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

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

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

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

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

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

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

12 (b) Prosthetic devices do not include hearing aids, dentures,  
13 bone-anchored hearing aids or cochlear implants. Prosthetic devices,  
14 except prosthetic implants, may be limited to \$12,500 per contract year.

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

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

18 (e) Nonexperimental transplants do not include pancreas-only  
19 transplants.

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

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

26 D. The director shall adopt rules necessary to limit, to the extent  
27 possible, the scope, duration and amount of services, including maximum  
28 limits for inpatient services that are consistent with federal regulations  
29 under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42  
30 United States Code section 1396 (1980)). To the extent possible and  
31 practicable, these rules shall provide for the prior approval of medically  
32 necessary services provided pursuant to this chapter.

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

42 F. The director shall adopt rules for the coverage of behavioral  
43 health services for persons who are eligible under section 36-2901,  
44 paragraph 6, subdivision (a). The administration acting through the  
45 regional behavioral health authorities shall establish a diagnostic and

1 evaluation program to which other state agencies shall refer children who  
2 are not already enrolled pursuant to this chapter and who may be in need  
3 of behavioral health services. In addition to an evaluation, the  
4 administration acting through regional behavioral health authorities shall  
5 also identify children who may be eligible under section 36-2901,  
6 paragraph 6, subdivision (a) or section 36-2931, paragraph 5 and shall  
7 refer the children to the appropriate agency responsible for making the  
8 final eligibility determination.

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

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

25 I. If the director does not receive bids within the amounts  
26 budgeted or if at any time the amount remaining in the Arizona health care  
27 cost containment system fund is insufficient to pay for full contract  
28 services for the remainder of the contract term, the administration, on  
29 notification to system contractors at least thirty days in advance, may  
30 modify the list of services required under subsection A of this section  
31 for persons defined as eligible other than those persons defined pursuant  
32 to section 36-2901, paragraph 6, subdivision (a). The director may also  
33 suspend services or may limit categories of expense for services defined  
34 as optional pursuant to title XIX of the social security act (P.L. 89-97;  
35 79 Stat. 344; 42 United States Code section 1396 (1980)) for persons  
36 defined pursuant to section 36-2901, paragraph 6, subdivision (a). Such  
37 reductions or suspensions do not apply to the continuity of care for  
38 persons already receiving these services.

39 J. All health and medical services provided under this article  
40 shall be provided in the geographic service area of the member, except:

41 1. Emergency services and specialty services provided pursuant to  
42 section 36-2908.

43 2. That the director may allow the delivery of health and medical  
44 services in other than the geographic service area in this state or in an  
45 adjoining state if the director determines that medical practice patterns

1 justify the delivery of services or a net reduction in transportation  
2 costs can reasonably be expected. Notwithstanding the definition of  
3 physician as prescribed in section 36-2901, if services are procured from  
4 a physician or primary care practitioner in an adjoining state, the  
5 physician or primary care practitioner shall be licensed to practice in  
6 that state pursuant to licensing statutes in that state that are similar  
7 to title 32, chapter 13, 15, 17 or 25 and shall complete a provider  
8 agreement for this state.

9 K. Covered outpatient services shall be subcontracted by a primary  
10 care physician or primary care practitioner to other licensed health care  
11 providers to the extent practicable for purposes including, but not  
12 limited to, making health care services available to underserved areas,  
13 reducing costs of providing medical care and reducing transportation  
14 costs.

15 L. The director shall adopt rules that prescribe the coordination  
16 of medical care for persons who are eligible for system services. The  
17 rules shall include provisions for transferring patients and medical  
18 records and initiating medical care.

19 M. Notwithstanding section 36-2901.08, monies from the hospital  
20 assessment fund established by section 36-2901.09 may not be used to  
21 provide EITHER OF THE FOLLOWING:

22 1. Chiropractic services as prescribed in subsection A, paragraph  
23 15 of this section.

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

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

29 N. THE ADMINISTRATION AND ITS CONTRACTORS SHALL COVER AND MAKE  
30 AVAILABLE KETAMINE INFUSION THERAPY THAT IS PROVIDED TO MEMBERS BY A  
31 PSYCHIATRIST WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 13 AS A DOCTOR  
32 OF MEDICINE OR CHAPTER 17 AS A DOCTOR OF OSTEOPATHIC MEDICINE.

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