Bill Number: S.B. 1491

Biggs Floor Amendment

Reference to: printed bill

Amendment drafted by: Leg Council

FLOOR AMENDMENT EXPLANATION

Added

- **As permanent law, add medically necessary chiropractic services as a covered service for all AHCCCS members.**
- **As session law, limit AHCCCS expenditures on added medically necessary chiropractic services to $1,000,000 from the General Fund in FY 2015.**

Revised

- **As session law, state that it is the intent of the Legislature that DHS may increase behavioral health service provider rates up to 2% beginning on October 1, 2013. (Senate Introduced permitted a 3% rate increase).**
- **Revise the language regarding counties' cost of care of the sexually violent persons at the Arizona State Hospital to clarify that the percent of county charges will not increase from the FY 2014 level.**
- **Correct a section reference with regard to the provision requiring deposit of all federal LTCSF balances into General Fund.**
- **As session law, revise the FY 2015 disproportionate share (DSH) distributions to cap the DSH payments from the Maricopa Special Health Care District at $89.9 million.**

Amendment explanation prepared by Carolyn Speroni

3/20/2014

BIGGS FLOOR AMENDMENT

SENATE AMENDMENTS TO S.B. 1491

(Reference to printed bill)

Page 13, strike lines 31 through 45

Strike page 14

Page 15, strike lines 1 through 15, insert:

"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; definition

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

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

2. Outpatient health services that are ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient health services include services provided by or under the direction of a physician or a primary care practitioner.

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

4. Medications that are ordered on prescription by a physician or a dentist licensed pursuant to title 32, chapter 11. Persons who are dually eligible for title XVIII and title XIX services must obtain available medications through a medicare licensed or certified medicare advantage prescription drug plan, a medicare prescription drug plan or any other entity

authorized by medicare to provide a medicare part D prescription drug benefit.

5. Medical supplies, durable medical equipment 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 ordered by a primary care physician or primary care practitioner.

10. Nonexperimental transplants approved for title XIX reimbursement.

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

12. Hospice care.

13. BEGINNING OCTOBER 1, 2014, MEDICALLY NECESSARY CHIROPRACTIC SERVICES AS DESCRIBED IN SECTION 32-925 THAT ARE ORDERED BY A PRIMARY CARE PHYSICIAN PURSUANT TO RULES ADOPTED BY THE ADMINISTRATION.

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

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

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

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

(b) Prosthetic devices do not include hearing aids, dentures, bone anchored hearing aids or cochlear implants. Prosthetic devices, except prosthetic implants, may be limited to twelve thousand five hundred dollars per contract year.

(c) Insulin pumps, percussive vests and orthotics are not covered health and medical services.

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

(e) Podiatry services do not include services performed by a podiatrist.

(f) Nonexperimental transplants do not include pancreas only transplants.

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

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

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

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

F. The director shall adopt rules for the coverage of behavioral health services for persons who are eligible under section 36-2901, paragraph 6, subdivision (a). The administration shall contract with the department of health services for the delivery of all medically necessary behavioral health services to persons who are eligible under rules adopted pursuant to this subsection. The division of behavioral health in the department of health services 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 division of behavioral health 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 for the provision of transportation services and rules providing for copayment by members for transportation for other than emergency purposes. Subject to approval by the centers for medicare and medicaid services, nonemergency medical transportation shall not be provided except for stretcher vans and ambulance transportation. Prior authorization is required for transportation by stretcher van and for medically necessary ambulance transportation initiated pursuant to a physician's direction. Prior authorization is not required for medically necessary ambulance transportation services rendered to members or eligible

persons initiated by dialing telephone number 911 or other designated emergency response systems.

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

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

J. Additional, reduced or modified hospitalization and medical care benefits may be provided under the system to enrolled members who are eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

K. 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 permit 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 similar to title 32, chapter 13, 15, 17 or 25 and shall complete a provider agreement for this state.

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

M. The director shall adopt rules that prescribe the coordination of medical care for persons who are eligible for system services. The rules shall include provisions for the transfer of patients, the transfer of medical records and the initiation of medical care.

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

Sec. 5. Section 36-2953, Arizona Revised Statutes, is amended to read:

36-2953. Department long-term care system fund; uniform accounting

A. The department shall establish and maintain a department long-term care system fund which is a separate fund to distinguish its revenues and its expenditures pursuant to this article from other programs funded or administered by the department. Subject to legislative appropriation, the fund shall be used to pay administrative and program costs associated with the operation of the system. The department long-term care system fund shall be divided as follows:

1. An account for eligibility determination pursuant to section 36-2933, if the administration enters into an interagency agreement with the department pursuant to section 36-2933, subsection E.

2. An account for the provision of long-term care services as prescribed in section 36-2939, subsections A and B.

B. The department long-term care system fund shall be comprised of:

1. Monies paid by the administration pursuant to the contract.

2. Amounts paid by third party payors.

3. Gifts, donations and grants from any source.

4. State appropriations for the department long-term care system pursuant to this article.

5. Interest on monies deposited in the long-term care system fund.

C. The department shall submit a prospective long-term care budget as prescribed by the administration.

D. The administration shall prescribe a uniform accounting system for the fund established pursuant to subsection A of this section. Technical assistance shall be provided by the administration to the department in order to facilitate the implementation of the uniform accounting system.

E. The department shall submit an annual audited financial and programmatic report for the preceding fiscal year as required by the administration. The report shall include beginning and ending fund balances, revenues and expenditures including specific identification of administrative costs for the system. The report shall include the number of members served by the system and the cost incurred for various types of services provided to members in a format prescribed by the director.

F. The department shall submit additional utilization and financial reports as required by the director.

G. The director shall make at least an annual review of the department's records and accounts.

H. ALL MONIES IN THE DEPARTMENT LONG-TERM CARE SYSTEM FUND THAT ARE UNEXPENDED AND UNENCUMBERED AT THE END OF THE FISCAL YEAR REVERT TO THE STATE GENERAL FUND ON OR BEFORE JUNE 30 OF THAT FISCAL YEAR. THE TRANSFER AMOUNT MAY BE ADJUSTED FOR REPORTED BUT UNPAID CLAIMS AND ESTIMATED INCURRED BUT UNREPORTED CLAIMS, SUBJECT TO APPROVAL BY THE ADMINISTRATION."

Renumber to conform

Page 15, between lines 29 and 30, insert:

"Sec. 8. AHCCCS; chiropractic services; expenditure limitation

Notwithstanding section 36-2907, Arizona Revised Statutes, as amended by this act, for fiscal year 2014-2015, the Arizona health care cost containment system administration shall provide medically necessary chiropractic services as described in section 32-925, Arizona Revised Statutes, but shall limit the general fund costs associated with these services to not more than $1,000,000 in that fiscal year."

Renumber to conform

Page 16, line 27, strike "county shall reimburse the"; strike "for"

Strike lines 28, 29 and 30, insert "may determine the percentage of the costs to be reimbursed by the county. It is the intent of the legislature that the department of health services not increase the percentage rate of the county share of costs in fiscal year 2014-2015, relative to fiscal year 2013-2014."

Page 18, line 5, strike "greater" insert "less"; strike ", the administration"

Strike lines 6, 7 and 8

Line 9, strike "$89,877,700"

Line 22, after the period insert "The disproportionate share hospital payment attributed to the Maricopa county special health care district may not exceed $89,877,700."

Page 24, line 4, strike "three" insert "two"

Amend title to conform

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