REFERENCE TITLE: AHCCCS; chiropractic services

State of Arizona
House of Representatives
Forty-eighth Legislature
First Regular Session
2007

# HB 2114

Introduced by
Representatives Stump, Mason, Murphy, Senator Allen: Representative Rios P

AN ACT

AMENDING SECTION 36-2907, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-2907.02; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM; PROVIDING FOR CONDITIONAL ENACTMENT.

(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

A. Unless modified pursuant to 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 excludes 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 but do not include occupational therapy, or speech therapy for eligible persons who are twenty-one years of age or older.

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. Beginning January 1, 2006, 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. Emergency dental care and extractions for persons who are at least twenty-one years of age.

6. Medical supplies, equipment and prosthetic devices, not including hearing aids, ordered by a physician or a primary care practitioner or dentures ordered by a dentist licensed pursuant to title 32, chapter 11. 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.

7. 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.

8. 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.

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 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.

10. Podiatry services performed by a podiatrist licensed pursuant to title 32, chapter 7 and ordered by a primary care physician or primary care practitioner.

11. Nonexperimental transplants approved for title XIX reimbursement.

12. Ambulance and nonambulance transportation.

13. BEGINNING OCTOBER 1, 2008, IF THE ADMINISTRATION RECEIVES A WAIVER PURSUANT TO SECTION 36-2907.02, MEDICALLY NECESSARY CHIROPRACTIC SERVICES THROUGH SELF-REFERRAL FOR A MINIMUM OF TWELVE VISITS IN AN ANNUAL CONTRACT PERIOD FOR INDIVIDUALS SPECIFIED IN SECTION 36-2907.02. FOR THE PURPOSES OF THIS PARAGRAPH:

(a) "CHIROPRACTIC SERVICES" MEANS ONLY NONSURGICAL AND NONINVASIVE TREATMENT OF NECK AND BACK PAIN THROUGH PHYSIOTHERAPY, MUSCULOSKELETAL MANIPULATION AND OTHER PHYSICAL CORRECTIONS OF MUSCULOSKELETAL CONDITIONS WITHIN THE SCOPE OF THE CHIROPRACTIC PRACTICE.

(b) "MUSCULOSKELETAL" MEANS ANY FUNCTION OF THE MUSCULOSKELETAL SYSTEM THAT IS INTEGRATED WITH NEUROLOGICAL FUNCTION AND THAT IS EXPRESSED BY BIOLOGICAL REGULATORY MECHANISMS.

B. Beginning on October 1, 2002, circumcision of newborn males is not a covered health and medical service.

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, which 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. 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.

Sec. 2. Title 36, chapter 29, article 1, Arizona Revised Statutes, is amended by adding section 36-2907.02, to read:

36-2907.02. Chiropractic care pilot program; report

A. BEGINNING OCTOBER 1, 2008, THE CHIROPRACTIC CARE PILOT PROGRAM IS ESTABLISHED. THE ADMINISTRATION SHALL ENROLL THREE THOUSAND MEMBERS WHO HAVE PREVIOUSLY RECEIVED TREATMENT THROUGH THE SYSTEM FOR NECK OR BACK PAIN. THE ADMINISTRATION SHALL PRESCRIBE BY RULE ADDITIONAL REQUIREMENTS FOR PROGRAM PARTICIPANTS.

B. PROGRAM PARTICIPANTS ARE ELIGIBLE TO RECEIVE CHIROPRACTIC SERVICES PURSUANT TO SECTION 36-2907, SUBSECTION A, PARAGRAPH 13.

C. THE ADMINISTRATION SHALL CONDUCT AN EVALUATION OF THE PILOT PROGRAM AND SHALL SUBMIT A REPORT OF ITS FINDINGS TO THE GOVERNOR, THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND THE PRESIDENT OF THE SENATE ON OR BEFORE SEPTEMBER 1, 2011. THE ADMINISTRATION SHALL PROVIDE A COPY OF THIS REPORT TO THE SECRETARY OF STATE AND THE DIRECTOR OF THE ARIZONA STATE LIBRARY, ARCHIVES AND PUBLIC RECORDS. THE EVALUATION SHALL INCLUDE THE FOLLOWING:

1. THE NUMBER OF PROGRAM PARTICIPANTS.

2. THE AVERAGE NUMBER OF TREATMENTS AND AVERAGE CLAIM COST OF CARE FOR EACH PROGRAM PARTICIPANT IN THE FISCAL YEAR BEFORE ENROLLING IN THE PILOT PROGRAM.

3. THE AVERAGE NUMBER OF TREATMENTS AND AVERAGE CLAIM COST OF CARE FOR EACH PROGRAM PARTICIPANT IN THE FISCAL YEAR AFTER ENROLLING IN THE PILOT PROGRAM.

4. AN ANALYSIS OF THE COST-EFFECTIVENESS OF THE CHIROPRACTIC SERVICES BASED ON THE DATA PRESCRIBED IN PARAGRAPHS 2 AND 3 AND ANY OTHER RELEVANT DATA.

D. THE ADMINISTRATION SHALL APPLY TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES FOR A WAIVER OF THE REQUIREMENTS OF 42 UNITED STATES CODE SECTION 1396a(a)(10)(B).

Sec. 3. Conditional enactment

A. Section 36-2907, Arizona Revised Statutes, as amended by this act, and section 36-2907.02, Arizona Revised Statutes, as added by this act, do not become effective unless the Arizona health care cost containment system administration receives a waiver of the requirements of 42 United States Code section 1396a(a)(10)(B) from the centers for medicare and medicaid services on or before September 30, 2008.

B. The director of the Arizona health care cost containment system administration shall notify in writing the director of the Arizona legislative council of the date on which the condition is met or if the condition is not met.