ARIZONA STATE SENATE

Fifty-Sixth Legislature, First Regular Session

FACT SHEET FOR S.B. 1726

health care; 2023-2024.

Purpose

Makes statutory and session law changes relating to health care necessary to implement the FY 2024 state budget.

Background

The Arizona Constitution prohibits substantive law from being included in the general appropriations, capital outlay appropriations and supplemental appropriations bills. However, it is often necessary to make statutory and session law changes to effectuate the budget. Thus, separate bills called budget reconciliation bills (BRBs) are introduced to enact these provisions. Because BRBs contain substantive law changes, the Arizona Constitution provides that they become effective on the general effective date, unless an emergency clause is enacted.

S.B. 1726 contains the budget reconciliation provisions for changes relating to health care.

Provisions

Interoperability Software Grant Program

1. Requires the Arizona Department of Administration (ADOA) to administer a competitive grant program that provides a single company that licenses an interoperability software technology solution to support acute care for rural hospitals, health care providers and trauma centers with resources to further treatment and care coordination with a focus on reducing public and private health care costs and unnecessary transportation costs.

2. Requires ADOA to award the grant by December 1, 2023.

3. Directs the Arizona Health Care Cost Containment System (AHCCCS) to work with ADOA to supplement the grant monies by identifying and applying to receive federal matching monies.

4. Requires the grant program to enable the implementation of a single licensed interoperability software technology solution that is shared by hospitals and health care providers to benefit patients, before and after discharge from the provider's care, and that is accessible to current and future providers via a mobile, native smartphone application.

5. Requires the software to be made available to rural hospitals, health care providers and trauma centers that wish to participate by enabling a hospital's electronic medical records system to interface with interoperability technology and other electronic medical records systems and providers to promote mobile connectivity between hospital systems and facilitate increased communication between hospital staff and providers that use different or distinctive online and mobile platforms and information systems when treating acute patients.

6. Directs ADOA to award one grant for an interoperability software technology solution that, at a minimum:
   a) complies with the Health Insurance Portability and Accountability Act (HIPAA) privacy standards;
   b) captures and forwards clinical data, including laboratory results and images, and provides synchronous patient clinical data to health care providers regardless of geographic location;
   c) provides a synchronous data exchange, that is not batched or delayed, at the point the clinical data is captured and available in the hospital's electronic record system;
   d) is capable of providing proactive alerts to health care providers on their smartphones or a smart device;
   e) allows synchronous and asynchronous communication via a native smartphone application;
   f) is mobile technology, can be used on multiple electronic devices and includes the industry standard built-in application for the two most popular operating systems and a built-in application available to all users;
   g) has patient-centric communication and is tracked with date and time stamping;
   h) is connected to the appropriate physician resources; and
   i) provides data to update cost reports to enhance emergency triage and to treat and transport patients.

7. Requires the grant recipient to demonstrate:
   a) that its interoperability software technology solution meets all requirements at least 30 days before applying for the grant; and
   b) proof of veteran employment.

8. Requires, for FY 2024, the grant recipient to provide ADOA a report that provides metrics and quantifies cost and time savings for using an interoperable software solution in health care that complies with HIPAA privacy standards.

9. Directs ADOA, in coordination with AHCCCS and by July 1, 2024, to provide a report on the allocation of grant funding and compiled analysis of the reports provided by the grant recipient to the:
   a) President of the Senate;
   b) Speaker of the House of Representatives (House);
   c) Chairpersons of the Health and Human Services Committees of the Senate and House;
   d) Director of the Joint Legislative Budget Committee (JLBC); and
   e) Director of the Governor's Office of Strategic Planning and Budgeting.

10. Specifies that monies appropriated for the grant program in the FY 2024 General Appropriations Act do not affect monies appropriated in FY 2023 for interoperability software technology solutions or any grant awarded to or contract with a grant recipient.

11. Repeals the grant program on July 1, 2024.

Collaborative Care Uptake Fund (Fund)

12. Establishes the Fund in the Department of Health Services (DHS) consisting of monies appropriated by the Legislature.

13. Subjects monies in the Fund to legislative appropriation and specifies that monies in the Fund are continuously appropriated.

14. Prohibits DHS from using more than three percent of Fund monies to administer the Fund.

15. Allows a primary care physician that receives a grant from the Fund to use the monies to:
    a) hire staff;
    b) identify and formalize contractual relationships with other health care practitioners, including health care practitioners who will function as psychiatric consultants and behavioral health care managers in providing behavioral health integration services through the collaborative care model;
    c) purchase or upgrade software and other resources needed to appropriately provide behavioral health integration services through the collaborative care model, including resources needed to establish a patient registry and implement measurement-based care; and
    d) for any other purposes DHS prescribes as necessary to support the collaborative care model.

16. Requires DHS to solicit proposals from and enter into grant agreements with eligible collaborative care technical assistance center applicants to provide technical assistance to primary care physicians on providing behavioral health integration services through the collaborative care model.

17. Requires, in the grant application, each collaborative care technical assistance center applicant to provide information on how the collaborative care technical assistance center will meet the prescribed assistance requirements in order to be eligible for a grant.

18. Requires a collaborative care technical assistance center that receives a grant to provide technical assistance to primary care physicians and assist the primary care physicians with:
    a) developing financial models and budgets for program launch and sustainability based on practice size;
    b) developing staffing models for essential staff roles, including care managers and consulting psychiatrists;
    c) providing information technology expertise to assist with building the model requirements into electronic health records, including assistance with care manager tools, patient registry, ongoing patient monitoring and patient records;
    d) providing training support for all key staff and operational consultation to develop practice workflows;
    e) establishing methods to ensure the sharing of best practices and operational knowledge among primary care physicians who provide behavioral health integration services through the collaborative care model; and
    f) any other purposes DHS prescribes as necessary to support the collaborative care model.

19. Defines *collaborative care model* as the evidence-based, integrated behavioral health service delivery method that is described as the psychiatric collaborative care model in 81 Federal Register 80230, that includes a formal collaborative arrangement among a primary care team consisting of a primary care physician, a care manager and a psychiatric consultant and that includes the following elements:
    a) care directed by the primary care team;
    b) structured care management;
    c) regular assessments of clinical status using developmentally appropriate, validated tools; and
    d) modification of treatment as appropriate.

20. Defines *collaborative care technical assistance center* as a health care organization that can provide educational support and technical assistance related to the collaborative care model.

21. Includes an academic medical center in the definition of *collaborative care technical assistance center*.

Dementia and Alzheimer's Disease

22. Designates DHS as the lead state agency to address Alzheimer's disease and related forms of dementia.

23. Requires the Director of DHS to establish a dementia services program within DHS that:
    a) facilitates the coordination and support of policies and programs in the Legislature and executive branch, including state agencies, that relate to Alzheimer's disease and related forms of dementia;
    b) facilitates the coordination, review, publication and implementation of the Alzheimer's disease state plan;
    c) facilitates and supports coordination of outreach programs and services between state agencies, local public health departments, tribal nations, educational institutions and community groups to foster public awareness and education regarding Alzheimer's disease and related forms of dementia;
    d) facilitates the coordination of services and activities between groups that are interested in dementia research, programs and services, including area agencies on aging, service providers, advocacy groups, legal services, emergency personnel, law enforcement, local public health departments, tribal nations and state colleges and universities;
    e) applies for federal funding and grants related to public health services for, and early detection and risk reduction of, Alzheimer's disease and related forms of dementia; and
    f) incorporates early detection and risk strategies into existing DHS-led public health programs.

24. Requires DHS to develop an Alzheimer's disease state plan that:
    a) assesses the current and future impact of Alzheimer's disease and related forms of dementia on the State of Arizona;
    b) assesses the existing state services and resources that address the needs of persons with Alzheimer's disease or a related form of dementia and their family caregivers;
    c) assesses the needs of persons of all cultural backgrounds who have Alzheimer's disease or a related form of dementia and how their lives are affected by the disease, including from younger-onset, through mid-state, to late-stage;
    d) assesses the state's capacity and capability to provide effective detection and diagnosis of cognitive impairments and dementia;
    e) identifies gaps in the provision of public and private services for persons with Alzheimer's disease or a related form of dementia;
    f) provides a strategic plan, including recommendations, for state action; and
    g) is published on the DHS public website.

25. Requires the strategic plan for state action, with regards to persons with Alzheimer's disease or a related form of dementia, to:
    a) increase access to care, support and treatment;

b) improve quality of care;
c) advance risk reduction, early detection and diagnosis; and
d) ensure a coordinated statewide response.

26. Requires, by July 1, 2024, and June 30, 2026, DHS to review the Alzheimer's disease state plan and submit an updated plan to the:
    a) Governor;
    b) President of the Senate;
    c) Speaker of the House; and
    d) Secretary of State.

27. Requires, in reviewing and updating the Alzheimer's disease state plan, DHS to collaborate with:
    a) persons who have Alzheimer's disease or a related form of dementia;
    b) those who directly care for persons with Alzheimer's disease or a related form of dementia; and
    c) public, private and nonprofit organizations focused on Alzheimer's care services, research, advocacy, health care and caregiver support.

28. Repeals Dementia and Alzheimer's disease state plan requirements on July 1, 2026.

29. Requires DHS to distribute monies appropriated in FY 2024 to implement a public education campaign to increase awareness of Alzheimer's disease and related forms of dementia in rural and underserved urban areas in Arizona to a nonprofit organization that:
    a) demonstrates expertise in memory loss, dementia and Alzheimer's disease;
    b) hosts, 24 hours a day, 7 days a week, a toll-free hotline, with interpreter services if needed, that is staffed by master's-level consultants to provide education on the signs and symptoms of Alzheimer's disease and related forms of dementia, decision making support, dementia crisis assistance, treatment options and referrals to local communities;
    c) provides care and support for those affected by Alzheimer's disease and related forms of dementia; and
    d) demonstrates experience in marketing and public awareness campaigns.

30. Requires DHS, by June 30, 2024, to submit a report on the impact of the public education campaign to the Governor, Speaker of the House, President of the Senate, and Secretary of State.

Psilocybin Research and Advisory Council

31. Requires the Director of DHS to provide, from monies appropriated, competitive research grants for whole mushroom psilocybin phase one, phase two and phase three clinical trials, that are capable of being approved by the U.S. Food and Drug Administration, to evaluate the effects of whole mushroom psilocybin on treating any of the following:
    a) post-traumatic stress disorder;
    b) symptoms associated with long COVID-19;
    c) depression;
    d) anxiety disorders;
    e) symptoms associated with end-of-life distress;

f) obsessive compulsive disorder;
g) substance abuse and addiction disorders;
h) eating disorders;
i) chronic pain;
j) inflammatory disorders;
k) autoimmune disorders;
l) seizure disorders; and
m) other degenerative disorders.

32. Requires DHS to announce the opening of the application process at least 30 days before applications are available and allow at least 30 days for applicants to complete submission.

33. Requires research grants to be awarded by February 1 of each year.

34. Specifies that clinical research trials for psilocybin must prioritize:
    a) using whole mushroom psilocybin cultivated under a schedule I license issued by the U.S. Drug Enforcement Administration; and
    b) using veterans, first responders, frontline health care workers and persons from underserved communities as the research subjects.

35. Prohibits, notwithstanding criminal drug offense laws, a person who receives a psilocybin research grant or any of the person's employees working on the clinical trial from being charged with or prosecuted for possession of psilocybin while working on the clinical trial.

36. Establishes the Psilocybin Research Advisory Council (Council) in DHS, consisting of the Director of DHS or the Director's designee who is employed by DHS, as well as each of the following members appointed by the Director:
    a) one medical or osteopathic physician with a federal license to psychedelics;
    b) one military veteran;
    c) one law enforcement officer; and
    d) one professor or researcher from a university under the jurisdiction of the Arizona Board of Regents and who specializes in clinical research or psychedelic studies.

37. Requires the Director of DHS to serve as Chairperson of the Council.

38. Entitles Council members to reimbursement of expenses.

39. Requires the Council to:
    a) establish criteria for the clinical trials that qualify to receive research grants;
    b) oversee the application process and review applications for the clinical trial research grants to assist the Director of DHS in selecting the most credible clinical trials to award the research grants;
    c) ensure that all advisory council meetings are open to the public and allow for public testimony; and
    d) make recommendations, by June 1 of each year, to the Governor, Speaker of the House, President of the Senate and DHS on psychedelic-assisted therapy based on federal and state research policy.

40. Repeals laws related to psilocybin research and the Council on July 1, 2026.

Student Registered Nurse Anesthetist Clinical Rotation Program (Program)

41. Establishes the Program, for FY 2024, within the Arizona Board of Nursing (AZBN) to expand the capacity of preceptor training programs at health care institutions for nurse anesthetist students.

42. Requires the AZBN to develop a grant program to distribute appropriated Program monies, for FY 2024, to licensed health care institutions to expand or develop clinical training placements for nurse anesthetist students, with preference given to expanding or developing clinical rotations in obstetrics, pediatrics and cardiovascular care.

43. Specifies that awarded Program grant monies are intended to supplement, not supplant, existing training program expenses covered by the health care institution grantee.

44. Requires the AZBN to establish an application process for Program grants.

45. Requires the AZBN to consider the following factors when determining grant awards:
    a) the geographic and population distribution;
    b) the number of nurse anesthetist students expected to be trained and retained; and
    c) the cost of the proposal for the number of nurse anesthetist students expected to participate and be retained, compared to other proposals.

Arizona Long-Term Care System (ALTCS)

46. Outlines the following FY 2024 county contributions for ALTCS:

County	Contribution Amount
Apache	$692,800
Cochise	$6,587,900
Coconino	$2,080,000
Gila	$2,852,300
Graham	$1,540,200
La Paz	$682,700
Maricopa	$240,195,400
Mohave	$10,847,500
Navajo	$2,867,700
Pima	$56,396,600
Pinal	$18,011,700
Santa Cruz	$2,582,800
Yavapai	$9,820,100
Yuma	$11,047,700

47. Directs the State Treasurer to collect from the counties the difference between the total contribution and the counties' share of the state's actual contribution, if the overall cost for ALTCS exceeds the amount specified in the FY 2024 General Appropriations Act.

48. Requires the counties' share of the state's contribution to comply with any federal maintenance of effort requirements.

49. Requires the Director of AHCCCS to notify the State Treasurer of the counties' share of the state's contribution and report the amount to the Director of JLBC.

50. Directs the State Treasurer to:
    a) withhold from any other monies payable to a county from any available state funding source, excluding the Highway User Revenue Fund (HURF), an amount necessary to fulfill that county's contribution requirement; and
    b) deposit the withheld amounts and amounts paid by counties into the ALTCS Fund.

County Acute Care

51. Outlines the following FY 2024 county acute care contributions:

County	Contribution Amount
Apache	$268,800
Cochise	$2,214,800
Coconino	$742,900
Gila	$1,413,200
Graham	$536,200
Greenlee	$190,700
La Paz	$212,100
Maricopa	$15,703,400
Mohave	$1,237,700
Navajo	$310,800
Pima	$14,951,800
Pinal	$2,715,600
Santa Cruz	$482,800
Yavapai	$1,427,800
Yuma	$1,325,100

52. Requires the State Treasurer, if a county does not provide funding as specified, to:
    a) subtract the amount owed by the county from any payments required to be made by the State Treasurer to the county plus interest on that amount, retroactive to the first day the funding was due; and
    b) if the amount withheld is insufficient to meet that county's funding requirement, withhold from any other monies payable to that county from any available state funding source, excluding HURF, an amount necessary to fulfill that county's requirement.

53. Requires payments equal to one twelfth of the total amount for county acute care contributions to be made to the State Treasurer by the fifth day of each month and requires the State Treasurer, on request from the Director of AHCCCS, to require that up to three months' payment be made in advance, if necessary.

54. Requires the State Treasurer to deposit the amounts paid and withheld into the AHCCCS Fund and the ALTCS Fund.

55. Allows the Director of AHCCCS, if payments made exceed the amount required to meet the costs incurred by AHCCCS for the hospitalization and medical care of eligible persons, to instruct the State Treasurer to:
    a) reduce the remaining payments to be paid by a specified amount; or
    b) provide to the counties specified amounts from the AHCCCS Fund and the ALTCS Fund.

56. Declares the Legislature's intent that Maricopa County acute care contributions be reduced in each subsequent year according to the changes in the Gross Domestic Product price deflator.

Disproportionate Share Hospital (DSH) Payments

57. Establishes the FY 2024 DSH payments as follows:
    a) $113,818,500 for a qualifying nonstate-operated public hospital, of which $4,202,300 is distributed to the Maricopa County Special Health Care District (District) and the remaining federal portion is deposited in the state General Fund (state GF);
    b) $28,474,900 for the Arizona State Hospital (ASH), of which the federal portion is deposited in the state GF; and
    c) $884,800 for private qualifying DSHs, which are hospitals that meet the mandatory definition of *qualifying DSHs* as defined by the federal Social Security Act (SSA), or DSHs that are located in Yuma County and contain at least 300 beds.

58. Outlines the following requirements once AHCCCS files a claim with the federal government and receives federal financial participation based on the amount certified by the District:
    a) if the certification is $113,818,500 or less and AHCCCS determines that the revised amount is correct, AHCCCS must notify the Governor, the President of the Senate and the Speaker of the House and distribute $4,202,300 to the District and deposit the balance of the federal financial participation in the state GF;
    b) if the certification is for an amount less than $113,818,500 and AHCCCS determines that the revised amount is incorrect, AHCCCS must notify the Governor, the President of the Senate and the Speaker of the House and must deposit the total amount of the federal financial participation in the state GF; or
    c) if the certification is for an amount greater than $113,818,500, AHCCCS must distribute $4,202,300 to the District and deposit $71,248,000 of the federal financial participation in the state GF.

59. Allows AHCCCS to make additional DSH payments to the District.

60. Outlines the following requirements once AHCCCS files a claim with the federal government and receives federal financial participation based on the amount certified by ASH:
    a) if the certification is for an amount less than $28,474,900, AHCCCS must notify the Governor, the President of the Senate and the Speaker of the House and must deposit the entire amount of federal financial participation in the state GF; and
    b) requires the certified public expense (CPE) form to contain both the total amount of qualifying DSH expenditures and the amount limited by the SSA.

61. Stipulates that, after DSH payment distributions are made, the allocation of DSH payments designated to political subdivisions, tribal governments and universities must be provided in the following order of priority to qualifying private hospitals located:
    a) in a county with a population of fewer than 400,000 persons;
    b) in a county with a population of at least 400,000 but fewer than 900,000 persons; and
    c) in a county with a population of 900,000 persons or more.

62. Requires the District, by May 1, 2024, and ASH, by March 31, 2024, to each provide a CPE form for qualifying DSH expenditures to AHCCCS.

63. Continues to require AHCCCS to assist the District and ASH in determining the amount of qualifying DSH expenditures.

AHCCCS

64. Raises, on October 1, 2023, the maximum allowable income for member eligibility under the Children's Health Insurance Program from 200 percent to 225 percent of the federal poverty level.

65. Continues to require AHCCCS to transfer to the counties any excess monies necessary to comply with the Patient Protection and Affordable Care Act, regarding the counties' proportional share of the state's contribution.

66. Declares the Legislature's intent that AHCCCS implement a Medicaid program within the available appropriation for FY 2024.

67. Continues to allow AHCCCS, for the contract year beginning October 1, 2023, and ending on September 30, 2024, to extend risk contingency rate settings for all managed care organizations (MCOs) and funding for all MCO administrative funding levels imposed for the contract year beginning October 1, 2010, and ending September 30, 2011.

Miscellaneous

68. Requires chiropractors to annually renew their license to practice by the last day of the chiropractor's birth month, rather than by January 1.

69. Continues to exclude county contributions for Proposition 204 administrative costs from county expenditure limitations.

70. Continues to exclude county contributions related to the costs of inpatient, in-custody competency restoration treatment from county expenditure limitations.

71. Defines terms

72. Makes technical and conforming changes.

73. Becomes effective on the general effective date.

Prepared by Senate Research
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MM/slp