State of Arizona
House of Representatives
Fifty-seventh Legislature
First Regular Session
2025

HOUSE BILL 2953

AN ACT

AMENDING TITLE 32, CHAPTER 15, ARTICLE 2, ARIZONA REVISED STATUTES, BY ADDING SECTION 32-1635.02; AMENDING SECTIONS 36-501 AND 36-526, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 18, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 5; REPEALING TITLE 36, CHAPTER 18, ARTICLE 5, ARIZONA REVISED STATUTES; AMENDING SECTION 36-2901.08, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 36-2903.18, 36-2903.19 AND 36-2903.20; AMENDING SECTIONS 36-2907 AND 36-2936, ARIZONA REVISED STATUTES; AMENDING LAWS 2023, CHAPTER 139, SECTION 4, AS AMENDED BY LAWS 2024, CHAPTER 215, SECTION 2; APPROPRIATING MONIES; RELATING TO HEALTH CARE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Title 32, chapter 15, article 2, Arizona Revised Statutes, is amended by adding section 32-1635.02, to read:

32-1635.02. Provisional licensure or certification; qualifications; notification; termination; definitions

A. THE BOARD SHALL ISSUE A PROVISIONAL LICENSE OR CERTIFICATE TO AN ADVANCED PRACTICE REGISTERED NURSE, A REGISTERED NURSE OR A LICENSED PRACTICAL NURSE WITHIN FIVE BUSINESS DAYS AFTER THE BOARD RECEIVES A COMPLETE APPLICATION AND THE FEES REQUIRED BY THE BOARD FOR AN OUT-OF-STATE NURSE WHO IS SEEKING LICENSURE OR CERTIFICATION IF ALL OF THE FOLLOWING APPLY AND THE PERSON INCLUDES A SWORN DECLARATION ATTESTING TO THE COMPLETENESS AND VERACITY OF THE INFORMATION:

1. THE PERSON HOLDS A CURRENT LICENSE OR CERTIFICATE TO PRACTICE AS AN ADVANCED PRACTICE REGISTERED NURSE, A REGISTERED NURSE OR A LICENSED PRACTICAL NURSE IN AT LEAST ONE OTHER STATE OF THE UNITED STATES, AND THE LICENSE OR CERTIFICATE IS IN GOOD STANDING IN ALL STATES OF THE UNITED STATES IN WHICH THE PERSON HOLDS A LICENSE OR CERTIFICATE.

2. THE PERSON PROVIDES PROOF OF A VALID AND UNENCUMBERED LICENSE OR CERTIFICATE IN ANOTHER STATE OF THE UNITED STATES THROUGH BOARD REVIEW OF A NATIONAL NURSE LICENSE VERIFICATION SYSTEM OR IN ANOTHER MANNER DETERMINED BY THE BOARD AS SUFFICIENT PROOF THAT THE PERSON IS IN GOOD STANDING WITH ALL LICENSING ENTITIES THAT HAVE ISSUED THE PERSON A LICENSE OR CERTIFICATE.

3. THE PERSON HAS NOT HAD A LICENSE OR CERTIFICATE REVOKED OR DENIED AND HAS NOT VOLUNTARILY SURRENDERED A LICENSE OR CERTIFICATE IN ANY STATE OF THE UNITED STATES.

4. THE PERSON DOES NOT HAVE A COMPLAINT OR INVESTIGATION PENDING BEFORE A LICENSING ENTITY IN ANY STATE OF THE UNITED STATES. IF THE PERSON HAS ANY COMPLAINT OR INVESTIGATION PENDING, THE FIVE-DAY TIME FRAME DOES NOT APPLY AND THE BOARD MAY DETERMINE WHETHER THE PERSON CAN SAFELY PRACTICE NURSING IN THIS STATE.

5. THE PERSON HAS SUBMITTED A FULL SET OF FINGERPRINTS TO THE BOARD FOR THE PURPOSE OF OBTAINING A STATE AND FEDERAL CRIMINAL RECORDS CHECK PURSUANT TO SECTION 41-1750 AND PUBLIC LAW 92-544. THE DEPARTMENT OF PUBLIC SAFETY MAY EXCHANGE THIS FINGERPRINT DATA WITH THE FEDERAL BUREAU OF INVESTIGATION.

6. THE PERSON IS A RESIDENT OF THIS STATE OR ATTESTS IN THE APPLICATION THAT THE PERSON IS PHYSICALLY WORKING OR HAS ACCEPTED AN OFFER TO PHYSICALLY WORK IN THIS STATE.

B. IF AN ADVANCED PRACTICE REGISTERED NURSE, A REGISTERED NURSE OR A LICENSED PRACTICAL NURSE APPLIES FOR A PROVISIONAL LICENSE OR CERTIFICATE PURSUANT TO THIS SECTION AND HAD DISCIPLINE IMPOSED BY ANY LICENSING ENTITY IN ANOTHER STATE OF THE UNITED STATES, THE FIVE-DAY TIME FRAME PRESCRIBED IN SUBSECTION A OF THIS SECTION DOES NOT APPLY AND THE

BOARD MAY DETERMINE WHETHER THE PERSON CAN SAFELY PRACTICE NURSING IN THIS STATE.

C. THE BOARD SHALL ACKNOWLEDGE BY WRITTEN OR ORAL COMMUNICATION TO AN APPLICANT FOR A PROVISIONAL LICENSE OR CERTIFICATE PURSUANT TO THIS SECTION THE DATE OF RECEIPT OF THE APPLICATION FOR PROVISIONAL LICENSURE OR CERTIFICATION. WITHIN FIVE BUSINESS DAYS AFTER RECEIPT OF THE APPLICATION, THE BOARD SHALL PROVIDE TO THE APPLICANT EITHER:

1. A NOTICE OF PROVISIONAL LICENSURE OR CERTIFICATION APPROVAL.

2. A WRITTEN EXPLANATION OF THE REASON OR REASONS THE APPLICANT IS NOT ELIGIBLE FOR PROVISIONAL LICENSURE OR CERTIFICATION. THE BOARD SHALL FURTHER INVESTIGATE THE APPLICATION AS NECESSARY TO DETERMINE WHETHER THE APPLICANT MAY BE LICENSED OR CERTIFIED PURSUANT TO THIS SECTION OR ANOTHER SECTION OF THIS ARTICLE.

D. A PERSON WHO APPLIES FOR OR RECEIVES A PROVISIONAL LICENSE OR CERTIFICATE PURSUANT TO THIS SECTION IS SUBJECT TO THE LAWS REGULATING THE PERSON'S PRACTICE IN THIS STATE AND IS SUBJECT TO THE BOARD'S JURISDICTION.

E. A PROVISIONAL LICENSE OR CERTIFICATE ISSUED PURSUANT TO THIS SECTION IS VALID ONLY IN THIS STATE AND ALLOWS THE PERSON TO WHOM IT IS ISSUED TO PRACTICE AS AN ADVANCED PRACTICE REGISTERED NURSE, A REGISTERED NURSE OR A LICENSED PRACTICAL NURSE IN THIS STATE.

F. EXCEPT AS PROVIDED IN SUBSECTION G OF THIS SECTION, A PROVISIONAL LICENSE OR CERTIFICATE ISSUED PURSUANT TO THIS SECTION MAY BE CONVERTED TO A REGULAR, SINGLE-STATE LICENSE OR CERTIFICATE SIX MONTHS AFTER THE PROVISIONAL LICENSE OR CERTIFICATE IS ISSUED AND IS VALID UNTIL THE REGULAR LICENSE OR CERTIFICATE IS REQUIRED TO BE RENEWED PURSUANT TO THIS ARTICLE.

G. THE BOARD MAY TERMINATE A PROVISIONAL LICENSE OR CERTIFICATE ISSUED PURSUANT TO THIS SECTION WITHIN SIX MONTHS AFTER ISSUANCE IF THE BOARD DETERMINES THAT THERE IS A REASONABLE BASIS TO REQUIRE RESTRICTIONS ON OR THE TERMINATION OF THE PROVISIONAL LICENSE OR CERTIFICATE.

H. ANY FEES REQUIRED PURSUANT TO THIS SECTION ARE WAIVED FOR VETERANS OF THE UNITED STATES ARMED FORCES AND SPOUSES OF ACTIVE DUTY MEMBERS OF THE UNITED STATES ARMED FORCES.

I. FOR THE PURPOSES OF THIS SECTION:

1. "LICENSING ENTITY" MEANS THE REGULATORY BODY OF A STATE TERRITORY OF THE UNITED STATES THAT IS RESPONSIBLE FOR REGULATING THE PRACTICE OF NURSING AND ADVANCED PRACTICE REGISTERED NURSING.

2. "RESIDENT" MEANS A PERSON WHO MEETS ONE OF THE FOLLOWING:

(a) HAS OBTAINED A DRIVER LICENSE OR NONOPERATING IDENTIFICATION LICENSE IN THIS STATE.

(b) HAS REGISTERED TO VOTE IN THIS STATE.

(c) DECLARES THIS STATE AS THE PERSON'S HOME STATE FOR FEDERAL TAX PURPOSES.

(d) HAS LIVED IN THIS STATE FOR MORE THAN SIX MONTHS IN THE PRECEDING YEAR.

(e) IS ACTIVE MILITARY OR AN ACTIVE MILITARY SPOUSE WHO IS CURRENTLY POSTED IN THIS STATE.

Sec. 2. Section 36-501, Arizona Revised Statutes, is amended to read:

36-501. Definitions

In this chapter, unless the context otherwise requires:

1. "Administration" means the Arizona health care cost containment system administration.

2. "Admitting officer" means a psychiatrist or other physician or psychiatric and mental health nurse practitioner with experience in performing psychiatric examinations who has been designated as an admitting officer of the evaluation agency by the person in charge of the evaluation agency.

3. "Authorized transporter" means a transportation entity that is contracted with a city, town or county to provide services pursuant to this chapter and that is either:

(a) An ambulance service that holds a valid certificate of necessity.

(b) A transportation provider authorized by this state to provide safe behavioral health transportation for individuals requiring transportation pursuant to this chapter.

4. "Chief medical officer" means the chief medical officer under the supervision of the superintendent of the state hospital.

5. "Contraindicated" means that access is reasonably likely to endanger the life or physical safety of the patient or another person.

6. "Court" means the superior court in the county in this state in which the patient resides or was found before screening or emergency admission under this title.

7. "Criminal history" means police reports, lists of prior arrests and convictions, criminal case pleadings and court orders, including a determination that the person has been found incompetent to stand trial pursuant to section 13-4510.

8. "Danger to others" means that the judgment of a person who has a mental disorder is so impaired that the person is unable to understand the person's need for treatment and as a result of the person's mental disorder the person's continued behavior can reasonably be expected, on the basis of competent medical opinion, to result in serious physical harm.

9. "Danger to self":

(a) Means behavior that, as a result of a mental disorder:

(i) Constitutes a danger of inflicting serious physical harm on oneself, including attempted suicide or the serious threat thereof, if the threat is such that, when considered in the light of its context and in

light of the individual's previous acts, it is substantially supportive of an expectation that the threat will be carried out.

(ii) Without hospitalization will result in serious physical harm or serious illness to the person.

(b) Does not include behavior that establishes only the condition of having a grave disability.

10. "Department" means the department of health services.

11. "Detention" means the taking into custody of a patient or proposed patient.

12. "Director" means the director of the administration.

13. "Evaluation" means:

(a) A professional multidisciplinary analysis that may include firsthand observations or remote observations by interactive audiovisual media and that is based on data describing the person's identity, biography and medical, psychological and social conditions carried out by a group of persons consisting of at least the following:

(i) Two licensed physicians who are qualified psychiatrists, if possible, or at least experienced in psychiatric matters, who shall examine and report their findings independently. The person against whom a petition has been filed shall be notified that the person may select one of the physicians. A psychiatric resident in a training program approved by the American medical association or by the American osteopathic association may examine the person in place of one of the psychiatrists if the resident is supervised in the examination and preparation of the affidavit and testimony in court by a qualified psychiatrist appointed to assist in the resident's training, and if the supervising psychiatrist is available for discussion with the attorneys for all parties and for court appearance and testimony if requested by the court or any of the attorneys.

(ii) Two other individuals, one of whom, if available, is a psychologist and in any event a social worker familiar with mental health and human services that may be available placement alternatives appropriate for treatment. An evaluation may be conducted on an inpatient basis, an outpatient basis or a combination of both, and every reasonable attempt shall be made to conduct the evaluation in any language preferred by the person.

(b) A physical examination that is consistent with the existing standards of care and that is performed by one of the evaluating physicians or by or under the supervision of a physician who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse practitioner who is licensed pursuant to title 32, chapter 15 if the results of that examination are reviewed or augmented by one of the evaluating physicians.

14. "Evaluation agency" means either of the following:

(a) A health care agency that is licensed by the department and that has been approved pursuant to this title to provide the services required of that agency by this chapter.

(b) A facility that is exempt from licensure pursuant to section 36-402, that possesses an accreditation from either a national commission on correctional health care or an American correctional association and that has been approved pursuant to this title to provide the services required of that facility by this chapter OR CHAPTER 18, ARTICLE 5 OF THIS TITLE.

15. "Family member" means a spouse, parent, adult child, adult sibling or other blood relative of a person undergoing treatment or evaluation pursuant to this chapter.

16. "Grave disability" means a condition evidenced by behavior in which a person, as a result of a mental disorder, is likely to come to serious physical harm or serious illness because the person is unable to provide for the person's own basic physical needs.

17. "Health care decision maker" has the same meaning prescribed in section 12-2801.

18. "Health care entity" means a health care provider, the department, the administration or a regional behavioral health authority that is under contract with the administration.

19. "Health care provider" means a health care institution as defined in section 36-401 that is licensed as a behavioral health provider pursuant to department rules or a mental health provider.

20. "Independent evaluator" means a licensed physician, psychiatric and mental health nurse practitioner or psychologist who is selected by the person to be evaluated or by the person's attorney.

21. "Informed consent" means a voluntary decision following presentation of all facts necessary to form the basis of an intelligent consent by the patient or guardian with no minimizing of known dangers of any procedures.

22. "Least restrictive treatment alternative" means the treatment plan and setting that infringe in the least possible degree with the patient's right to liberty and that are consistent with providing needed treatment in a safe and humane manner.

23. "Licensed physician" means any medical doctor or doctor of osteopathy who is either:

(a) Licensed in this state.

(b) A full-time hospital physician licensed in another state and serving on the staff of a hospital operated or licensed by the United States government.

24. "Medical director of an evaluation agency" means a psychiatrist, or other licensed physician experienced in psychiatric matters, who is designated in writing by the governing body of the agency

as the person in charge of the medical services of the agency for the purposes of this chapter and may include the chief medical officer of the state hospital.

25. "Medical director of a mental health treatment agency" means a psychiatrist, or other licensed physician experienced in psychiatric matters, who is designated in writing by the governing body of the agency as the person in charge of the medical services of the agency for the purposes of this chapter and includes the chief medical officer of the state hospital.

26. "Mental disorder" means a substantial disorder of the person's emotional processes, thought, cognition or memory. Mental disorder is distinguished from:

(a) Conditions that are primarily those of drug abuse, alcoholism or intellectual disability, unless, in addition to one or more of these conditions, the person has a mental disorder.

(b) The declining mental abilities that directly accompany impending death.

(c) Character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a mental disorder.

27. "Mental health provider" means any physician or provider of mental health or behavioral health services who is involved in evaluating, caring for, treating or rehabilitating a patient.

28. "Mental health treatment agency" means any of the following:

(a) The state hospital.

(b) A health care agency that is licensed by the department and that provides the services that are required of the agency by this chapter.

(c) A facility that is exempt from licensure pursuant to section 36-402, that possesses an accreditation from either a national commission on correctional health care or an American correctional association and that provides the services that are required of the facility by this chapter.

29. "Outpatient treatment" or "combined inpatient and outpatient treatment" means any treatment program not requiring continuous inpatient hospitalization.

30. "Outpatient treatment plan" means a treatment plan that does not require continuous inpatient hospitalization.

31. "Patient" means any person who is undergoing examination, evaluation or behavioral or mental health treatment under this chapter.

32. "Peace officers" means sheriffs of counties, constables, marshals and policemen of cities and towns.

33. "Persistent or acute disability" means a severe mental disorder that meets all the following criteria:

(a) Significantly impairs judgment, reason, behavior or capacity to recognize reality.

(b) If not treated, has a substantial probability of causing the person to suffer or continue to suffer severe and abnormal mental, emotional or physical harm.

(c) Substantially impairs the person's capacity to make an informed decision regarding treatment, and this impairment causes the person to be incapable of understanding and expressing an understanding of the advantages and disadvantages of accepting treatment and understanding and expressing an understanding of the alternatives to the particular treatment offered after the advantages, disadvantages and alternatives are explained to that person.

(d) Has a reasonable prospect of being treatable by outpatient, inpatient or combined inpatient and outpatient treatment.

34. "Prepetition screening" means the review of each application requesting court-ordered evaluation, including an investigation of facts alleged in the application, an interview with each applicant and an interview, if possible, with the proposed patient. The purpose of the interview with the proposed patient is to assess the problem, explain the application and, when indicated, attempt to persuade the proposed patient to receive, on a voluntary basis, evaluation or other services.

35. "Prescribed form" means a form established by a court or the rules of the administration in accordance with the laws of this state.

36. "Professional" means a physician who is licensed pursuant to title 32, chapter 13 or 17, a psychologist who is licensed pursuant to title 32, chapter 19.1 or a psychiatric and mental health nurse practitioner who is certified pursuant to title 32, chapter 15.

37. "Proposed patient" means a person for whom an application for evaluation has been made or a petition for court-ordered evaluation has been filed.

38. "Prosecuting agency" means the county attorney, attorney general or city attorney who applied or petitioned for an evaluation or treatment pursuant to this chapter.

39. "Psychiatric and mental health nurse practitioner" means a registered nurse practitioner as defined in section 32-1601 who has completed an adult or family psychiatric and mental health nurse practitioner program and who is certified as an adult or family psychiatric and mental health nurse practitioner by the state board of nursing.

40. "Psychiatrist" means a licensed physician who has completed three years of graduate training in psychiatry in a program approved by the American medical association or the American osteopathic association.

41. "Psychologist" means a person who is licensed under title 32, chapter 19.1 and who is experienced in the practice of clinical psychology.

42. "Records" means all communications that are recorded in any form or medium and that relate to patient examination, evaluation or behavioral or mental health treatment. Records include medical records that are prepared by a health care provider or other providers. Records do not include:

(a) Materials that are prepared in connection with utilization review, peer review or quality assurance activities, including records that a health care provider prepares pursuant to section 36-441, 36-445, 36-2402 or 36-2917.

(b) Recorded telephone and radio calls to and from a publicly operated emergency dispatch office relating to requests for emergency services or reports of suspected criminal activity.

43. "Regional behavioral health authority" has the same meaning prescribed in section 36-3401.

44. "Screening agency" means a health care agency that is licensed by the department and that provides those services required of the agency by this chapter.

45. "Social worker" means a person who has completed two years of graduate training in social work in a program approved by the council of social work education and who has experience in mental health.

46. "State hospital" means the Arizona state hospital.

47. "Superintendent" means the superintendent of the state hospital.

48. "Voluntary evaluation" means the ongoing collection and analysis of a person's medical, psychological, psychiatric and social conditions in order to initially determine if a health disorder exists and if there is a need for behavioral health services and, on an ongoing basis, to ensure that the person's service plan is designed to meet the person's and the person's family's current needs and long-term goals.

Sec. 3. Section 36-526, Arizona Revised Statutes, is amended to read:

36-526. Emergency admission; examination; petition for court-ordered evaluation

A. On presentation of the person for emergency admission, an admitting officer of an evaluation agency shall perform an examination of the person's psychiatric and physical condition and may admit the person to the agency as an emergency patient if the admitting officer finds, as a result of the examination and investigation of the application for emergency admission, that there is reasonable cause to believe that the person, as a result of a mental disorder, is a danger to self or others, has a persistent or acute disability or a grave disability and is unable or unwilling to undergo voluntary evaluation and that during the time

necessary to complete the prepetition screening procedures set forth in sections 36-520 and 36-521 the person is likely without immediate hospitalization to suffer serious physical harm or serious illness or to inflict serious physical harm on another person. If a person is hospitalized pursuant to this section, the admitting officer may notify a screening agency and seek its assistance or guidance in developing alternatives to involuntary confinement and in counseling the person and the person's family.

B. On the same or a succeeding court day, the medical director in charge of the agency shall file a petition for a court-ordered evaluation, unless the person has been discharged or has become a voluntary patient. The petition need not comply with the provisions of this chapter requiring preparation and filing of a prepetition screening report but shall meet all other requirements and shall seek an appropriate order pursuant to section 36-529.

C. IF THE MEDICAL DIRECTOR OF AN EVALUATION AGENCY IN A COUNTY WITH A POPULATION OF MORE THAN ONE MILLION PERSONS AND LESS THAN ONE MILLION FIVE HUNDRED THOUSAND PERSONS, AFTER AN EXAMINATION OR EVALUATION, DETERMINES THAT THE PROPOSED PATIENT IS AN IMPAIRED PERSON AS DEFINED IN SECTION 36-2081, UNTIL DECEMBER 31, 2027, THE MEDICAL DIRECTOR OF AN EVALUATION AGENCY MAY FILE A PETITION FOR COURT-ORDERED STABILIZATION PURSUANT TO SECTION 36-2083.

Sec. 4. Title 36, chapter 18, Arizona Revised Statutes, is amended by adding article 5, to read:

ARTICLE 5. INVOLUNTARY STABILIZATION

36-2081. Definitions

IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "ADMINISTRATION" MEANS THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION.

2. "DEPARTMENT" MEANS THE DEPARTMENT OF HEALTH SERVICES.

3. "DETAIN" MEANS TO INVOLUNTARY ADMIT A PATIENT, PROPOSED PATIENT OR IMPAIRED PERSON TO AN EVALUATION AGENCY.

4. "EVALUATION AGENCY" HAS THE SAME MEANING PRESCRIBED IN SECTION 36-501.

5. "IMPAIRED PERSON" MEANS AN INDIVIDUAL WHO, AS A RESULT OF INTOXICATION, WITHDRAWAL OR SUBSTANCE-INDUCED SYMPTOMS, HAS IMPAIRED JUDGMENT CAUSING THE INDIVIDUAL TO BE INCAPABLE OF MAKING OR COMMUNICATING RATIONAL DECISIONS WITH REGARD TO THE INDIVIDUAL'S SAFETY, HEALTH OR BASIC PERSONAL NEEDS, SUCH AS FOOD, CLOTHING, SHELTER OR MEDICAL CARE.

6. "MEDICAL DIRECTOR OF AN EVALUATION AGENCY" HAS THE SAME MEANING PRESCRIBED IN SECTION 36-501.

7. "PSYCHIATRIC AND MENTAL HEALTH NURSE PRACTITIONER" HAS THE SAME MEANING PRESCRIBED IN SECTION 36-501.

8. "PSYCHIATRIST" HAS THE SAME MEANING AS PRESCRIBED IN SECTION 36-501.

9. "STABILIZATION PERIOD" MEANS THE TIME PERIOD FOR WHICH AN IMPAIRED PERSON MAY BE ADMITTED INVOLUNTARILY TO AN EVALUATION AGENCY FOR THE PURPOSES OF ALLOWING THE EFFECTS OF SUBSTANCES TO RESOLVE SUCH THAT THE PERSON NO LONGER MEETS THE DEFINITION OF IMPAIRED PERSON.

36-2082. Impaired persons; civil and legal rights; records; confidentiality

AN IMPAIRED PERSON WHO IS INVOLUNTARILY ADMITTED FOR A STABILIZATION PERIOD PURSUANT TO THIS ARTICLE HAS ALL OF THE CIVIL AND LEGAL RIGHTS ENUMERATED IN CHAPTER 5, ARTICLE 2 OF THIS TITLE. ALL RECORDS PERTAINING TO AN IMPAIRED PERSON AND THE INFORMATION CONTAINED IN THOSE RECORDS ARE CONFIDENTIAL, ARE NOT PUBLIC RECORDS AND MAY BE DISCLOSED ONLY AS PROVIDED IN CHAPTER 5, ARTICLE 2 OF THIS TITLE.

36-2083. Petition for court-ordered stabilization

A. UNTIL DECEMBER 31, 2027, A PETITION FOR COURT-ORDERED STABILIZATION MAY BE FILED BY THE MEDICAL DIRECTOR OF AN EVALUATION AGENCY BASED ON A PERSONAL ASSESSMENT AND REVIEW OF AN INDIVIDUAL'S MEDICAL RECORD AND MUST BE ACCOMPANIED BY AN AFFIDAVIT FROM THE MEDICAL DIRECTOR OF AN EVALUATION AGENCY DETAILING ALL OF THE FOLLOWING:

1. THAT THE INDIVIDUAL IS AN IMPAIRED PERSON AND THE CLINICAL FACTS THAT SUPPORT THAT CONCLUSION.

2. THAT THE INDIVIDUAL IS EITHER UNABLE OR UNWILLING TO CONSENT TO VOLUNTARY ADMISSION.

3. THE REASONS WHY DISCHARGING THE INDIVIDUAL WOULD BE UNSAFE.

4. THE REASONS WHY PROCEEDINGS UNDER CHAPTER 5 OF THIS TITLE ARE INAPPROPRIATE.

5. THE DATE THE INDIVIDUAL WAS INITIALLY INVOLUNTARILY ADMITTED TO THE EVALUATION AGENCY PURSUANT TO CHAPTER 5 OF THIS TITLE.

B. THE PETITION FOR COURT-ORDERED STABILIZATION SHALL REQUEST THAT THE COURT ISSUE AN ORDER ADMITTING THE IMPAIRED PERSON TO THE EVALUATION AGENCY FOR A STABILIZATION PERIOD OF NOT MORE THAN FIVE CALENDAR DAYS AFTER THE DATE THE INDIVIDUAL WAS INVOLUNTARILY ADMITTED TO THE EVALUATION AGENCY PURSUANT TO CHAPTER 5 OF THIS TITLE.

C. A PETITION FOR COURT-ORDERED STABILIZATION MAY NOT BE FILED SOLELY TO DETAIN AN INDIVIDUAL WHO IS AT RISK OF USING SUBSTANCES BUT WHO IS NOT CURRENTLY INTOXICATED, IN WITHDRAWAL OR HAVING SUBSTANCE-INDUCED SYMPTOMS.

36-2084. Order for stabilization period; duty of counsel; personal service

A. IF THE COURT, AFTER REVIEWING THE PETITION FOR COURT-ORDERED STABILIZATION, DETERMINES THAT INSUFFICIENT EVIDENCE HAS BEEN PRESENTED TO FIND THAT THE INDIVIDUAL IS AN IMPAIRED PERSON, THE COURT SHALL DENY THE PETITION FOR COURT-ORDERED STABILIZATION AND THE EVALUATION AGENCY SHALL IMMEDIATELY RELEASE THE IMPAIRED PERSON.

B. IF THE COURT, AFTER REVIEWING THE PETITION FOR COURT-ORDERED STABILIZATION, DETERMINES THAT THERE IS REASONABLE CAUSE TO BELIEVE THAT THE INDIVIDUAL IS AN IMPAIRED PERSON, THE COURT SHALL GRANT THE PETITION FOR COURT-ORDERED STABILIZATION FOR A PERIOD OF NOT MORE THAN FIVE CALENDAR DAYS AFTER THE DATE THE IMPAIRED PERSON WAS INVOLUNTARILY ADMITTED TO THE EVALUATION AGENCY PURSUANT TO CHAPTER 5 OF THIS TITLE.

C. THE COURT SHALL APPOINT COUNSEL FOR THE IMPAIRED PERSON AT THE TIME OF ISSUING THE ORDER FOR STABILIZATION. AN ATTORNEY WHO IS APPOINTED TO REPRESENT THE IMPAIRED PERSON SHALL CONFER WITH THE IMPAIRED PERSON WITHIN TWENTY-FOUR HOURS AFTER APPOINTMENT AND INFORM THE IMPAIRED PERSON OF THE PERSON'S RIGHTS.

D. A COPY OF ANY ORDER ISSUED BY THE COURT PURSUANT TO THIS SECTION, TOGETHER WITH A COPY OF THE PETITION FOR COURT-ORDERED STABILIZATION, SHALL BE PERSONALLY SERVED ON THE IMPAIRED PERSON AS PRESCRIBED BY LAW OR COURT RULE OR AS ORDERED BY THE COURT.

E. IF AN IMPAIRED PERSON IS INVOLUNTARILY DETAINED FOR STABILIZATION, THE IMPAIRED PERSON SHALL BE INFORMED BY THE IMPAIRED PERSON'S APPOINTED ATTORNEY OF THE RIGHT TO A HEARING TO DETERMINE WHETHER THE IMPAIRED PERSON SHOULD BE INVOLUNTARILY DETAINED FOR STABILIZATION AND TO BE REPRESENTED AT THE HEARING BY AN ATTORNEY. IF THE IMPAIRED PERSON REQUESTS A HEARING TO DETERMINE WHETHER THE IMPAIRED PERSON SHOULD BE INVOLUNTARILY DETAINED FOR STABILIZATION, THE COURT SHALL SCHEDULE A HEARING AT ITS EARLIEST OPPORTUNITY TO DETERMINE WHETHER THERE IS A REASONABLE BASIS FOR THE DETENTION.

36-2085. Duty of evaluation agency

A. EACH DAY THAT AN IMPAIRED PERSON IS DETAINED UNDER AN ORDER FOR STABILIZATION THE IMPAIRED PERSON MUST BE OFFERED TREATMENT FOR THE IMPAIRED PERSON'S IMPAIRMENT TO WHICH THEY MAY CONSENT. THE IMPAIRED PERSON MAY NOT BE TREATED FOR IMPAIRMENT WITHOUT THE IMPAIRED PERSON'S EXPRESS CONSENT, EXCEPT THAT SECLUSION AND MECHANICAL OR PHARMACOLOGICAL RESTRAINTS MAY BE EMPLOYED AS EMERGENCY MEASURES FOR THE SAFETY OF THE IMPAIRED PERSON OR OTHERS PURSUANT TO SECTION 36-2087.

B. THE EVALUATION AGENCY SHALL ASSESS THE IMPAIRED PERSON EACH DAY TO DETERMINE WHETHER THE PERSON REMAINS IMPAIRED. IF THE PERSON NO LONGER MEETS THE DEFINITION OF AN IMPAIRED PERSON, THE EVALUATION AGENCY SHALL EITHER RELEASE THE PERSON FROM THE COURT-ORDERED STABILIZATION PERIOD AND DISCHARGE THE PERSON FROM THE FACILITY OR ADMIT THE PERSON TO THE EVALUATION AGENCY ON A VOLUNTARY BASIS.

C. THE EVALUATION AGENCY SHALL COMPLY WITH THE QUALITY OF TREATMENT PROVISIONS PRESCRIBED IN SECTION 36-2086, AS APPLICABLE.

36-2086. Quality of treatment; clinical records; postrelease plan of care

A. SUBJECT TO THE RIGHT TO REFUSE PSYCHIATRIC AND MEDICAL TREATMENT PURSUANT TO SECTIONS 36-512 AND 36-513 AND PURSUANT TO RULES OF THE ADMINISTRATION, EACH IMPAIRED PERSON UNDERGOING STABILIZATION CARE

PURSUANT TO THIS ARTICLE SHALL RECEIVE PHYSICAL CARE AND TREATMENT THAT IS DELIVERED IN A MANNER THAT ALLOWS THE IMPAIRED PERSON'S FAMILY MEMBERS OR GUARDIAN, IF APPLICABLE, TO PARTICIPATE IN THE CARE AND TREATMENT, WHEN APPROPRIATE, FOR THE FULL PERIOD THE IMPAIRED PERSON IS DETAINED. THE EVALUATION AGENCY PROVIDING CARE AND TREATMENT SHALL KEEP A CLINICAL RECORD FOR EACH IMPAIRED PERSON THAT DETAILS ALL MEDICAL EVALUATIONS AND ALL CARE AND TREATMENT RECEIVED BY THE IMPAIRED PERSON.

B. AN EVALUATION AGENCY ADMINISTERING OBSERVATION OR INPATIENT STABILIZATION CARE AND TREATMENT, IN CONJUNCTION WITH THE COMMUNITY TREATMENT AGENCY, IF APPLICABLE, AND BEFORE THE RELEASE OF AN IMPAIRED PERSON, SHALL PREPARE A PLAN FOR THE IMPAIRED PERSON'S CARE AFTER RELEASE AND SHALL PROVIDE THE PLAN TO THE IMPAIRED PERSON'S GUARDIAN, IF APPLICABLE.

36-2087. Seclusion; restraint; treatment

AN IMPAIRED PERSON UNDERGOING STABILIZATION PURSUANT TO THIS ARTICLE SHALL NOT BE SUBJECTED TO SECLUSION OR MECHANICAL OR PHARMACOLOGICAL RESTRAINTS EXCEPT IN THE CASE OF AN EMERGENCY FOR THE SAFETY OF THE IMPAIRED PERSON OR OTHERS OR AS A PART OF A WRITTEN PLAN FOR THE STABILIZATION OF THE IMPAIRED PERSON THAT IS PREPARED BY STAFF MEMBERS RESPONSIBLE FOR THE IMPAIRED PERSON'S CARE AND PURSUANT TO RULES ADOPTED BY THE DEPARTMENT. ANY INSTANCE OF SECLUSION OR RESTRAINT MUST BE PROPERLY RECORDED IN THE IMPAIRED PERSON'S MEDICAL RECORD. THE USE OF ANY RESTRAINT OR SECLUSION MEASURE SHALL BE GOVERNED BY WRITTEN PROCEDURES OF THE EVALUATION AGENCY CARING FOR THE IMPAIRED PERSON AND IS SUBJECT TO THE RULES OF THE DEPARTMENT.

36-2088. Maximum time of stabilization period; medical director determination; release; immunity

A. AN IMPAIRED PERSON WHO IS UNDERGOING A COURT-ORDERED STABILIZATION PERIOD MAY NOT BE DETAINED FOR MORE THAN FIVE CALENDAR DAYS AFTER THE DATE THE IMPAIRED PERSON WAS INVOLUNTARILY ADMITTED TO THE EVALUATION AGENCY.

B. AN IMPAIRED PERSON WHO IS ADMITTED FOR A STABILIZATION PERIOD MAY BE RELEASED AT ANY TIME IF IN THE OPINION OF THE MEDICAL DIRECTOR OF AN EVALUATION AGENCY RELEASE IS APPROPRIATE. THE MEDICAL DIRECTOR OF AN EVALUATION AGENCY IS NOT CIVILLY LIABLE FOR ANY ACT COMMITTED BY A RELEASED PERSON IF THE MEDICAL DIRECTOR OF AN EVALUATION AGENCY HAS IN GOOD FAITH FOLLOWED THE REQUIREMENTS OF THIS ARTICLE. THE PERSON MAY CONTINUE CARE AND TREATMENT ON A VOLUNTARY BASIS AT ANY TIME AND MUST BE PROVIDED THE OPPORTUNITY FOR VOLUNTARY ADMISSION EACH DAY.

C. IF AN IMPAIRED PERSON WHO IS ADMITTED FOR A STABILIZATION PERIOD IS RELEASED, THE PETITION FOR COURT-ORDERED STABILIZATION MUST BE RETAINED TOGETHER WITH A WRITTEN STATEMENT BY THE MEDICAL DIRECTOR OF AN EVALUATION AGENCY STATING THE REASON THE RELEASE WAS APPROPRIATE.

36-2089. County attorney; duties

WHEN A PHYSICIAN OR OTHER PERSON FILES A PETITION FOR COURT-ORDERED STABILIZATION ON BEHALF OF AN EVALUATION AGENCY, THE COUNTY ATTORNEY FOR THE COUNTY IN WHICH THE PROCEEDING IS INITIATED SHALL REPRESENT THE PERSON WHO FILED THE PETITION OR THE EVALUATION AGENCY IN ANY JUDICIAL PROCEEDING FOR COURT-ORDERED STABILIZATION AND SHALL DEFEND ALL CHALLENGES TO THE DETENTION.

36-2090. Costs; financial responsibility

A. THE COSTS OF THE COURT PROCEEDINGS AND SERVICES PROVIDED UNDER THIS ARTICLE SHALL BE CHARGED TO THE ADMINISTRATION OR, IF AVAILABLE, TO ANOTHER THIRD-PARTY PAYOR. THE IMPAIRED PERSON MAY NOT BE CHARGED FOR SERVICES PROVIDED UNDER THIS ARTICLE.

B. AN EVALUATION AGENCY IS NOT FINANCIALLY RESPONSIBLE FOR SERVING THE DOCUMENTS REQUIRED BY SECTION 36-2084, SUBSECTION D.

36-2091. Report; review

A. ON OR BEFORE JANUARY 1, 2028, A COUNTY PRESCRIBED IN SECTION 36-2092 SHALL SUBMIT A REPORT TO THE GOVERNOR AND THE CHAIRPERSONS OF THE HEALTH AND HUMAN SERVICES COMMITTEES, OR THEIR SUCCESSOR COMMITTEES, IN THE SENATE AND THE HOUSE OF REPRESENTATIVES, AND SHALL PROVIDE A COPY TO THE SECRETARY OF STATE, THAT INCLUDES AT LEAST THE FOLLOWING INFORMATION RELATING TO COURT-ORDERED STABILIZATION PURSUANT TO THIS ARTICLE:

1. THE NUMBER OF IMPAIRED PERSONS WHO RECEIVED COURT-ORDERED STABILIZATION.

2. THE AVERAGE LENGTH OF STAY OF IMPAIRED PERSONS.

3. A LIST OF THE SUBSTANCES INVOLVED IN APPLICABLE CASES.

4. THE NUMBER AND PERCENTAGES OF IMPAIRED PERSONS WHO AGREED TO VOLUNTARY TREATMENT AND ADDITIONAL TIME IN THE EVALUATION AGENCY.

5. THE LOCATIONS TO WHICH IMPAIRED PERSONS WERE DISCHARGED, BY NUMBER AND PERCENTAGE.

6. THE NUMBER AND PERCENTAGES OF IMPAIRED PERSONS WHO RECEIVED COURT-ORDERED STABILIZATION AND WHO HAD A CO-OCCURRING MENTAL HEALTH DIAGNOSIS.

7. THE NAME OF THE PAYOR OF THE COURT-ORDERED STABILIZATION SERVICES.

8. WHETHER IMPAIRED PERSONS WHO RECEIVED COURT-ORDERED STABILIZATION HAD REPEAT APPLICATIONS FILED ON THEIR BEHALF AND RECEIVED SUBSEQUENT COURT-ORDERED STABILIZATION.

B. THE HEALTH AND HUMAN SERVICES COMMITTEES, OR THEIR SUCCESSOR COMMITTEES, IN THE SENATE AND THE HOUSE OF REPRESENTATIVES SHALL REVIEW THE REPORT SUBMITTED PURSUANT TO SUBSECTION A OF THIS SECTION AND DETERMINE WHETHER COURT-ORDERED STABILIZATION PURSUANT TO THIS ARTICLE SHOULD BE CONTINUED, MODIFIED OR DISCONTINUED.

36-2092. Applicability

THIS ARTICLE APPLIES ONLY IN A COUNTY WITH A POPULATION OF MORE THAN ONE MILLION PERSONS AND LESS THAN ONE MILLION FIVE HUNDRED THOUSAND PERSONS.

Sec. 5. Delayed repeal

Title 36, chapter 18, article 5, Arizona Revised Statutes, as added by this act, is repealed from and after December 31, 2028.

Sec. 6. Section 36-2901.08, Arizona Revised Statutes, is amended to read:

36-2901.08. Hospital assessment

A. The director shall establish, administer and collect an assessment on hospital revenues, discharges or bed days for the purpose of funding the nonfederal share of the costs, ~~except for~~ INCLUDING A PORTION OF THE costs of the services described in section 36-2907, subsection F, that are incurred ~~beginning January 1, 2014~~ and that are not covered by the proposition 204 protection account established by section 36-778 and the Arizona tobacco litigation settlement fund established by section 36-2901.02 or any other monies appropriated to cover these costs, for all of the following individuals:

1. Persons who are defined as eligible pursuant to section 36-2901.07.

2. Persons who do not meet the eligibility standards described in the state plan or the section 1115 waiver that were in effect immediately before November 27, 2000, but who meet the eligibility standards described in the state plan as effective October 1, 2001.

3. Persons who are defined as eligible pursuant to section 36-2901.01 but who do not meet the eligibility standards in either section 36-2934 or the state plan in effect as of January 1, 2013.

B. The director shall adopt rules regarding the method for determining the assessment, the amount or rate of the assessment, and modifications or exemptions from the assessment. The assessment is subject to approval by the federal government to ensure that the assessment is not established or administered in a manner that causes a reduction in federal financial participation.

C. The director may establish modifications or exemptions to the assessment. In determining the modifications or exemptions, the director may consider factors including the size of the hospital, the specialty services available to patients and the geographic location of the hospital.

D. Before implementing the assessment, and thereafter if the methodology is modified, the director shall present the methodology to the joint legislative budget committee for review.

E. The administration shall not collect an assessment for costs associated with service after the effective date of any reduction of the federal medical assistance percentage established by 42 United States Code

section 1396d(y) or 1396d(z) that is applicable to this state to less than eighty ~~per cent~~ PERCENT.

F. The administration shall deposit the revenues collected pursuant to this section in the hospital assessment fund established by section 36-2901.09.

G. A hospital shall not pass the cost of the assessment on to patients or third-party payors that are liable to pay for care on a patient's behalf. As part of its financial statement submissions pursuant to section 36-125.04, a hospital shall submit to the department of health services an attestation that it has not passed on the cost of the assessment to patients or third-party payors.

H. If a hospital does not comply with this section as prescribed by the director, the director may suspend or revoke the hospital's Arizona health care cost containment system provider agreement registration. If the hospital does not comply within one hundred eighty days after the director suspends or revokes the hospital's provider agreement, the director shall notify the director of the department of health services, who shall suspend or revoke the hospital's license pursuant to section 36-427.

Sec. 7. Title 36, chapter 29, article 1, Arizona Revised Statutes, is amended by adding sections 36-2903.18, 36-2903.19 and 36-2903.20, to read:

36-2903.18. Data matching agreements; review of member eligibility information; eligibility redeterminations; waiver requests

A. THE ADMINISTRATION SHALL ENTER INTO A DATA MATCHING AGREEMENT WITH THE DEPARTMENT OF REVENUE TO IDENTIFY MEMBERS WHO HAVE LOTTERY OR GAMBLING WINNINGS OF $3,000 OR MORE. THE ADMINISTRATION SHALL REVIEW THIS INFORMATION ON AT LEAST A MONTHLY BASIS. IF A MEMBER FAILS TO DISCLOSE WINNINGS OF $3,000 OR MORE AND IS IDENTIFIED THROUGH THE DATABASE MATCH, THE ADMINISTRATION SHALL CONSIDER THE MEMBER'S FAILURE TO DISCLOSE THE INFORMATION A VIOLATION OF THE SYSTEM'S TERMS OF ELIGIBILITY.

B. ON AT LEAST A MONTHLY BASIS, THE ADMINISTRATION SHALL RECEIVE AND REVIEW DEATH RECORD INFORMATION FROM THE DEPARTMENT OF HEALTH SERVICES CONCERNING MEMBERS AND SHALL ADJUST SYSTEM ELIGIBILITY ACCORDINGLY.

C. ON AT LEAST A QUARTERLY BASIS, THE ADMINISTRATION SHALL RECEIVE AND REVIEW INFORMATION FROM THE DEPARTMENT OF ECONOMIC SECURITY CONCERNING MEMBERS THAT INDICATES A CHANGE IN CIRCUMSTANCES THAT MAY AFFECT ELIGIBILITY, INCLUDING CHANGES TO UNEMPLOYMENT BENEFITS, EMPLOYMENT STATUS OR WAGES.

D. ON AT LEAST A MONTHLY BASIS, THE ADMINISTRATION SHALL REVIEW INFORMATION CONCERNING MEMBERS THAT INDICATES A CHANGE IN CIRCUMSTANCES THAT MAY AFFECT ELIGIBILITY, INCLUDING POTENTIAL CHANGES IN RESIDENCY AS IDENTIFIED BY OUT-OF-STATE ELECTRONIC BENEFIT TRANSFER CARD TRANSACTIONS.

E. ON AT LEAST A QUARTERLY BASIS, THE ADMINISTRATION SHALL RECEIVE AND REVIEW INFORMATION FROM THE DEPARTMENT OF REVENUE CONCERNING MEMBERS THAT INDICATES A CHANGE IN CIRCUMSTANCES THAT MAY AFFECT ELIGIBILITY FOR THE SYSTEM, INCLUDING POTENTIAL CHANGES IN INCOME, WAGES OR RESIDENCY AS IDENTIFIED BY TAX RECORDS.

F. UNLESS REQUIRED BY FEDERAL LAW, THE ADMINISTRATION MAY NOT ACCEPT SELF-ATTESTATION OF INCOME, RESIDENCY, AGE, HOUSEHOLD COMPOSITION, CARETAKER OR RELATIVE STATUS OR RECEIPT OF OTHER HEALTH INSURANCE COVERAGE WITHOUT INDEPENDENT VERIFICATION BEFORE ENROLLMENT. THE ADMINISTRATION MAY NOT REQUEST THE AUTHORITY TO WAIVE OR DECLINE TO PERIODICALLY CHECK ANY AVAILABLE INCOME-RELATED DATA SOURCES TO VERIFY ELIGIBILITY.

G. THE ADMINISTRATION MAY NOT ACCEPT ELIGIBILITY DETERMINATIONS FOR THE SYSTEM FROM AN EXCHANGE ESTABLISHED PURSUANT TO 42 UNITED STATES CODE SECTION 18041(c). THE ADMINISTRATION MAY ACCEPT ASSESSMENTS FROM AN EXCHANGE ESTABLISHED PURSUANT TO 42 UNITED STATES CODE SECTION 18041(c) BUT SHALL INDEPENDENTLY VERIFY ELIGIBILITY AND MAKE ELIGIBILITY DETERMINATIONS.

H. IF THE ADMINISTRATION RECEIVES INFORMATION CONCERNING A MEMBER THAT INDICATES A CHANGE IN THE MEMBER'S CIRCUMSTANCES THAT MAY AFFECT ELIGIBILITY, THE ADMINISTRATION SHALL REVIEW THE MEMBER'S ELIGIBILITY.

I. SUBJECT TO APPROVAL BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, THE ADMINISTRATION SHALL IMPLEMENT QUARTERLY REDETERMINATIONS FOR CONTINUED ELIGIBILITY UNDER THIS ARTICLE. THIS SUBSECTION DOES NOT APPLY TO A MEMBER WHO HAS A DISABILITY.

J. THE ADMINISTRATION MAY EXECUTE A MEMORANDUM OF UNDERSTANDING WITH ANY OTHER DEPARTMENT OF THIS STATE FOR INFORMATION REQUIRED TO BE SHARED PURSUANT TO THIS SECTION. THE ADMINISTRATION MAY CONTRACT WITH ONE OR MORE INDEPENDENT VENDORS TO PROVIDE ADDITIONAL DATA OR INFORMATION THAT MAY INDICATE A CHANGE IN CIRCUMSTANCES AND AFFECT AN INDIVIDUAL'S ELIGIBILITY.

K. ON OR BEFORE APRIL 1, 2026, THE ADMINISTRATION SHALL SUBMIT TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES ANY WAIVER REQUESTS NECESSARY TO IMPLEMENT THIS SECTION.

36-2903.19. Presumptive eligibility; limits; standards; notification; training

A. THE ADMINISTRATION SHALL REQUEST APPROVAL FROM THE CENTERS FOR MEDICARE AND MEDICAID SERVICES FOR A SECTION 1115 WAIVER TO ALLOW THE ADMINISTRATION TO ELIMINATE MANDATORY HOSPITAL PRESUMPTIVE ELIGIBILITY AND RESTRICT PRESUMPTIVE ELIGIBILITY DETERMINATIONS TO CHILDREN AND PREGNANT WOMEN ELIGIBILITY GROUPS. IF APPROVAL FOR THE SECTION 1115 WAIVER IS DENIED, THE ADMINISTRATION SHALL RESUBMIT A SUBSEQUENT REQUEST FOR APPROVAL WITHIN TWELVE MONTHS AFTER EACH DENIAL.

B. UNLESS REQUIRED BY FEDERAL LAW, THE ADMINISTRATION MAY NOT DESIGNATE ITSELF AS A QUALIFIED HEALTH ENTITY FOR THE PURPOSE OF MAKING

PRESUMPTIVE ELIGIBILITY DETERMINATIONS OR FOR ANY PURPOSE NOT EXPRESSLY AUTHORIZED BY STATE LAW.

C. WHEN MAKING PRESUMPTIVE ELIGIBILITY DETERMINATIONS, A QUALIFIED HOSPITAL SHALL DO ALL OF THE FOLLOWING:

1. NOTIFY THE ADMINISTRATION OF EACH PRESUMPTIVE ELIGIBILITY DETERMINATION WITHIN FIVE WORKING DAYS AFTER THE DATE THE DETERMINATION IS MADE.

2. ASSIST INDIVIDUALS WHO ARE DETERMINED PRESUMPTIVELY ELIGIBLE UNDER THE SYSTEM WITH COMPLETING AND SUBMITTING A FULL APPLICATION FOR SYSTEM ELIGIBILITY.

3. NOTIFY EACH APPLICANT IN WRITING AND ON ALL RELEVANT FORMS WITH PLAIN LANGUAGE AND LARGE PRINT THAT IF THE APPLICANT DOES NOT FILE A FULL APPLICATION FOR SYSTEM ELIGIBILITY WITH THE ADMINISTRATION BEFORE THE LAST DAY OF THE FOLLOWING MONTH, PRESUMPTIVE ELIGIBILITY COVERAGE WILL END ON THE LAST DAY OF THE FOLLOWING MONTH.

4. NOTIFY EACH APPLICANT THAT IF THE APPLICANT FILES A FULL APPLICATION FOR SYSTEM ELIGIBILITY WITH THE ADMINISTRATION BEFORE THE LAST DAY OF THE FOLLOWING MONTH, PRESUMPTIVE ELIGIBILITY COVERAGE WILL CONTINUE UNTIL AN ELIGIBILITY DETERMINATION IS MADE ON THE APPLICATION THAT WAS FILED.

D. THE ADMINISTRATION SHALL APPLY THE FOLLOWING STANDARDS TO ESTABLISH AND ENSURE THAT ACCURATE PRESUMPTIVE ELIGIBILITY DETERMINATIONS ARE MADE BY EACH QUALIFIED HOSPITAL:

1. WHETHER THE QUALIFIED HOSPITAL SUBMITTED TO THE ADMINISTRATION THE PRESUMPTIVE ELIGIBILITY CARD WITHIN FIVE WORKING DAYS AFTER THE DETERMINATION DATE.

2. WHETHER A FULL APPLICATION FOR SYSTEM ELIGIBILITY WAS RECEIVED BY THE ADMINISTRATION BEFORE THE EXPIRATION OF THE PRESUMPTIVE ELIGIBILITY PERIOD.

3. IF A FULL APPLICATION WAS RECEIVED BY THE ADMINISTRATION, WHETHER THE INDIVIDUAL WAS FOUND TO BE ELIGIBLE UNDER THE SYSTEM.

E. IF THE ADMINISTRATION DETERMINES THAT A QUALIFIED HOSPITAL FAILS TO MEET ANY OF THE STANDARDS ESTABLISHED UNDER SUBSECTION D OF THIS SECTION FOR ANY PRESUMPTIVE ELIGIBILITY DETERMINATION THAT THE QUALIFIED HOSPITAL MADE, THE ADMINISTRATION SHALL NOTIFY THE QUALIFIED HOSPITAL IN WRITING WITHIN FIVE DAYS AFTER THE DETERMINATION. THE NOTICE SHALL INCLUDE:

1. FOR THE FIRST VIOLATION, BOTH OF THE FOLLOWING:

(a) A DESCRIPTION OF THE STANDARD THAT WAS NOT MET AND AN EXPLANATION OF WHY IT WAS NOT MET.

(b) CONFIRMATION THAT A SECOND FINDING WILL REQUIRE THAT ALL APPLICABLE HOSPITAL STAFF PARTICIPATE IN MANDATORY TRAINING BY THE ADMINISTRATION ON HOSPITAL PRESUMPTIVE ELIGIBILITY RULES.

2. FOR THE SECOND VIOLATION, ALL OF THE FOLLOWING:

(a) A DESCRIPTION OF THE STANDARD THAT WAS NOT MET AND AN EXPLANATION OF WHY IT WAS NOT MET.

(b) CONFIRMATION THAT ALL APPLICABLE HOSPITAL STAFF WILL BE REQUIRED TO PARTICIPATE IN A MANDATORY TRAINING BY THE ADMINISTRATION ON HOSPITAL PRESUMPTIVE ELIGIBILITY RULES, INCLUDING THE DATE, TIME AND LOCATION OF THE TRAINING AS DETERMINED BY THE ADMINISTRATION.

(c) A DESCRIPTION OF AVAILABLE APPELLATE PROCEDURES BY WHICH A QUALIFIED HOSPITAL MAY DISPUTE THE FINDING AND REMOVE THE FINDING FROM THE QUALIFIED HOSPITAL'S RECORD BY PROVIDING CLEAR AND CONVINCING EVIDENCE THAT THE STANDARD WAS MET.

(d) CONFIRMATION THAT IF THE QUALIFIED HOSPITAL SUBSEQUENTLY FAILS TO MEET ANY OF THE STANDARDS FOR PRESUMPTIVE ELIGIBILITY FOR ANY DETERMINATION, THE QUALIFIED HOSPITAL WILL NO LONGER BE QUALIFIED TO MAKE PRESUMPTIVE ELIGIBILITY DETERMINATIONS UNDER THE SYSTEM.

3. FOR THE THIRD VIOLATION, ALL OF THE FOLLOWING:

(a) A DESCRIPTION OF THE STANDARD THAT WAS NOT MET AND AN EXPLANATION OF WHY IT WAS NOT MET.

(b) A DESCRIPTION OF AVAILABLE APPELLATE PROCEDURES BY WHICH A QUALIFIED HOSPITAL MAY DISPUTE THE FINDING AND REMOVE THE FINDING FROM THE HOSPITAL'S RECORD BY PROVIDING CLEAR AND CONVINCING EVIDENCE THAT THE STANDARD WAS MET.

(c) CONFIRMATION THAT, EFFECTIVE IMMEDIATELY, THE HOSPITAL IS NO LONGER QUALIFIED TO MAKE PRESUMPTIVE ELIGIBILITY DETERMINATIONS UNDER THE SYSTEM.

36-2903.20. Eligibility; retroactive limitation; waiver request

A. NOTWITHSTANDING ANY PROVISION OF THIS ARTICLE OR THE RULES ADOPTED PURSUANT TO THIS ARTICLE TO THE CONTRARY, SUBJECT TO THE APPROVAL BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, ELIGIBILITY UNDER THIS ARTICLE FOR ANY ELIGIBLE PERSON IS THE FIRST DAY OF THE MONTH THAT THE ELIGIBLE PERSON SUBMITTED A FULL APPLICATION TO THE ADMINISTRATION.

B. ON OR BEFORE APRIL 1, 2026, THE ADMINISTRATION SHALL SUBMIT TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES ANY WAIVER REQUEST NECESSARY TO IMPLEMENT THIS SECTION.

Sec. 8. Section 36-2907, Arizona Revised Statutes, is amended to read:

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

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.

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

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

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

~~(e)~~ (d) Nonexperimental transplants do not include pancreas-only transplants.

~~(f)~~ (e) 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 ANY 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.

3. SPEECH THERAPY PROVIDED IN AN OUTPATIENT SETTING TO ELIGIBLE PERSONS WHO ARE AT LEAST TWENTY-ONE YEARS OF AGE.

4. COCHLEAR IMPLANTS TO ELIGIBLE PERSONS WHO ARE AT LEAST TWENTY-ONE YEARS OF AGE.

~~0.~~ N. For the purposes of this section, "ambulance" has the same meaning prescribed in section 36-2201.

Sec. 9. Section 36-2936, Arizona Revised Statutes, is amended to read:

36-2936. Preadmission screening programs; functional tests; screening review; rules

A. The director shall adopt rules establishing a uniform statewide preadmission screening program to determine if a person who has met the eligibility criteria prescribed in section 36-2934 is eligible for institutional services pursuant to this article. To be eligible for institutional services or home and community based services ~~as defined in section 36-2931~~, a person shall have a nonpsychiatric medical condition or have a developmental disability as defined in section 36-551 that, by itself or in combination with other medical conditions, necessitates the level of care that is provided in a nursing facility or intermediate care facility. These rules shall establish a uniform preadmission screening instrument that assesses the functional, medical, nursing, social and developmental needs of the applicant. FOR ELDERLY APPLICANTS AND ADULT APPLICANTS WITH PHYSICAL DISABILITIES, THE PREADMISSION SCREENING INSTRUMENT SHALL ALSO ASSESS COGNITIVE NEEDS REGARDING PROMPTING, MONITORING AND SUPERVISING ACTIVITIES OF DAILY LIVING. THE PREADMISSION

SCREENING INSTRUMENT SHALL WEIGH COGNITIVE IMPAIRMENT AND PHYSICAL IMPAIRMENT AT THE SAME WEIGHT IF THE IMPAIRMENT PRODUCES A SIMILAR LEVEL OF FUNCTIONAL DIFFICULTY.

B. A person is not eligible to receive home and community based services unless that person has been determined to need institutional services as determined by the preadmission screening instrument pursuant to subsection D of this section. The administration shall establish guidelines for the periodic reassessment of each member.

C. Preadmission screening conducted pursuant to subsection B of this section shall be conducted telephonically or virtually, unless the administration determines it is necessary to conduct the assessment in person or the applicant being screened or the applicant's representative requests an in-person assessment. The administration shall provide notice to applicants that the purpose of preadmission screening is to conduct a meaningful review of an applicant's medical needs, functional capacity, social and developmental needs and emotional and cognitive behaviors. The notice shall inform applicants that the applicant or the applicant's representative may request an in-person assessment and may request accommodations in the preadmission screening process under the Americans with disabilities act of 1990.

D. Preadmission screening conducted pursuant to subsection B of this section shall be conducted by a registered nurse who is licensed pursuant to title 32, chapter 15 or by a social worker. The nurse or social worker shall have a physician who is licensed pursuant to title 32, chapter 13 or 17 available for consultation and may use the applicant's attending physician's physical assessment form, if appropriate, in assessing needs for long-term care services under this article. A physician who receives a referral from the nurse or social worker may use the physician's medical judgment to determine the medical eligibility of an applicant for the system or the continued medical eligibility of a member or eligible person. In the medical referral, the physician shall use the established combined thresholds for functional ability and medical condition as a guide to determine the risk of institutionalization.

E. If a person who is eligible for services pursuant to this article, who is enrolled with a program contractor pursuant to this article and who is enrolled with a program contractor pursuant to section 36-2940 fails the preadmission screening for institutional services pursuant to subsection A of this section at the time of a reassessment, the administration may administer a second preadmission screening designed to measure the functioning level of the person based on rules adopted by the director. If the person meets the established thresholds of the functional preadmission screening, the person is eligible for home and community based services pursuant to section 36-2939, subsection A, paragraphs 2, 3 and 4, subsection B, paragraph 2 and subsection C. If a person who is determined eligible pursuant to this subsection is

institutionalized pursuant to section 36-2939, including residence in an intermediate care facility, institution for mental disease, inpatient psychiatric facility or nursing facility, the person has a maximum of ninety days to vacate the institutional setting and relocate to a home and community based setting approved pursuant to section 36-2939.

F. If the person is determined not to need services pursuant to this section, the administration shall provide the person with information on other available community services.

G. The administration or its designee shall complete the preadmission screening under subsection A of this section within eight days, excluding Saturdays and holidays, and excluding the time period allowed to determine eligibility pursuant to section 36-2934.

H. If a provider who contracts with the administration pursuant to section 36-2904, subsection A is dissatisfied with any action or decision of the administration regarding the eligibility of a person for the system as prescribed in this article, that provider may file a grievance in accordance with the provider grievance procedure prescribed in section 36-2932, subsection I, paragraph 1. If the director determines pursuant to the grievance process that the person should have been determined eligible pursuant to section 36-2933, the director may reimburse the provider for the net cost of services provided pursuant to this article after the cumulative time periods allowed pursuant to section 36-2934 and this section.

I. In addition to those persons seeking services pursuant to this article, the preadmission screening conducted pursuant to this section shall be made available to all other persons applying for admission to a nursing care institution. The cost of preadmission screenings conducted by the administration pursuant to this subsection shall be borne by the state. The administration shall provide nursing care institutions and the general public on request with detailed information about the preadmission screening program and booklets that describe in clear and simple language the availability of services and benefits from the system. The booklet shall:

1. Explain the availability of preadmission screening that will assess the functional, medical, nursing and social needs of the patient and make recommendations on services that meet the patient's needs as identified by the preadmission screening assessment.

2. Describe the availability of public and private services appropriate to meet the patient's needs in institutions and alternatives to institutions.

3. Explain financial eligibility standards for the Arizona long-term care system and its effect on separate and community property.

J. In addition to the preadmission screening program established in this section, the administration shall implement the preadmission screening program as set forth in section 1919 of the social security act.

For persons applying for admission to a title XIX certified nursing care institution, an initial level I preadmission screening shall be conducted by the administration on all nursing care institution applicants who are applying for eligibility pursuant to section 36-2933 and by the nursing care institution on all other nursing care institution applicants. The administration shall develop a uniform identification screening instrument, which shall be used by the nursing care institution and the administration in conducting the initial level I screens. If the identification screen indicates the applicant may be mentally ill, the applicant shall be referred to the administration, which shall conduct the level II preadmission screening review using a level II screening instrument developed by the administration. If the identification screen indicates the applicant may have an intellectual disability, the applicant shall be referred to the department, which shall conduct the level II preadmission screening review using a level II screening instrument developed by the department.

K. Within ten working days a nursing care institution shall notify the administration for a person who is mentally ill or the department of economic security for a person with developmental disabilities and the department of child safety if the person is a minor dependent of this state about any significant change that occurs in the physical or mental condition of a member who is residing in the nursing care institution. The administration or the department of economic security shall conduct a subsequent level II screening review of the member within the time frame required by the administration after the notification by the nursing care institution.

Sec. 10. Laws 2023, chapter 139, section 4, as amended by Laws 2024, chapter 215, section 2, is amended to read:

Sec. 4. Department of health services; collaborative care uptake fund; exemption; technical assistance grants; delayed repeal; transfer of monies; definitions

A. The collaborative care uptake fund is established in the department. The fund consists of monies appropriated by the legislature. Monies in the fund are continuously appropriated and are exempt from the provisions of section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations. The department may not use more than three percent of the monies deposited in the fund to administer the fund.

B. The department shall use the collaborative care uptake fund monies to award grants to primary care physicians who are in a medical practice with not more than fifty employees to meet the initial costs of establishing and delivering behavioral health integration services through the collaborative care model and for technical assistance grants pursuant to subsection D of this section.

C. A primary care physician who receives a grant under this section may use the grant monies:

1. To hire staff.

2. To 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.

3. To 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.

4. For any other purposes the department prescribes as necessary to support the collaborative care model.

D. The department shall 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. Each collaborative care technical assistance center applicant must provide in the grant application information on how the collaborative care technical assistance center will meet the assistance requirements prescribed in subsection E of this section in order to be eligible for a grant.

E. A collaborative care technical assistance center that receives a grant under subsection D of this section shall provide technical assistance to primary care physicians and shall assist the primary care physicians with the following:

1. Developing financial models and budgets for program launch and sustainability based on practice size.

2. Developing staffing models for essential staff roles, including care managers and consulting psychiatrists.

3. 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.

4. Providing training support for all key staff and operational consultation to develop practice workflows.

5. 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.

6. For any other purposes the department prescribes as necessary to support the collaborative care model.

F. From and after June 30, ~~2025~~ 2027, this section is repealed and any unexpended and unencumbered monies remaining in the collaborative care

uptake fund established by this section are transferred to the state general fund.

G. For the purposes of this section:

1. "Collaborative care model" means 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.

(d) Modification of treatment as appropriate.

2. "Collaborative care technical assistance center":

(a) Means a health care organization that can provide educational support and technical assistance related to the collaborative care model.

(b) Includes an academic medical center.

3. "Department" means the department of health services.

4. "Primary care physician" has the same meaning prescribed in section 36-2901, Arizona Revised Statutes.

Sec. 11. Department of health services; dementia awareness; report

A. The department of health services shall distribute the monies appropriated for fiscal year 2025-2026 in the general appropriations act for Alzheimer's disease and dementia awareness to a nonprofit organization to implement a public education campaign to increase awareness of Alzheimer's disease and dementia in rural and underserved urban areas in this state. The nonprofit organization that receives monies pursuant to this subsection must meet all of the following:

1. Demonstrate expertise in memory loss, dementia and Alzheimer's disease.

2. Host a toll-free hotline that is available twenty-four hours a day, seven days a week, with interpreter service if needed, and that is staffed by master's level consultants to provide education on Alzheimer's disease signs and symptoms, decision-making support, dementia crisis assistance, treatment options and referrals to local community resources.

3. Provide care and support for those affected by Alzheimer's disease and other dementias.

4. Demonstrate experience in marketing and public awareness campaigns.

B. On or before November 1, 2026, the department of health services shall submit a report regarding the impact of the public awareness campaign to the governor, the president of the senate and the speaker of

the house of representatives. The department shall submit a copy of the report to the secretary of state.

Sec. 12. Arizona state board of nursing; student registered nurse anesthetists; clinical rotation program; definitions

A. The student registered nurse anesthetist clinical rotation program is established for fiscal year 2025-2026 in the Arizona state board of nursing to expand the capacity of preceptor training programs at health care institutions for registered nurse anesthetist students.

B. The Arizona state board of nursing shall develop a grant program for fiscal year 2025-2026 to distribute monies appropriated for fiscal year 2025-2026 in the general appropriations act for the student registered nurse anesthetist clinical rotation program to health care institutions that are licensed pursuant to title 36, chapter 4, Arizona Revised Statutes, to pay for the direct and indirect costs related to expanding or developing clinical training placements for registered nurse anesthetist students, with preference given to expanding or developing clinical rotations in obstetrics, pediatrics, cardiovascular, thoracic and neurological care.

C. Grant monies awarded pursuant to this section are intended to supplement and not supplant existing training program expenses covered by the health care institution grantee. A grant may fund a clinical training placement through an anesthesia provider group contracted with a health care institution, through an authorized preceptor or through a health care institution directly. Not more than twenty percent of a grant award may be spent on the indirect costs of expanding or developing clinical training placements. Grant monies shall be distributed to grantees before the expenses for expanding or developing clinical rotations are incurred. The grantees shall return all monies to the Arizona state board of nursing that are not spent on the direct and indirect costs related to expanding or developing clinical rotations.

D. The Arizona state board of nursing shall establish an application process for the grant program. The Arizona state board of nursing shall consider the following factors when determining grant awards:

1. The geographic and population distribution.

2. The number of registered nurse anesthetist students expected to be trained and retained.

3. The cost of the proposal for the number of registered nurse anesthetist students expected to participate and be retained compared to other proposals.

E. For the purposes of this section:

1. "Authorized preceptor" means a certified registered nurse anesthetist or physician anesthesiologist that provides a preceptorship in an operating room that allows a student registered nurse anesthetist to

meet the council on accreditation of nurse anesthesia educational program requirements.

2. "Health care institution" has the same meaning prescribed in section 36-401, Arizona Revised Statutes.

Sec. 13. Department of administration; grant program; technology solution; hospital interoperability; reports; delayed repeal; definitions

A. Notwithstanding section 41-703.01, Arizona Revised Statutes, for fiscal years 2025-2026, 2026-2027 and 2027-2028, the department of administration shall 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. The grant recipient may not use a third-party vendor to comply with any of the grant program requirements. The department of administration shall award the grant under this program not later than September 30, 2025.

B. The Arizona health care cost containment system shall work with the department of administration to supplement the grant monies by identifying and applying to receive federal matching monies.

C. The grant program shall 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 provider care and that is accessible to current and future providers via a mobile, native smartphone application.

D. The software shall 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. The department of administration shall award one grant for an interoperability software technology solution that, at a minimum:

1. Complies with the health insurance portability and accountability act privacy standards (45 Code of Federal Regulations part 160 and part 164, subpart E).

2. Captures and forwards clinical data, including laboratory results and images, and provides synchronous patient clinical data to health care providers regardless of geographic location.

3. 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.

4. Is capable of providing proactive alerts to health care providers on their smartphones or a smart device.

5. Allows both synchronous and asynchronous communication via a native smartphone application.

6. Is mobile and can be used on multiple electronic devices. The mobile technology must include, at a minimum, the industry standard built-in application for the two most popular operating systems and a built-in application available to all users.

7. Has patient-centric communication and is tracked with date and time stamping.

8. Is connected to the appropriate physician resources.

9. Provides data to update cost reports to enhance emergency triage and to treat and transport patients.

E. The grant recipient shall demonstrate both of the following:

1. That its interoperability software technology solution meets all of the requirements of subsection D of this section at least thirty days before applying for the grant.

2. Proof of veteran employment.

F. For fiscal years 2025-2026, 2026-2027 and 2027-2028, the grant recipient shall provide to the department of administration a report that provides metrics and quantifies cost and time savings for using an interoperable software solution in health care that complies with the health insurance portability and accountability act privacy standards (45 Code of Federal Regulations part 160 and part 164, subpart E). On or before June 30 of each fiscal year, the department of administration in coordination with the Arizona health care cost containment system shall provide to the president of the senate, the speaker of the house of representatives, the chairpersons of the health and human services committees of the senate and the house of representatives and the directors of the joint legislative budget committee and the governor's office of strategic planning and budgeting a report on the allocation of grant funding and a compiled analysis of the reports provided by the grant recipient.

G. Monies appropriated for the purposes of this section do not affect the monies appropriated in fiscal year 2022-2023 for interoperability software technology solutions or any grant awarded to or contract with a grant recipient pursuant to section 41-703.01, Arizona Revised Statutes.

H. This section is repealed from and after December 31, 2028.

I. For the purposes of this section:

1. "Mobile" means available to end users on a smart device via a native application and not an internet page or web portal.

2. "Native" means an application that is specifically developed for the hardware and operating system that runs the application.

3. "Rural" means a county with a population of less than nine hundred thousand persons.

4. "Veteran employment" means a business organization that employs an individual or has a company officer who served and who was honorably discharged from or released under honorable conditions from service in the United States armed forces.

Sec. 14. ALTCS; county contributions; fiscal year 2025-2026

A. Notwithstanding section 11-292, Arizona Revised Statutes, county contributions for the Arizona long-term care system for fiscal year 2025-2026 are as follows:

1.	Apache	$ 707,000
2.	Cochise	$ 7,510,100
3.	Coconino	$ 2,122,700
4.	Gila	$ 3,173,800
5.	Graham	$ 2,339,400
6.	Greenlee	$ 66,900
7.	La Paz	$ 828,800
8.	Maricopa	$275,201,600
9.	Mohave	$ 10,438,200
10.	Navajo	$ 2,926,600
11.	Pima	$ 63,729,700
12.	Pinal	$ 17,094,300
13.	Santa Cruz	$ 2,949,900
14.	Yavapai	$ 7,808,600
15.	Yuma	$ 12,640,000

B. If the overall cost for the Arizona long-term care system exceeds the amount specified in the general appropriations act for fiscal year 2025-2026, the state treasurer shall collect from the counties the difference between the amount specified in subsection A of this section and the counties' share of the state's actual contribution. The counties' share of the state's contribution must comply with any federal maintenance of effort requirements. The director of the Arizona health care cost containment system administration shall notify the state treasurer of the counties' share of the state's contribution and report the amount to the director of the joint legislative budget committee. The state treasurer shall withhold from any other monies payable to a county from whatever state funding source is available an amount necessary to fulfill that county's requirement specified in this subsection. The state treasurer may not withhold distributions from the Arizona highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes. The state treasurer shall deposit the amounts withheld pursuant to this subsection and amounts paid pursuant to subsection A of this section in the long-term care system fund established by section 36-2913, Arizona Revised Statutes.

Sec. 15. AHCCCS; disproportionate share payments; fiscal year 2025-2026

A. Disproportionate share payments for fiscal year 2025-2026 made pursuant to section 36-2903.01, subsection O, Arizona Revised Statutes, include:

1. $28,474,900 for the Arizona state hospital. The Arizona state hospital shall provide a certified public expense form for the amount of qualifying disproportionate share hospital expenditures made on behalf of this state to the Arizona health care cost containment system administration on or before March 31, 2026. The administration shall assist the Arizona state hospital in determining the amount of qualifying disproportionate share hospital expenditures. Once the administration files a claim with the federal government and receives federal financial participation based on the amount certified by the Arizona state hospital, the administration shall deposit the entire amount of federal financial participation in the state general fund. If the certification provided is for an amount less than $28,474,900, the administration shall notify the governor, the president of the senate and the speaker of the house of representatives and shall deposit the entire amount of federal financial participation in the state general fund. The certified public expense form provided by the Arizona state hospital must contain both the total amount of qualifying disproportionate share hospital expenditures and the amount limited by section 1923(g) of the social security act.

2. $884,800 for private qualifying disproportionate share hospitals. The Arizona health care cost containment system administration shall make payments to hospitals consistent with this appropriation and the terms of the state plan, but payments are limited to those hospitals that either:

(a) Meet the mandatory definition of disproportionate share qualifying hospitals under section 1923 of the social security act.

(b) Are located in Yuma county and contain at least three hundred beds.

B. After the distributions made pursuant to subsection A of this section, the allocations of disproportionate share hospital payments made pursuant to section 36-2903.01, subsection P, Arizona Revised Statutes, shall be made available in the following order to qualifying private hospitals that are:

1. Located in a county with a population of fewer than four hundred thousand persons.

2. Located in a county with a population of at least four hundred thousand persons but fewer than nine hundred thousand persons.

3. Located in a county with a population of at least nine hundred thousand persons.

Sec. 16. AHCCCS transfer; counties; federal monies; fiscal year 2025-2026

On or before December 31, 2026, notwithstanding any other law, for fiscal year 2025-2026, the Arizona health care cost containment system administration shall transfer to the counties the portion, if any, as may be necessary to comply with section 10201(c)(6) of the patient protection and affordable care act (P.L. 111-148), regarding the counties' proportional share of this state's contribution.

Sec. 17. County acute care contributions; fiscal year 2025-2026; intent

A. Notwithstanding section 11-292, Arizona Revised Statutes, for fiscal year 2025-2026 for the provision of hospitalization and medical care, the counties shall contribute the following amounts:

1.	Apache	$ 268,800
2.	Cochise	$ 2,214,800
3.	Coconino	$ 742,900
4.	Gila	$ 1,413,200
5.	Graham	$ 536,200
6.	Greenlee	$ 190,700
7.	La Paz	$ 212,100
8.	Maricopa	$14,783,900
9.	Mohave	$ 1,237,700
10.	Navajo	$ 310,800
11.	Pima	$14,951,800
12.	Pinal	$ 2,715,600
13.	Santa Cruz	$ 482,800
14.	Yavapai	$ 1,427,800
15.	Yuma	$ 1,325,100

B. If a county does not provide funding as specified in subsection A of this section, the state treasurer shall subtract the amount owed by the county to the Arizona health care cost containment system fund and the long-term care system fund established by section 36-2913, Arizona Revised Statutes, from any payments required to be made by the state treasurer to that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona Revised Statutes, plus interest on that amount pursuant to section 44-1201, Arizona Revised Statutes, retroactive to the first day the funding was due. If the monies the state treasurer withholds are insufficient to meet that county's funding requirements as specified in subsection A of this section, the state treasurer shall withhold from any other monies payable to that county from whatever state funding source is available an amount necessary to fulfill that county's requirement. The state treasurer may not withhold distributions from the Arizona highway user revenue fund pursuant to title 28, chapter 18, article 2, Arizona Revised Statutes.

C. Payment of an amount equal to one-twelfth of the total amount determined pursuant to subsection A of this section shall be made to the state treasurer on or before the fifth day of each month. On request from the director of the Arizona health care cost containment system administration, the state treasurer shall require that up to three months' payments be made in advance, if necessary.

D. The state treasurer shall deposit the amounts paid pursuant to subsection C of this section and amounts withheld pursuant to subsection B of this section in the Arizona health care cost containment system fund and the long-term care system fund established by section 36-2913, Arizona Revised Statutes.

E. If payments made pursuant to subsection C of this section exceed the amount required to meet the costs incurred by the Arizona health care cost containment system for the hospitalization and medical care of those persons defined as an eligible person pursuant to section 36-2901, paragraph 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of the Arizona health care cost containment system administration may instruct the state treasurer either to reduce remaining payments to be paid pursuant to this section by a specified amount or to provide to the counties specified amounts from the Arizona health care cost containment system fund and the long-term care system fund established by section 36-2913, Arizona Revised Statutes.

F. The legislature intends that the Maricopa county contribution pursuant to subsection A of this section be reduced in each subsequent year according to the changes in the GDP price deflator. For the purposes of this subsection, "GDP price deflator" has the same meaning prescribed in section 41-563, Arizona Revised Statutes.

Sec. 18. Proposition 204 administration; exclusion; county expenditure limitations

County contributions for the administrative costs of implementing sections 36-2901.01 and 36-2901.04, Arizona Revised Statutes, that are made pursuant to section 11-292, subsection O, Arizona Revised Statutes, are excluded from the county expenditure limitations.

Sec. 19. Competency restoration; exclusion; county expenditure limitations

County contributions made pursuant to section 13-4512, Arizona Revised Statutes, are excluded from the county expenditure limitations.

Sec. 20. AHCCCS; risk contingency rate setting

Notwithstanding any other law, for the contract year beginning October 1, 2025 and ending September 30, 2026, the Arizona health care cost containment system administration may continue the risk contingency rate setting for all managed care organizations and the funding for all managed care organizations administrative funding levels that were imposed for the contract year beginning October 1, 2010 and ending September 30, 2011.

Sec. 21. AHCCCS; acute care contracts; extension

Notwithstanding any law to the contrary, the Arizona health care cost containment system administration shall extend the existing acute care contracts with all contracted managed care organizations through September 30, 2028.

Sec. 22. AHCCCS; preadmission screening instrument; staff training manuals

The Arizona health care cost containment system administration shall update the elderly and adults with physical disabilities preadmission screening instrument and staff training manuals for the purposes of section 36-2936, Arizona Revised Statutes, as amended by this act.

Sec. 23. Legislative intent; implementation of program

The legislature intends that for fiscal year 2025-2026 the Arizona health care cost containment system administration implement a program within the available appropriation.

Sec. 24. Effective date

Sections 36-2903.18 and 36-2903.19, Arizona Revised Statutes, as added by this act, are effective from and after December 31, 2025.