2016 HEALTH LEGISLATIVE REPORT

AS OF JUNE 1, 2016

Following is a Health Legislative Report for the Fifty-Second Legislature, Second Regular Session (2016), including those bill summaries of the legislation signed into law this session (unless otherwise indicated) with the most relevance to the practice of psychiatry through the close of the legislative session. The bill summaries and histories are copyrighted by Arizona Capitol Reports, L.L.C. If you would like any additional information, please contact the APS Lobbyist, Joe Abate, at 602-380-8337. If you are interested in being a part of the Legislative Committee of APS, chaired by Dr. Roland Segal, please contact teri@azmed.org.

H2306: HEALTHCARE PROVIDERS; FAMILY MEMBERS; COVERAGE

All health and disability insurance contracts and policies issued, delivered or renewed on or after July 1, 2017 in Arizona are required to provide coverage for lawful health care services provided by a health care provider to a subscriber regardless of the familial relationship of the provider to the subscriber if that service would be covered were it provided not a subscriber who was not related to the provider.

H2310: BIOLOGICAL PRODUCTS; PRESCRIPTION ORDERS

A pharmacist is permitted to substitute a biological product for a prescribed biological product only if a list of specified conditions is met, including that the U.S. Food and Drug Administration has determined the substituted product to be an "interchangeable biological product" (defined) and that the prescribing physician does not designate that substitution is prohibited. Effective January 1, 2017.

H2355: OPIOID ANTAGONISTS; PRESCRIPTION; DISPENSING; ADMINISTRATION

A licensed physician, nurse practitioner or other health professional who has prescribing authority and is acting within the scope of practice is authorized to prescribe or dispense naloxone hydrochloride or any other opioid antagonist that is approved by the U.S. Food and Drug Administration to a person who is at risk of experiencing an opioid-related overdose or a family member or community organization that may be in a position to assist that person. Before prescribing an opioid antagonist, a physician, nurse practitioner or other health professional is authorized to require the person receiving the prescription to provide in writing a factual basis for a reasonable conclusion that the person or entity meets the statutory requirements for being able to receive an opioid antagonist. A pharmacist is authorized to dispense without a prescription, according to Board of Pharmacy protocols, naloxone hydrochloride or any other opioid antagonist that is approved by the U.S. Food and Drug Administration to a person who is at risk of experiencing an opioid-related overdose or to a family member or community member who is in a position to assist that person. A person is authorized to administer an opioid antagonist that is prescribed or dispensed in accordance with the protocol specified by the health professional or pharmacist to a person who is experiencing an opioid-related overdose. Physicians, pharmacists and persons who take these actions with reasonable care and in good faith are immune from specified liability except in cases of wanton or willful neglect. Also, school district governing boards are required to prescribe and enforce policies and procedures for the emergency administration of naloxone hydrochloride or any other opioid antagonist approved by the U.S. Food and Drug Administration by a district employee.

H2362: NURSE LICENSURE COMPACT

Enacts and adopts a Nurse Licensure Compact to allow nurses to obtain a multistate license to practice registered or licensed practical/vocational nursing issued by a home state that will be recognized by each party state as authorizing a nurse to practice in that state. Criteria for an applicant to obtain or retain a multistate license are specified. Authorizes party state licensing boards to take a list of specified actions relating to multistate licensure. Requires all party states to participate in a coordinated licensure information system.

Establishes an Interstate Commission of Nurse Licensure Compact Administrators and establishes Commission powers and duties, including rulemaking authority. Provides for oversight dispute resolution and enforcement of Compact provisions. Also establishes procedures for withdrawal, amendment, construction and severability of the Compact. The Compact does not alter the scope of practice of a registered nurse practicing in Arizona. Becomes effective on the earlier of December 31, 2018 or the enactment into law of the Compact by at least 26 other states.

H2442: BEHAVIORAL HEALTH; URGENT NEED; CHILDREN

If a dependent child who is in the legal custody of the Department of Child Safety (DCS) is placed in an out-of-home placement, DCS is required to give the out-of-home placement contact information for the child's caseworker, the child's regional behavioral health authority (RBHA) designated point of contact, the telephone number to the AHCCCS customer service line, a list of AHCCCS providers and information regarding the out-of-home placement's rights, if applicable. If the out-of-home placement or an adoptive parent of an eligible child identifies an urgent need for the child to receive behavioral health services, the parent is permitted to directly contact a RBHA for a screening and evaluation of the child. The RBHA is required to dispatch an assessment team within 72 hours after being notified that the child has entered out-of-home placement or within 2 hours after being notified that the child has immediate needs, and must provide an initial evaluation of the child within 7 calendar days. If after the screening and evaluation it is determined that the child needs services, the RBHA is required to provide an initial appointment for the child within 21 calendar days. If the initial service is not provided within 21 days, the parent may access services directly from any AHCCCS provider regardless of whether the provider is contracted with the RBHA. If an out-of-home placement or adoptive parent recognizes that a child is in need of crisis services and the crisis service provider in that county is not responsive, the parent may contact the RBHA designated point of contact to coordinate crisis services for the child. A parent cannot be considered as having abused, neglected or abandoned or be charged with abuse, neglect or abandonment of a foster or adoptive child for seeking inpatient treatment or an out-of-home placement if the child's behavioral health needs pose a risk to the safety and welfare of the family, or solely for bringing into the home a biological, foster or adoptive child whose behavioral health needs pose a risk to the safety and welfare of the family. DCS is prohibited from using as the basis for removing a foster child from a licensed foster parent the parent's request to disrupt a foster child or the dissolution of an adoption that occurred based on that the parent was unable to receive services that the child was statutorily entitled to receiver or based on that the foster or adoptive child threatened the health or safety of the adoptive family. Additionally, if a child who has been in foster care is returned to the child's home then removed again from the child's home, DCS is required to notify all foster homes in which the child previously resided that the child has been removed, and DCS is required to place the child in a foster home in which the child has resided, unless the placement is not in the best interests of the child or none of the prior foster homes wants the placement.

H2502: MEDICAL LICENSURE COMPACT

Enacts the Interstate Medical Licensure Compact to establish a comprehensive and streamlined process allowing physicians to become licensed in multiple states. Adopts the prevailing standard for licensure and requires the physician to be under the jurisdiction of the state medical board where the patient is located. Establishes license eligibility and application requirements. Establishes an Interstate Medical Licensure Compact Commission and establishes Commission powers and duties, Provides for withdrawal from the Compact and dissolution of the Compact. The Compact becomes effective and binding on legislative enactment of the Compact by at least seven states. Beginning July 1, 2017, the Arizona Medical Board (MD Board) and the Arizona Board of Osteopathic Examiners in Medicine and Surgery (DO Board) are each authorized to issue a temporary license to allow a physician who is not an Arizona licensee to practice in Arizona for a total of up to 250 consecutive days if the physician holds an active and unrestricted license to practice medicine in a U.S. state or territory, has never had a license suspended or revoked, is not the subject of an unresolved complaint, has applied for an Arizona

license, and has paid any applicable fees. The temporary license cannot be renewed or extended. The MD Board or DO Board is required to approve or deny an application for a temporary license within 30 days. The MD Board and DO Boards are each authorized to establish by rule a fee for temporary licensure.

The MD Board and DO Board are each prohibited from requiring an applicant for licensure to hold or maintain a "specialty certification" (defined) as a condition of licensure in Arizona. Additionally, employers are prohibited from requiring a physician to seek licensure through the Compact as a condition of initial or continued employment. The MD Board and DO Board are required to post notice of any Commission action that may affect a physician's license, and are prohibited from spending any monies received from applicants who are not applying for licensure through the Compact on any activities, obligations or duties required by the Compact. The MD Board and DO Board are each required to create a proposal for the expedited licensure of a physician who is licensed in at least one other state, whose license is in good standing and who chooses not to be licensed through the Compact, and are each required to submit a report to the Legislature by December 1, 2017. Appropriates $50,000 and 3 FTE positions from the Arizona Medical Board Fund in FY2016-17 to the MD Board for licensure. Severability clause. Capitol Reports Note: Legislative staff indicate that the threshold of seven state enactments has been surpassed and the Compact therefore becomes effective on the general effective date.

H2503: PSYCHOLOGISTS; LICENSURE COMPACT

Enacts a Psychology Interjurisdictional Compact to regulate the practice of telepsychology, defined as the provision of psychological services using telecommunication technologies, across state boundaries. Establishes conditions of telepsychology practice. Establishes a Psychology Interjurisdictional Compact Commission and establishes Commission powers and duties. Provides for withdrawal from the Compact and amendments to the Compact. An employer is prohibited from requiring a psychologist to seek licensure through the Compact as a condition of initial or continued employment as a psychologist in Arizona. Severability clause.

H2599: AHCCCS; PROVIDER PARTICIPATION; EXCLUSIONS

The AHCCCS Administration is required to "exclude" (defined) from participation in AHCCCS any individual or entity that meets any basis for mandatory exclusion described in federal law. The AHCCCS Administration, in its sole discretion, is permitted to exclude from participation in AHCCCS any individual or entity that has met any basis for permissive exclusion described in federal law or committed a list of prohibited acts. Does not exclude any other basis for exclusion as determined by the AHCCCS Administration. Severability clause.

H2704: BUDGET; BRB; HEALTH; FY2106-17

Makes various policy changes in the area of public health that affect the budget. Monies from the Tobacco Tax and Health Care Fund that are required to be deposited in the Medically Needy Account in an amount of 70 cents of each dollar may be used to provide behavioral health care services to eligible persons, in addition to health care services. Responsibility for services for addictive behavior, including alcohol abuse and drug abuse is transferred to AHCCCS, from the Department of Health Services (DHS), and the Interagency Coordinating Council for those services is repealed. DHS is authorized to use monies in the Interagency Service Agreement for Behavioral Health Services Fund only to pay for Title 19 behavioral health service claims for services provided on or before June 30, 2016, and the Fund is repealed on September 1, 2020. Establishes the Intergovernmental Agreements for County Behavioral Health Services Fund consisting of county monies received by the AHCCCS Administration to provide behavioral health services to person identified through agreements with the counties. Beginning the later of January 1, 2017 or on approval by the Centers for Medicare and Medicaid Services, "340B covered entities" (defined) are required to submit point-of-sale prescription and physician-administered drug claims for members for drugs that are identified in the 340B pricing file, whether or not the drugs are purchased under the 340B drug pricing program, and the claims must include a professional fee of the lesser of

either the "actual acquisition cost" or the "340B ceiling price" (both defined). The AHCCCS Administration or a contractor is required to reimburse claims at the amount submitted plus a professional fee as determined by the AHCCCS Administration unless a contract specified a different professional fee. These requirements do not apply to licensed hospitals and outpatient facilities that are owned or operated by a licensed hospital. By November 1, 2016, the AHCCCS Administration is required to report to the Governor and the Legislature on the technological feasibility and costs of applying those requirements to licensed hospitals and outpatient facilities that are owned or operated by a licensed hospital. Establishes the Delivery System Reform Incentive Payment Fund to pay costs incurred under the section 1115 waiver authority associated with delivery system reform incentive payments and designated state health programs, and requires the AHCCCS Administration to administer the Fund. The list of services that Arizona Long-Term Care System (ALTCS) contractors must provide to members is expanded to include dental services in an annual amount of up to $1,000 per member. Specifies county contributions for ALTCS, and AHCCCS acute care and hospitalization and medical care for FY2016-17. For the contract year beginning October 1, 2015 and ending September 30, 2016, the AHCCCS Administration is authorized to continue the risk contingency rate setting for all managed care organizations and the funding for all managed care organizations administrative funding levels that was imposed for the contract year beginning October 1, 2010. The list of medically necessary health and medical services that AHCCCS contractors are required to provide is modified to require podiatry services to be performed by a licensed podiatrist, instead of excluding podiatry services performed by a licensed podiatrist. Repeals the prohibition on the AHCCCS capitation rate exceeding 1.5 percent in FY2016-17 and FY2017-18, which was contained in the FY2015-16 budget. Counties are required to reimburse DHS for 31 percent of the costs of a commitment of a sexually violent individual for FY2016-17. Municipalities and counties are required to reimburse DHS for 100 percent of the costs of a defendant's inpatient, in custody competency restoration treatment for FY2016-17. Disproportionate share hospitals (DSH) payments for FY2016-17 include $113.8 million for a qualifying nonstarter operated public hospital, $4.2 million of which must be distributed to the Maricopa County Special Health Care District, $28.5 million for the Arizona State Hospital, and $884,800 for private qualifying hospitals. After these DSH payments are made, the allocations of DSH payment must be made available first to qualifying private hospitals located outside of the Phoenix Metropolitan statistical area and the Tucson metropolitan statistical area before being made available to qualifying private hospitals within those areas. Establishes various reporting requirements.

H2705: BUDGET; BRB; HUMAN SERVICES; FY2016-17

Makes various policy changes in the areas of human services that affect the budget. Beginning on or before November 1, 2016, the Department of Economic Security (DES) is required to submit an annual update for review by the Joint Legislative Budget Committee on the Arizona Training Program and associated group homes. Information that must be included in the update is specified. For FY2016-17, DES is authorized to reduce maximum income eligibility levels for child care assistance in order to manage within appropriated and available monies. During FY2016-17, DES is required to screen and test each adult recipient of Temporary Assistance for Needy Families cash assistance who DES has reasonable cause to believe engages in the illegal use of controlled substances, and any recipient who tests positive for the use of a controlled substance that was not prescribed by a licensed health professional is ineligible to receive benefits for one year. Retroactive to July 1, 2015, the Department of Child Safety (DCS) is prohibited from spending in FY2015-16 any federal Temporary Assistance for Needy Families block grant monies in excess of $218.73 million unless either DES or DCS receives a supplemental appropriation of the block grant monies in FY2015-16. The Auditor General is required to provide various reports concerning DCS to the Governor and the Legislature, and deadlines for the reports are specified. DCS is required to review the implementation of foster home licensing rules, hold public meetings to solicit input from foster families on the implementation of foster home licensing rules, identify any modifications required and report its findings in the review to the Legislature by December 31, 2016.

S1169: MENTAL HEALTH POWER OF ATTORNEY

Various changes to statutes relating to mental health care power of attorney. The physician that determines that a person lacks the ability to give informed consent may be a specialist in neurology, in addition to psychiatry or psychology. If a patient admitted to or being treated in an outpatient psychiatric facility under the authority of an agent pursuant to a mental health care power of attorney manifests the desire to disqualify an agent or revoke the power of attorney and requests in writing to be discharged from the facility, the facility is required to either discharge the patient within 48 hours, excluding weekends and legal holidays, or to initiate proceedings for court ordered evaluation or treatment on the following court day. Some exceptions. Except during times when the principal has been found to be incapable, the principal under a mental health care power of attorney may disqualify an agent or revoke all or any portion of the power of attorney.

S1196: SILVER ALERT; ALZHEIMER'S DISEASE

The silver alert notification system may be used to issue and coordinate alerts following the report of a missing person who has Alzheimer's disease or dementia.

S1283: CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM

Beginning the later of October 1, 2017, or 60 days after the statewide health information exchange has integrated the Controlled Substances Prescription Monitoring Program data in the exchange, a medical practitioner, before prescribing an opioid analgesic or benzodiazepine controlled substance listed in schedule II, III or IV for a patient, is required to obtain a patient utilization report regarding the patient for the preceding 12 months from the Program's central database tracking system at the beginning of each new course of treatment and at least quarterly while that prescription remains a part of the treatment. Some exceptions. The State Board of Pharmacy is required to contract with a third party to conduct an analysis of the Program and complete a report on specified information by January 1, 2017. The Board is required to deliver the report to the Governor and the Legislature by January 15, 2017. By October 1, 2016 and every quarter for the following four years, the Board is required to complete a quarterly report on the number and names of electronic health records companies that have integrated or are in the process of integrating the Program's central database, and to post the reports on the Board website.

S1326: BEHAVIORAL HEALTH; DEPENDENT CHILDREN; REPORTING

Retroactive to December 31, 2015 and through December 31, 2018, the AHCCCS Administration is required to prepare and issue a quarterly financial and program accountability trends report to the Governor and the Legislature. Retroactive to December 31, 2015 and through December 31, 2018, the Department of Child Safety is required to issue a quarterly financial and program accountability trend report to the Governor and the Legislature. Information that must be included in the reports is specified.

S1363: INSURANCE COVERAGE; TELEMEDICINE

Health and disability insurance policies or contracts executed or renewed on or after January 1, 2018 are required to provide coverage for health care services for trauma, burn, cardiology, infectious diseases, mental health disorders, neurologic diseases, dermatology and pulmonology that are provided through "telemedicine" (defined as the use of interactive audio, video or other electronic media for diagnosis, consultation or treatment) if the service would be covered were it provided through in-person consultation and if the service is provided to a subscriber receiving the service in Arizona, instead of only in a rural region of Arizona. Does not apply to limited benefit coverage. Effective January 1, 2018.

S1442: MENTAL HEALTH SERVICES; INFO DISCLOSURE

Requirements for a health care provider or entity to disclose confidential health care records are modified to allow the disclosure to relatives/ close personal friends or any other person identified by the patient as otherwise authorized or required by state or federal law. If the patient is present or otherwise available and

has the capacity to make health care decisions, the health care entity is permitted to disclose the information if the patient agrees verbally or in writing, the patient is given an opportunity to object and does not object, or the entity reasonably infers from the circumstances that the patient does not object. If the patient is not present or the opportunity to agree or object to the disclosure cannot practicably be provided, the entity may disclose the information if the entity determines that the disclosure is in the best interests of the patient. Factors a provider or entity must consider in determining whether the release of information is in the best interest of the patient are specified. Information disclosed under these provisions can only include information that is directly relevant to the person's involvement with the patient's health care or payment related to the patient's health care. A health care entity is required to keep a record of the name and contact information of any person to whom any patient information is released.

S1445: HEALTH CARE SERVICES; PATIENT EDUCATION

The state, state agencies, political subdivisions and private entities contracted with a health profession regulatory board are prohibited from "punishing" (defined) a health professional, directly or indirectly, for making a patient aware of or educating or advising a patient about "lawful health care services" (defined) for which there is a reasonable basis including the "off-label use11 (defined) of health care services or health care-related research or data. Unless an entity has a sincerely held religious or moral belief, the entity is prohibited from restricting a health professional who is an employee of or affiliated or contracted with the entity for making a patient aware of or educating or advising a patient about lawful health care services, including the off-label use of health care services or health care-related research or data.

S1457: KIDSCARE ENROLLMENT; EMPOWERMENT SCHOLARSHIPS; DISABILITIES

Total enrollment in the state Children's Health Insurance Program (KidsCare) is no longer limited based on the annual appropriations made by the legislature and an enrollment cap. Within five days after the effective date of this legislation, the AHCCCS Administration is required to submit to the Centers for Medicare and Medicaid Services (CMMS) a state plan amendment for KidsCare to resume enrollment in KidsCare, and to project the enrollment rate for KidsCare for the remainder of federal fiscal years 2015-16 and 2016-17 and request from CMMS any additional allotment needed to resume enrollment. The statutory changes to KidsCare are conditionally enacted on CMMS approving the state's plan amendment to resume enrollment in KidsCare by July 1, 2017, Also, beginning January 1, 2017, the list of authorized expenses for monies in an empowerment scholarship account (ESA) for a qualified student with a disability is expanded to include costs associated with an "annual education plan" (defined) conducted by an independent evaluation team. The Department of Education is required to prescribe minimum qualifications for independent evaluation teams and factors that teams must use to determine whether the qualified student will be eligible to continue to receive ESA monies through the school year in which the student reaches 22 years of age. Establishes the Annual Education Plan Development Council in the Dept. to develop eligibility criteria for a student with a disability to receive ESA monies beyond 18 years of age. The Council is required to report its findings and recommendations to the Superintendent of Public Instruction by December 31, 2016, and self-repeals January 1, 2017.