State of Arizona
Senate
Fifty-fourth Legislature
Second Regular Session
2020

CHAPTER 4

SENATE BILL 1523

AN ACT

AMENDING SECTION 20-157.01, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 5, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1138; AMENDING TITLE 20, ARIZONA REVISED STATUTES, BY ADDING CHAPTER 28; AMENDING TITLE 36, CHAPTER 1, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 7; AMENDING TITLE 36, CHAPTER 34, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 36-3436 AND 36-3436.01; AMENDING SECTION 36-3504, ARIZONA REVISED STATUTES; APPROPRIATING MONIES; RELATING TO MENTAL HEALTH.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 20-157.01, Arizona Revised Statutes, is amended to read:

20-157.01. Confidentiality of insurer files and records; access by director; definition

A. Pursuant to the director's authority under sections 20-156, 20-157, 20-160, ~~and~~ 20-466 AND 20-3502, an insurer shall comply with a request to produce any documents, reports or other materials, whether maintained in written or electronic format, from an insurer's claim file OR AN INSURER'S RECORD THAT IS REQUIRED TO COMPLY WITH CHAPTER 28, ARTICLE 1 OF THIS TITLE.

B. Any documents, reports or other materials that are provided to the director pursuant to this section are confidential and are not subject to disclosure, including discovery or subpoena, unless the subpoena is issued by the attorney general or a county attorney or by a court at the request of the attorney general, a county attorney or any other law enforcement agency. The director may ~~only~~ disclose the information ONLY to a state or federal agency or officer pursuant to a lawful request, subpoena or formal discovery procedure. If the requesting party cannot warrant confidentiality pursuant to section 20-158, subsection I, the information that is provided pursuant to discovery, subpoena or lawful request as provided for in this subsection remains confidential. The director shall make reasonable efforts to notify an insurer of any request for a subpoena for documents, reports or other materials in an ~~insurer~~ INSURER'S claim file or OTHER record that are produced by the insurer pursuant to this section so that the insurer may assert, in a court of competent jurisdiction, any applicable privileges.

C. The director may use the documents, reports or other materials in the furtherance of any regulatory action brought by the director or in actions brought against the director.

D. For the purposes of this section, "insurer claim file" includes medical records, repair estimates, adjuster notes, insurance policy provisions, recordings or transcripts of witness interviews and any other records regarding coverage, settlement, payment or denial OR ADJUSTMENT of a claim asserted under an insurance policy.

Sec. 2. Title 20, chapter 5, article 1, Arizona Revised Statutes, is amended by adding section 20-1138, to read:

20-1138. Health insurance policies; member identification cards; applicability

A. AN IDENTIFICATION CARD THAT INCLUDES INFORMATION FACILITATING A SUBSCRIBER'S, ENROLLEE'S OR INSURED'S ACCESS TO SERVICES OR COVERAGE UNDER AN INDIVIDUAL OR GROUP HEALTH INSURANCE CONTRACT, EVIDENCE OF COVERAGE OR POLICY ISSUED OR RENEWED IN THIS STATE BY A HOSPITAL AND MEDICAL SERVICE CORPORATION, HEALTH CARE SERVICES ORGANIZATION OR DISABILITY INSURER MUST PROMINENTLY DISPLAY THE LETTERS "AZDOI" IN CAPITAL LETTERS ON THE BOTTOM

FRONT OF THE IDENTIFICATION CARD AND A TELEPHONE NUMBER THAT A SUBSCRIBER, ENROLLEE OR INSURED MAY CALL FOR CUSTOMER ASSISTANCE.

B. THIS SECTION APPLIES TO IDENTIFICATION CARDS FOR ANY INDIVIDUAL OR GROUP CONTRACT, EVIDENCE OF COVERAGE OR POLICY ISSUED OR RENEWED FROM AND AFTER DECEMBER 31, 2021.

Sec. 3. Title 20, Arizona Revised Statutes, is amended by adding chapter 28, to read:

CHAPTER 28

MENTAL HEALTH PARITY

ARTICLE 1. GENERAL PROVISIONS

20-3501. Definitions

IN THIS CHAPTER, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "CLASSIFICATION OF BENEFITS" MEANS THE FOLLOWING CLASSIFICATIONS OF BENEFITS PROVIDED BY A HEALTH PLAN:

(a) INPATIENT, IN-NETWORK.

(b) INPATIENT, OUT-OF-NETWORK.

(c) OUTPATIENT, IN-NETWORK.

(d) OUTPATIENT, OUT-OF-NETWORK.

(e) EMERGENCY CARE.

(f) PRESCRIPTION BENEFITS.

2. "HEALTH CARE INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION, HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION THAT ISSUES A HEALTH PLAN IN THIS STATE.

3. "HEALTH PLAN" MEANS AN INDIVIDUAL HEALTH PLAN OR ACCOUNTABLE HEALTH PLAN THAT PROVIDES MENTAL HEALTH SERVICES OR MENTAL HEALTH BENEFITS, THAT FINANCES OR PROVIDES COVERED HEALTH CARE SERVICES, THAT IS ISSUED BY A HEALTH CARE INSURER IN THIS STATE AND THAT IS SUBJECT TO THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT.

4. "MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT" MEANS THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (42 UNITED STATES CODE SECTION 300gg-26) AND IMPLEMENTING REGULATIONS.

5. "PRODUCT NETWORK TYPE" MEANS THE NETWORK MODEL ASSOCIATED WITH THE TYPE OF HEALTH PLAN UNDER WHICH COVERED HEALTH CARE IS DELIVERED, SUCH AS A HEALTH CARE SERVICES ORGANIZATION, PREFERRED PROVIDER NETWORK ORGANIZATION, POINT OF SERVICE PLAN OR INDEMNITY PLAN.

6. "TREATMENT LIMITS":

(a) MEANS LIMITS ON BENEFITS BASED ON THE FREQUENCY OF TREATMENT, NUMBER OF VISITS, DAYS OF COVERAGE, DAYS IN A WAITING PERIOD OR OTHER SIMILAR LIMITS ON THE SCOPE OR DURATION OF TREATMENT.

(b) INCLUDES BOTH QUANTITATIVE TREATMENT LIMITS THAT ARE EXPRESSED NUMERICALLY AND NONQUANTITATIVE TREATMENT LIMITS THAT OTHERWISE LIMIT THE SCOPE OR DURATION OF BENEFITS FOR TREATMENT UNDER A HEALTH PLAN.

(c) DOES NOT INCLUDE A PERMANENT EXCLUSION OF ALL BENEFITS FOR A PARTICULAR CONDITION OR DISORDER.

20-3502. Compliance with federal law; report

A. EACH HEALTH CARE INSURER THAT ISSUES A HEALTH PLAN IN THIS STATE SHALL COMPLY WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT.

B. AFTER JANUARY 1, 2022, ON A DATE SPECIFIED BY THE DIRECTOR, EACH HEALTH CARE INSURER THAT ISSUES A HEALTH PLAN IN THIS STATE SHALL SUBMIT A REPORT TO THE DEPARTMENT FOR EACH FULLY INSURED PRODUCT NETWORK TYPE THE HEALTH CARE INSURER ISSUES. IF THE HEALTH CARE INSURER DETERMINES THAT THE INFORMATION TO BE REPORTED VARIES BY NETWORK OR PLAN, OR VARIES IN THE INDIVIDUAL, SMALL GROUP OR LARGE GROUP MARKET, THE HEALTH CARE INSURER MUST SUBMIT A REPORT FOR EACH VARIATION. EACH REPORT MUST DO THE FOLLOWING:

1. DESCRIBE THE PROCESS THAT IS USED TO DEVELOP OR SELECT THE MEDICAL NECESSITY CRITERIA FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AND THE PROCESS USED TO DEVELOP OR SELECT THE MEDICAL NECESSITY CRITERIA FOR MEDICAL AND SURGICAL BENEFITS.

2. IDENTIFY ALL NONQUANTITATIVE TREATMENT LIMITS THAT ARE APPLIED TO MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS AND ALL NONQUANTITATIVE TREATMENT LIMITS THAT ARE APPLIED TO MEDICAL AND SURGICAL BENEFITS WITHIN EACH CLASSIFICATION OF BENEFITS.

3. DEMONSTRATE THROUGH ANALYSIS THAT FOR ANY NONQUANTITATIVE TREATMENT LIMIT APPLIED TO MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS IN A CLASSIFICATION OF BENEFITS, AS WRITTEN AND IN OPERATION, ANY PROCESS, STRATEGY, EVIDENTIARY STANDARD OR OTHER FACTOR USED IN APPLYING THE NONQUANTITATIVE TREATMENT LIMIT TO MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS IN THE CLASSIFICATION ARE COMPARABLE TO, AND APPLIED NOT MORE STRINGENTLY THAN, ANY PROCESS, STRATEGY, EVIDENTIARY STANDARD OR OTHER FACTOR USED IN APPLYING THE TREATMENT LIMIT FOR MEDICAL AND SURGICAL BENEFITS IN THE CLASSIFICATION.

C. IN ADDITION TO ANALYZING THE REPORTS PRESCRIBED IN SUBSECTION B OF THIS SECTION, THE DEPARTMENT SHALL ALSO EVALUATE HEALTH PLAN COMPLIANCE WITH THE STANDARDS RELATED TO FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITS DESCRIBED IN THIS SECTION. THE DEPARTMENT SHALL PERFORM THIS ANALYSIS DURING ITS REVIEW OF REQUIRED HEALTH CARE INSURER FORM FILINGS, BUT MAY ALSO REQUIRE A HEALTH CARE INSURER TO SUBMIT ADDITIONAL DATA RELATING TO ITS METHODS FOR COMPLYING WITH FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMIT STANDARDS. THE DEPARTMENT MAY COLLECT AND ANALYZE DATA FOR EACH HEALTH CARE INSURER'S LARGE GROUP PLANS THROUGH A SEPARATE, CONSOLIDATED REPORT.

D. THE HEALTH PLAN MAY NOT APPLY ANY FINANCIAL REQUIREMENT OR QUANTITATIVE TREATMENT LIMIT TO MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS IN ANY CLASSIFICATION THAT IS MORE RESTRICTIVE THAN THE PREDOMINANT FINANCIAL REQUIREMENT OR QUANTITATIVE TREATMENT LIMIT OF THAT TYPE APPLIED TO SUBSTANTIALLY ALL MEDICAL AND SURGICAL BENEFITS IN THE

SAME CLASSIFICATION, UNLESS THE REQUIREMENT OR TREATMENT LIMIT IS MODIFIED BY ONE OF THE FOLLOWING EXCEPTIONS:

1. MULTITIERED PRESCRIPTION DRUG BENEFITS. IF A HEALTH PLAN APPLIES DIFFERENT LEVELS OF FINANCIAL REQUIREMENTS TO DIFFERENT TIERS OF PRESCRIPTION DRUG BENEFITS THAT ARE BASED ON REASONABLE FACTORS DETERMINED IN ACCORDANCE WITH THE REQUIREMENTS FOR NONQUANTITATIVE TREATMENT LIMITS AND WITHOUT REGARD TO WHETHER A DRUG IS GENERALLY PRESCRIBED WITH RESPECT TO MEDICAL AND SURGICAL BENEFITS OR WITH RESPECT TO MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS, THE HEALTH PLAN SATISFIES THE PARITY REQUIREMENTS OF THIS SECTION WITH RESPECT TO PRESCRIPTION DRUG BENEFITS. FOR THE PURPOSES OF THIS PARAGRAPH, "REASONABLE FACTORS" INCLUDE COST, EFFICACY, GENERIC VERSUS BRAND NAME AND MAIL ORDER VERSUS PHARMACY PICK UP.

2. MULTIPLE NETWORK TIERS. IF A HEALTH PLAN PROVIDES BENEFITS THROUGH MULTIPLE TIERS OF IN-NETWORK PROVIDERS, INCLUDING AN IN-NETWORK TIER OF PREFERRED PROVIDERS WITH MORE GENEROUS COST SHARING TO PARTICIPANTS THAN A SEPARATE IN-NETWORK TIER OF PARTICIPATING PROVIDERS, THE HEALTH PLAN MAY DIVIDE ITS BENEFITS PROVIDED ON AN IN-NETWORK BASIS INTO SUBCLASSIFICATIONS THAT REFLECT NETWORK TIERS, IF THE TIERING IS BASED ON REASONABLE FACTORS DETERMINED IN ACCORDANCE WITH THE REQUIREMENTS FOR NONQUANTITATIVE TREATMENT LIMITS AND WITHOUT REGARD TO WHETHER A PROVIDER PROVIDES SERVICES WITH RESPECT TO MEDICAL AND SURGICAL BENEFITS OR MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS IN ANY SUBCLASSIFICATION THAT IS MORE RESTRICTIVE THAN THE PREDOMINANT FINANCIAL REQUIREMENT OR TREATMENT LIMIT THAT APPLIES TO SUBSTANTIALLY ALL MEDICAL AND SURGICAL BENEFITS IN THE SUBCLASSIFICATION.

3. SUBCLASSIFICATIONS ALLOWED FOR OFFICE VISITS THAT ARE SEPARATE FROM OTHER OUTPATIENT SERVICES. FOR THE PURPOSES OF APPLYING THE FINANCIAL REQUIREMENTS AND TREATMENT LIMITS PRESCRIBED BY THIS SECTION, A HEALTH PLAN MAY DIVIDE ITS BENEFITS PROVIDED ON AN OUTPATIENT BASIS INTO THE TWO SUBCLASSIFICATIONS DESCRIBED IN THIS PARAGRAPH. AFTER THE SUBCLASSIFICATIONS ARE ESTABLISHED, THE HEALTH PLAN OR HEALTH CARE INSURER MAY NOT IMPOSE ANY FINANCIAL REQUIREMENT OR QUANTITATIVE TREATMENT LIMIT ON MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS IN ANY SUBCLASSIFICATION THAT IS MORE RESTRICTIVE THAN THE PREDOMINANT FINANCIAL REQUIREMENT OR QUANTITATIVE TREATMENT LIMIT THAT APPLIES TO SUBSTANTIALLY ALL MEDICAL AND SURGICAL BENEFITS IN THE SUBCLASSIFICATION. SUBCLASSIFICATIONS FOR GENERALISTS AND SPECIALISTS ARE PROHIBITED. ONLY THE FOLLOWING TWO SUBCLASSIFICATIONS ARE ALLOWED UNDER THIS PARAGRAPH:

(a) OFFICE AND PHYSICIAN VISITS.

(b) ALL OTHER OUTPATIENT ITEMS AND SERVICES, INCLUDING OUTPATIENT SURGERY, FACILITY CHARGES FOR DAY TREATMENT CENTERS, LABORATORY CHARGES OR OTHER SIMILAR MEDICAL ITEMS.

E. A HEALTH INSURER SHALL FILE THE REPORT REQUIRED BY SUBSECTION B OF THIS SECTION ONCE EVERY THREE YEARS. IN YEARS IN WHICH THE REPORT REQUIRED BY SUBSECTION B OF THIS SECTION IS NOT REQUIRED TO BE FILED, THE HEALTH CARE INSURER SHALL FILE A SUMMARY OF CHANGES MADE TO THE MEDICAL NECESSITY CRITERIA AND NONQUANTITATIVE TREATMENT LIMITS AND A WRITTEN ATTESTATION THAT SPECIFIES THAT THE HEALTH CARE INSURER IS IN COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT. THE DEPARTMENT MAY REQUIRE THE HEALTH CARE INSURER TO RESPOND TO ADDITIONAL QUESTIONS THAT ARE RELATED TO THE SUMMARY OF CHANGES OR TO SUPPLY ADDITIONAL DATA TO VERIFY COMPLIANCE. THREE YEARS AFTER THE HEALTH CARE INSURER SUBMITS AN ORIGINAL REPORT REQUIRED BY SUBSECTION B OF THIS SECTION OR AN UPDATED OR REFILED REPORT DESCRIBED IN THIS SUBSECTION, THE HEALTH CARE INSURER MAY EITHER:

1. FILE AN UPDATED REPORT.

2. RESUBMIT THE HEALTH CARE INSURER'S CURRENTLY FILED REPORT IF THE HEALTH CARE INSURER FILES A WRITTEN ATTESTATION TO THE DEPARTMENT THAT SPECIFIES THAT THERE HAVE BEEN NO CHANGES.

F. EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, IF A HEALTH CARE INSURER PROVIDED THE INFORMATION REQUIRED BY THIS SECTION IN AN EXISTING FILING OR REPORT, THE DEPARTMENT MAY NOT REQUIRE THE HEALTH CARE INSURER TO SUBMIT ANY ADDITIONAL FILING OR REPORT. THE DEPARTMENT IS NOT PROHIBITED FROM OTHERWISE REQUESTING INFORMATION OR DATA THAT IS NECESSARY TO VERIFY COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OR THIS CHAPTER. THE DEPARTMENT SHALL ANALYZE THE INFORMATION REQUIRED BY THIS SECTION THAT THE HEALTH CARE INSURER PREVIOUSLY SUBMITTED IN AN EXISTING FILING OR REPORT TO DETERMINE COMPLIANCE WITH THE REPORT REQUIRED BY THIS SECTION. THE DEPARTMENT MAY ESTABLISH BY RULE THE TERMS REGARDING ANY REQUIRED RESUBMITTAL OF INFORMATION.

G. ALL DOCUMENTS, REPORTS OR OTHER MATERIALS PROVIDED TO THE DIRECTOR PURSUANT TO THIS SECTION ARE CONFIDENTIAL AND ARE NOT SUBJECT TO DISCLOSURE. SECTION 20-157.01, SUBSECTION B APPLIES TO THIS SECTION.

20-3503. Enforcement and oversight

A. THE DEPARTMENT SHALL ENFORCE THIS CHAPTER.

B. ON OR BEFORE JANUARY 1, 2021, THE DEPARTMENT SHALL DEVELOP A WEB PAGE THAT PROVIDES THE FOLLOWING INFORMATION IN NONTECHNICAL AND READILY UNDERSTANDABLE LANGUAGE:

1. CONSUMER-FRIENDLY INFORMATION CONCERNING THE SCOPE AND APPLICABILITY OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT AND THE MENTAL HEALTH PARITY REQUIREMENTS THAT APPLY TO HEALTH CARE INSURERS THAT ISSUE HEALTH PLANS IN THIS STATE.

2. A STEP-BY-STEP GUIDE WITH SUPPORTING INFORMATION THAT EXPLAINS HOW CONSUMERS CAN FILE AN APPEAL OR COMPLAINT WITH THE DEPARTMENT CONCERNING AN ALLEGED VIOLATION OF THIS CHAPTER. THE GUIDE MUST ALSO PROMINENTLY DISPLAY A LINK TO THE UNITED STATES DEPARTMENT OF LABOR'S WEBSITE, OR A RELATED WEBSITE, THAT PROVIDES INFORMATION ON APPEALS OR

COMPLAINTS BY CONSUMERS WHO ARE COVERED BY SELF-INSURED PLANS THAT ARE REGULATED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (P.L. 93-406; 88 STAT. 829).

C. ON OR BEFORE JANUARY 1, 2023, THE DEPARTMENT SHALL POST TO THE WEB PAGE PRESCRIBED IN SUBSECTION B OF THIS SECTION AN AGGREGATED SUMMARY OF ITS ANALYSIS OF THE REPORTS FILED BY HEALTH CARE INSURERS PURSUANT TO SECTION 20-3502, SUBSECTION B, INCLUDING ANY CONCLUSIONS REGARDING INDUSTRY COMPLIANCE WITH THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT. THE DEPARTMENT MAY NOT POST ANY INFORMATION THAT:

1. CONTAINS ANY PROPRIETARY OR CONFIDENTIAL INFORMATION OF A HEALTH CARE INSURER.

2. ENABLES A PERSON TO DETERMINE THE IDENTITY OF A HEALTH CARE INSURER.

D. BEGINNING IN 2022, THE DEPARTMENT SHALL INCLUDE IN ITS ANNUAL REPORT A SUMMARY OF ALL STAKEHOLDER OUTREACH AND REGULATORY ACTIVITY RELATED TO THE IMPLEMENTATION, OVERSIGHT AND ENFORCEMENT OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT AND THE REQUIREMENTS OF THIS CHAPTER.

20-3504. Access to behavioral health services for minors

A. NOTWITHSTANDING ANY OTHER PROVISION OF THIS TITLE, ANY HEALTH CARE INSURER THAT ISSUES A HEALTH PLAN IN THIS STATE THAT INCLUDES MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS MAY NOT DENY ANY CLAIM FOR MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS FOR A MINOR SOLELY ON GROUNDS THAT THE MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICE WAS PROVIDED IN A SCHOOL OR OTHER EDUCATIONAL SETTING OR ORDERED BY A COURT IF THE SERVICE WAS PROVIDED BY AN IN-NETWORK PROVIDER OR BY AN OUT-OF-NETWORK PROVIDER ONLY AS ALLOWED BY THE HEALTH PLAN THAT COVERS THE SUBSCRIBER, ENROLLEE OR INSURED.

B. THIS SECTION DOES NOT REQUIRE A HEALTH CARE INSURER TO APPROVE A CLAIM OR PROVIDE REIMBURSEMENT FOR A MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICE PROVIDED BY AN OUT-OF-NETWORK PROVIDER EXCEPT AS ALLOWED BY THE HEALTH PLAN THAT COVERS THE SUBSCRIBER, ENROLLEE OR INSURED.

C. A HEALTH CARE INSURER MAY REQUIRE THAT ANY MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICE OFFERED BY A MENTAL HEALTH PROVIDER IN AN EDUCATIONAL SETTING BE PROVIDED IN A FACILITY OR LOCATION THAT IS APPROPRIATE FOR THE TYPE OF SERVICE PROVIDED AND IN A MANNER THAT COMPLIES WITH APPLICABLE LAWS GOVERNING THE PROVISION OF HEALTH CARE SERVICES, INCLUDING PRIVACY AND PARENTAL CONSENT LAWS.

D. CLAIMS FOR COVERED MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES THAT ARE PROVIDED BY AN OUT-OF-NETWORK PROVIDER AND THAT ARE NOT COVERED BY THE SUBSCRIBER'S, ENROLLEE'S OR INSURED'S HEALTH PLAN SOLELY BECAUSE THE PROVIDER IS AN OUT-OF-NETWORK PROVIDER SHALL BE PAID FROM THE CHILDREN'S BEHAVIORAL HEALTH SERVICES FUND ESTABLISHED BY SECTION 36-3436.

20-3505. Mental health parity advisory committee; members; committee termination

A. THE MENTAL HEALTH PARITY ADVISORY COMMITTEE IS ESTABLISHED TO ADVISE THE DIRECTORS OF THE DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS AND DEPARTMENT OF HEALTH SERVICES RELATING TO MATTERS PERTINENT TO MENTAL HEALTH PARITY, INCLUDING RECOMMENDATIONS RELATED TO CASE MANAGEMENT, DISCHARGE PLANNING AND EXPEDITED REVIEW AND APPEALS PROCESSES FOR CASES INVOLVING SUICIDAL IDEATION. THE DIRECTOR OF THE DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS SHALL APPOINT THE FOLLOWING MEMBERS TO THE COMMITTEE:

1. FOUR MEMBERS WHO REPRESENT HEALTH CARE INSURERS.

2. ONE MEMBER WHO IS A LICENSED BEHAVIORAL HEALTH SERVICES PROVIDER.

3. ONE MEMBER WHO REPRESENTS A BEHAVIORAL HEALTH ADVOCACY ORGANIZATION.

4. AT LEAST THREE MEMBERS OR FAMILY MEMBERS WHO ARE NOT EMPLOYED BY OR CONTRACTED WITH THE STATE AND WHO HAVE BEEN AFFECTED BY SUICIDE, SUBSTANCE USE OR A MENTAL HEALTH DISORDER.

5. AT LEAST ONE MEMBER WHO REPRESENTS A HOSPITAL THAT PROVIDES INPATIENT BEHAVIORAL HEALTH SERVICES.

B. THE DIRECTOR OF THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM MAY SERVE IN AN ADVISORY CAPACITY AT THE REQUEST OF THE DIRECTOR OF THE DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS OR THE DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES.

C. THE COMMITTEE ESTABLISHED BY THIS SECTION ENDS ON JULY 1, 2028 PURSUANT TO SECTION 41-3103.

Sec. 4. Title 36, chapter 1, Arizona Revised Statutes, is amended by adding article 7, to read:

ARTICLE 7. SUICIDE MORTALITY

36-199. Suicide mortality review team; members; duties; review team termination

A. THE SUICIDE MORTALITY REVIEW TEAM IS ESTABLISHED IN THE DEPARTMENT OF HEALTH SERVICES. THE HEAD OF EACH OF THE FOLLOWING ENTITIES OR THAT PERSON'S DESIGNEE SHALL SERVE ON THE REVIEW TEAM:

1. THE DEPARTMENT OF HEALTH SERVICES.

2. THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

3. THE DEPARTMENT OF ECONOMIC SECURITY.

4. THE GOVERNOR'S OFFICE OF YOUTH, FAITH AND FAMILY.

5. THE DEPARTMENT OF EDUCATION.

6. THE ARIZONA COUNCIL OF HUMAN SERVICES PROVIDERS.

7. THE DEPARTMENT OF PUBLIC SAFETY.

B. THE DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES SHALL APPOINT THE FOLLOWING MEMBERS TO SERVE ON THE REVIEW TEAM:

1. A MEDICAL EXAMINER WHO IS A RURAL FORENSIC PATHOLOGIST.

2. A MEDICAL EXAMINER WHO IS A METROPOLITAN FORENSIC PATHOLOGIST.

3. A REPRESENTATIVE OF A TRIBAL GOVERNMENT.
4. A REPRESENTATIVE OF A HEALTH CARE INSURER.
5. A PUBLIC MEMBER.
6. A REPRESENTATIVE OF AN EMERGENCY MANAGEMENT SYSTEM PROVIDER.
7. A HEALTH CARE PROFESSIONAL FROM A STATEWIDE ASSOCIATION REPRESENTING PEDIATRICIANS.
8. A HEALTH CARE PROFESSIONAL FROM A STATEWIDE ASSOCIATION REPRESENTING PHYSICIANS.
9. A HEALTH CARE PROFESSIONAL FROM A STATEWIDE ASSOCIATION REPRESENTING NURSES.
10. A REPRESENTATIVE OF AN ASSOCIATION OF COUNTY HEALTH OFFICERS.
11. A REPRESENTATIVE OF AN ASSOCIATION REPRESENTING HOSPITALS.
12. A PROFESSIONAL WHO SPECIALIZES IN THE PREVENTION, DIAGNOSIS AND TREATMENT OF BEHAVIORAL HEALTH PROBLEMS.
13. A COUNTY SHERIFF, OR THE SHERIFF'S DESIGNEE, WHO REPRESENTS A COUNTY WITH A POPULATION OF LESS THAN FIVE HUNDRED THOUSAND PERSONS AND A COUNTY SHERIFF, OR THE SHERIFF'S DESIGNEE, WHO REPRESENTS A COUNTY WITH A POPULATION OF AT LEAST FIVE HUNDRED THOUSAND PERSONS.
14. A REPRESENTATIVE OF A VETERANS ORGANIZATION OR MILITARY FAMILY ADVOCACY PROGRAM.
15. A REPRESENTATIVE OF A STATEWIDE ASSOCIATION REPRESENTING AREA AGENCIES ON AGING.
16. A REPRESENTATIVE OF A NONPROFIT COMMUNITY-BASED ORGANIZATION PROVIDING SUICIDE PREVENTION SERVICES.
17. A REPRESENTATIVE OF A RURAL HEALTH ORGANIZATION.

C. THE REVIEW TEAM SHALL:

1. DEVELOP A SUICIDE MORTALITIES DATA COLLECTION SYSTEM.
2. CONDUCT AN ANNUAL ANALYSIS ON THE INCIDENCES AND CAUSES OF SUICIDES IN THIS STATE DURING THE PRECEDING FISCAL YEAR.
3. ENCOURAGE AND ASSIST IN THE DEVELOPMENT OF LOCAL SUICIDE MORTALITY REVIEW TEAMS.
4. DEVELOP STANDARDS AND PROTOCOLS FOR LOCAL SUICIDE MORTALITY REVIEW TEAMS AND PROVIDE TRAINING AND TECHNICAL ASSISTANCE TO THESE TEAMS.
5. DEVELOP PROTOCOLS FOR SUICIDE INVESTIGATIONS, INCLUDING PROTOCOLS FOR LAW ENFORCEMENT AGENCIES, PROSECUTORS, MEDICAL EXAMINERS, HEALTH CARE FACILITIES AND SOCIAL SERVICE AGENCIES.
6. STUDY THE ADEQUACY OF STATUTES, ORDINANCES, RULES, TRAINING AND SERVICES TO DETERMINE WHAT CHANGES ARE NEEDED TO DECREASE THE INCIDENCE OF PREVENTABLE SUICIDES AND, AS APPROPRIATE, TAKE STEPS TO IMPLEMENT THESE CHANGES.
7. EDUCATE THE PUBLIC REGARDING THE INCIDENCES AND CAUSES OF SUICIDE AS WELL AS THE PUBLIC'S ROLE IN PREVENTING THESE DEATHS.
8. DESIGNATE A MEMBER OF THE REVIEW TEAM TO SERVE AS CHAIRPERSON.

D. REVIEW TEAM MEMBERS ARE NOT ELIGIBLE TO RECEIVE COMPENSATION, BUT MEMBERS APPOINTED PURSUANT TO SUBSECTION B OF THIS SECTION ARE

ELIGIBLE FOR REIMBURSEMENT OF EXPENSES PURSUANT TO TITLE 38, CHAPTER 4, ARTICLE 2.

E. THE DEPARTMENT OF HEALTH SERVICES SHALL PROVIDE PROFESSIONAL AND ADMINISTRATIVE SUPPORT TO THE TEAM.

F. THE REVIEW TEAM ESTABLISHED BY THIS SECTION ENDS ON JULY 1, 2028 PURSUANT TO SECTION 41-3103.

36-199.01. Access to information; confidentiality; violation; classification

A. ON REQUEST OF THE CHAIRPERSON OF THE SUICIDE MORTALITY REVIEW TEAM OR A LOCAL TEAM AND AS NECESSARY TO CARRY OUT THE TEAM'S DUTIES, THE CHAIRPERSON SHALL BE PROVIDED, WITHIN FIVE DAYS EXCLUDING WEEKENDS AND HOLIDAYS, WITH ACCESS TO INFORMATION AND RECORDS REGARDING A SUICIDE THAT IS BEING REVIEWED BY THE TEAM. THE TEAM MAY REQUEST THE INFORMATION AND RECORDS FROM ANY OF THE FOLLOWING:

1. A PROVIDER OF MEDICAL, DENTAL, NURSING OR MENTAL HEALTH CARE.

2. A HEALTH CARE INSURER.

3. THIS STATE OR A POLITICAL SUBDIVISION OF THIS STATE THAT MIGHT ASSIST THE TEAM IN REVIEWING THE FATALITY.

B. A LAW ENFORCEMENT AGENCY, WITH THE APPROVAL OF THE PROSECUTING ATTORNEY, MAY WITHHOLD FROM A REVIEW TEAM INVESTIGATIVE RECORDS THAT MIGHT INTERFERE WITH A PENDING CRIMINAL INVESTIGATION OR PROSECUTION.

C. THE DIRECTOR OF THE DEPARTMENT OF HEALTH SERVICES OR THE DIRECTOR'S DESIGNEE MAY APPLY TO THE SUPERIOR COURT FOR A SUBPOENA AS NECESSARY TO COMPEL THE PRODUCTION OF BOOKS, RECORDS, DOCUMENTS AND OTHER EVIDENCE RELATED TO THE PERSON WHO DIED BY SUICIDE. SUBPOENAS ISSUED UNDER THIS SUBSECTION SHALL BE SERVED AND, ON APPLICATION TO THE COURT BY THE DIRECTOR OR THE DIRECTOR'S DESIGNEE, ENFORCED IN THE MANNER PROVIDED BY LAW FOR THE SERVICE AND ENFORCEMENT OF SUBPOENAS. A LAW ENFORCEMENT AGENCY IS NOT REQUIRED TO PRODUCE THE INFORMATION REQUESTED UNDER THE SUBPOENA IF THE SUBPOENAED EVIDENCE RELATES TO A PENDING CRIMINAL INVESTIGATION OR PROSECUTION. ALL RECORDS SHALL BE RETURNED TO THE AGENCY OR ORGANIZATION ON COMPLETING THE REVIEW. THE REVIEW TEAM MAY NOT KEEP WRITTEN REPORTS OR RECORDS CONTAINING IDENTIFYING INFORMATION.

D. ALL INFORMATION AND RECORDS ACQUIRED BY THE SUICIDE MORTALITY REVIEW TEAM OR ANY LOCAL TEAM ARE CONFIDENTIAL AND ARE NOT SUBJECT TO SUBPOENA, DISCOVERY OR INTRODUCTION INTO EVIDENCE IN ANY CIVIL OR CRIMINAL PROCEEDING, EXCEPT THAT INFORMATION, DOCUMENTS AND RECORDS THAT ARE OTHERWISE AVAILABLE FROM OTHER SOURCES ARE NOT IMMUNE FROM SUBPOENA, DISCOVERY OR INTRODUCTION INTO EVIDENCE THROUGH THOSE SOURCES SOLELY BECAUSE THEY WERE PRESENTED TO OR REVIEWED BY A TEAM PURSUANT TO THIS ARTICLE.

E. MEMBERS OF A TEAM, PERSONS ATTENDING A TEAM MEETING AND PERSONS WHO PRESENT INFORMATION TO A TEAM MAY NOT BE QUESTIONED IN ANY CIVIL OR CRIMINAL PROCEEDING REGARDING INFORMATION PRESENTED IN OR OPINIONS FORMED AS A RESULT OF A MEETING. THIS SUBSECTION DOES NOT PREVENT A PERSON FROM

TESTIFYING TO INFORMATION THAT IS OBTAINED INDEPENDENTLY OF THE TEAM OR THAT IS PUBLIC INFORMATION.

F. PURSUANT TO POLICIES ADOPTED BY THE SUICIDE MORTALITY REVIEW TEAM, A MEMBER OF THE SUICIDE MORTALITY REVIEW TEAM OR A LOCAL TEAM MAY CONTACT, INTERVIEW OR OBTAIN INFORMATION BY REQUEST OR SUBPOENA FROM A FAMILY MEMBER OF A DECEASED PERSON WHO DIED BY SUICIDE. THE SUICIDE MORTALITY REVIEW TEAM OR A LOCAL TEAM MUST APPROVE ANY CONTACT, INTERVIEW, REQUEST OR SUBPOENA BEFORE THE TEAM MEMBER CONTACTS, INTERVIEWS OR OBTAINS INFORMATION FROM THE FAMILY MEMBER OF A DECEASED PERSON WHO DIED BY SUICIDE.

G. MEETINGS OF THE SUICIDE MORTALITY REVIEW TEAM OR A LOCAL TEAM ARE CLOSED TO THE PUBLIC AND ARE NOT SUBJECT TO TITLE 38, CHAPTER 3, ARTICLE 3.1 IF THE TEAM IS REVIEWING INFORMATION ON AN INDIVIDUAL WHO DIED BY SUICIDE. ALL OTHER TEAM MEETINGS ARE OPEN TO THE PUBLIC.

H. A PERSON WHO VIOLATES THE CONFIDENTIALITY REQUIREMENTS OF THIS SECTION IS GUILTY OF A CLASS 2 MISDEMEANOR.

Sec. 5. Title 36, chapter 34, article 3, Arizona Revised Statutes, is amended by adding sections 36-3436 and 36-3436.01, to read:

36-3436. Children's behavioral health services fund; exemption; use of monies

A. THE CHILDREN'S BEHAVIORAL HEALTH SERVICES FUND IS ESTABLISHED CONSISTING OF MONIES APPROPRIATED TO THE FUND, ANY GIFTS OR DONATIONS TO THE FUND AND INTEREST EARNED ON THOSE MONIES. THE DIRECTOR SHALL ADMINISTER THE FUND.

B. MONIES IN THE FUND:

1. ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190 RELATING TO LAPSING OF APPROPRIATIONS.

2. ARE CONTINUOUSLY APPROPRIATED.

C. THE ADMINISTRATION SHALL ENTER INTO AN AGREEMENT WITH ONE OR MORE CONTRACTORS FOR CHILDREN'S BEHAVIORAL HEALTH SERVICES USING MONIES FROM THE CHILDREN'S BEHAVIORAL HEALTH SERVICES FUND TO PAY FOR BEHAVIORAL HEALTH SERVICES FOR CHILDREN. TO BE ELIGIBLE TO RECEIVE BEHAVIORAL HEALTH SERVICES PAID BY THE FUND, AN INDIVIDUAL MUST MEET ALL OF THE FOLLOWING CONDITIONS:

1. MEET THE LEGAL AGE REQUIREMENTS FOR SCHOOL ADMISSION UNDER TITLE 15 AT THE TIME THE INDIVIDUAL WAS ADMITTED AND BE ENROLLED IN SCHOOL.

2. BE UNINSURED OR UNDERINSURED.

3. BE REFERRED FOR BEHAVIORAL HEALTH SERVICES BY AN EDUCATIONAL INSTITUTION.

4. HAVE WRITTEN PARENTAL CONSENT TO OBTAIN THE BEHAVIORAL HEALTH SERVICES.

5. RECEIVE THE BEHAVIORAL HEALTH SERVICES BY A CONTRACTED LICENSED BEHAVIORAL HEALTH PROVIDER.

6. RECEIVE THE BEHAVIORAL HEALTH SERVICES ON OR OFF SCHOOL GROUNDS.

D. IN ADDITION TO TERMS AND CONDITIONS THE DIRECTOR DEEMS APPROPRIATE, THE AGREEMENT BETWEEN THE ADMINISTRATION AND EACH CONTRACTOR SHALL REQUIRE THAT:

1. THE MONIES ALLOCATED IN THE AGREEMENT NOT BE USED FOR PERSONS WHO ARE ELIGIBLE UNDER TITLE XIX OR TITLE XXI OF THE SOCIAL SECURITY ACT. PREFERENCE SHALL BE GIVEN TO PERSONS WITH LOWER HOUSEHOLD INCOMES.

2. THE CONTRACTOR COORDINATE BENEFITS PROVIDED UNDER THIS SECTION WITH ANY THIRD PARTIES THAT ARE LEGALLY RESPONSIBLE FOR THE COST OF SERVICES.

3. THE CONTRACTOR MAKE PAYMENTS TO PROVIDERS BASED ON CONTRACTS WITH PROVIDERS OR, IN THE ABSENCE OF A CONTRACT, AT THE CAPPED FEE SCHEDULE ESTABLISHED BY THE ADMINISTRATION.

4. THE CONTRACTOR SUBMIT EXPENDITURE REPORTS MONTHLY IN A FORMAT DETERMINED BY THE DIRECTOR FOR REIMBURSEMENT OF SERVICES PROVIDED UNDER THE AGREEMENT. THE AGREEMENT MAY ALSO PROVIDE FOR ADDITIONAL REIMBURSEMENT FOR ADMINISTERING THE AGREEMENT IN AN AMOUNT NOT TO EXCEED EIGHT PERCENT OF THE EXPENDITURES FOR SERVICES.

5. THE ADMINISTRATION NOT BE HELD FINANCIALLY RESPONSIBLE TO THE CONTRACTOR FOR ANY COSTS INCURRED BY THE CONTRACTOR IN EXCESS OF THE MONIES ALLOCATED IN THE AGREEMENT.

E. THE ADMINISTRATION MAY IMPOSE COST SHARING REQUIREMENTS ON A SLIDING FEE SCALE FOR BEHAVIORAL HEALTH SERVICES PROVIDED BY CONTRACTORS.

F. THE ADMINISTRATION SHALL ACT AS PAYOR OF LAST RESORT FOR PERSONS WHO ARE ELIGIBLE PURSUANT TO THIS SECTION. ON RECEIPT OF SERVICES UNDER THIS SECTION, A PERSON IS DEEMED TO HAVE ASSIGNED TO THE ADMINISTRATION ALL RIGHTS TO ANY TYPE OF MEDICAL BENEFIT TO WHICH THE PERSON IS ENTITLED.

G. THIS SECTION DOES NOT ESTABLISH:

1. AN ENTITLEMENT FOR ANY PERSON TO RECEIVE ANY PARTICULAR SERVICE.

2. A DUTY ON THE ADMINISTRATION TO PROVIDE SERVICES OR SPEND MONIES IN EXCESS OF THE MONIES IN THE FUND.

36-3436.01. School-based behavioral health services; referrals; requirements; annual report

A. BEFORE A SCHOOL PROVIDES SCHOOL-BASED REFERRALS FOR BEHAVIORAL HEALTH SERVICES TO A CONTRACTED BEHAVIORAL HEALTH SERVICES PROVIDER EITHER PURSUANT TO THE CHILDREN'S BEHAVIORAL HEALTH SERVICES FUND ESTABLISHED BY SECTION 36-3436 OR FOR SERVICES PROVIDED THROUGH THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM, THE SCHOOL DISTRICT GOVERNING BOARD OR CHARTER SCHOOL GOVERNING BODY SHALL ADOPT POLICIES RELATING TO SCHOOL-BASED REFERRALS. THESE POLICIES SHALL BE VETTED AT A PUBLIC MEETING IN WHICH THE SCHOOL DISTRICT GOVERNING BOARD OR CHARTER SCHOOL GOVERNING BODY CONSIDERS ANY COMMENTS SUBMITTED BY THE PUBLIC BEFORE THE GOVERNING BOARD OR GOVERNING BODY ADOPTS THE POLICIES. THE SCHOOL DISTRICT GOVERNING BOARD OR CHARTER SCHOOL GOVERNING BODY SHALL POST THE POLICES ADOPTED PURSUANT TO THIS SECTION ON EACH APPLICABLE SCHOOL WEBSITE. THE POLICIES SHALL INCLUDE THE FOLLOWING:

1. A PROCESS TO ALLOW A PARENT TO ANNUALLY OPT INTO THE SCHOOL-BASED REFERRALS.

2. A PROCESS TO CONDUCT A SURVEY OF PARENTS WHOSE CHILDREN WERE REFERRED TO AND RECEIVED BEHAVIORAL HEALTH SERVICES PURSUANT TO THIS SECTION. THE SURVEY MAY BE COMPLETED ONLINE. THE SURVEY SHALL INCLUDE AT LEAST THE FOLLOWING:

(a) WHETHER THE PARENT OPTED INTO THE PROGRAM.

(b) WHETHER THE PARENT WAS NOTIFIED BEFORE THE REFERRAL TOOK PLACE.

(c) WHETHER THE BEHAVIORAL HEALTH SERVICES REFERRED WERE APPROPRIATE TO MEET THE STUDENT'S NEED.

(d) WHETHER THE PARENT IS SATISFIED WITH THE CHOICE OF BEHAVIORAL HEALTH SERVICES PROVIDERS.

(e) WHETHER THE PARENT INTENDS TO OPT INTO A PROGRAM AGAIN IN THE FOLLOWING SCHOOL YEAR.

3. A REQUIREMENT THAT EACH SCHOOL'S WEBSITE CONTAIN A LIST OF BEHAVIORAL HEALTH SERVICES PROVIDERS WITH WHOM THE SCHOOL CONTRACTS.

B. AT THE END OF EACH SCHOOL YEAR, EACH PARTICIPATING SCHOOL DISTRICT AND CHARTER SCHOOL SHALL REPORT TO THE ADMINISTRATION THE SCHOOL SURVEY RESULTS.

C. THE ADMINISTRATION SHALL COMPILE A REPORT BASED ON THE SURVEYS RECEIVED FROM PARTICIPATING SCHOOL DISTRICTS AND CHARTER SCHOOLS AS WELL AS UTILIZATION DATA FOR BEHAVIORAL HEALTH SERVICES RECEIVED PURSUANT TO THE CHILDREN'S BEHAVIORAL HEALTH SERVICES FUND ESTABLISHED BY SECTION 36-3436. ON OR BEFORE DECEMBER 31 EACH YEAR, THE ADMINISTRATION SHALL PROVIDE THE REPORT TO THE GOVERNOR, THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND PROVIDE A COPY OF THE REPORT TO THE SECRETARY OF STATE. THE REPORT SHALL INCLUDE AT LEAST ALL OF THE FOLLOWING INFORMATION:

1. THE NUMBER OF STUDENTS SERVED.

2. THE TYPES OF BEHAVIORAL HEALTH SERVICES PROVIDED.

3. THE COSTS OF THE BEHAVIOR HEALTH SERVICES PROVIDED.

Sec. 6. Section 36-3504, Arizona Revised Statutes, is amended to read:

36-3504. Child fatality review fund

A. The child fatality review fund is established consisting of appropriations, monies received pursuant to section ~~36-342~~ 36-341, subsection E and gifts, grants and donations made to the department of health services to implement subsection B of this section. The department of health services shall administer the fund. The department shall deposit, pursuant to sections 35-146 and 35-147, all monies it receives in the fund.

B. The department of health services shall use fund monies to staff the state child fatality review team AND THE SUICIDE MORTALITY REVIEW TEAM and to train and support local child fatality review teams AND SUICIDE MORTALITY REVIEW TEAMS.

C. Monies spent for the purposes specified in subsection B of this section are subject to legislative appropriation. Any fee revenue collected in excess of ~~one hundred thousand dollars~~ $200,000 in any fiscal year is appropriated from the child fatality review fund to the child abuse prevention fund established pursuant to section 8-550.01, subsection A, to be used for healthy start programs.

Sec. 7. Arizona health care cost containment system; behavioral health survey of schools; report; delayed repeal

A. The Arizona health care cost containment system shall conduct a survey of public schools to obtain information regarding the referral of behavioral health services to students by contracted licensed behavioral health providers. The survey shall include all of the following:

1. The types of behavioral health providers providing the services.

2. The types of settings where behavioral health services were delivered to students.

3. The number of students who received services.

4. The most common diagnoses that resulted in the need for services.

B. On or before December 31, 2022, the Arizona health care cost containment system shall provide a copy of the result of the survey to the governor, the president of the senate and the speaker of the house of representatives and provide a copy of the report to the secretary of state.

C. This section is repealed from and after June 30, 2023.

Sec. 8. Rulemaking; department of insurance and financial institutions

A. On or before April 1, 2021, the department of insurance and financial institutions shall adopt by rule both of the following:

1. Forms or worksheets that health care insurers must use to prepare the reports required by section 20-3502, Arizona Revised Statutes, as added by this act.

2. Standards to determine compliance with the mental health parity and addiction equity act.

B. The department of insurance and financial institutions may also allow health care insurers to demonstrate compliance with subsection A of this section and section 20-3502, Arizona Revised Statutes, as added by this act, by other means that are at least as comprehensive as the forms or worksheets required by subsection A, paragraph 1 of this section.

C. In developing the forms, worksheets or other means that health care insurers must use to prepare the reports required by section 20-3502, Arizona Revised Statutes, as added by this act, the department of insurance and financial institutions shall:

1. Conduct workshops and listening sessions to seek and obtain input from stakeholders, including health care insurers, behavioral health providers, advocacy organizations and individuals who have been impacted by mental health or substance use disorders.

2. Review the United States department of labor's self-compliance tool for the mental health parity and addiction equity act and other reasonable and applicable resources.

Sec. 9. Rulemaking; department of health services

A. The department of health services shall adopt rules relating to admitting and discharging patients who have attempted suicide or exhibit suicidal ideation from inpatient care at a health care institution. The rules shall include protocols based on best practices for requiring health care institutions to implement discharge protocols and provide information to patients and caregivers on a continuum during the stay, including at admission and before and at discharge.

B. The rules shall address the following topics:

1. The availability and contact information of age appropriate crisis services.

2. Information and referrals to the next appropriate level of treatment and care after discharge, including scheduling treatment when practicable.

3. Information on the department of insurance and financial institution's website relating to how to challenge an adverse decision by a health care insurer or health plan.

4. Conducting a suicide assessment before discharging a patient and informing the patient and caregivers of the results.

C. Notwithstanding any other law, for the purposes of this section, the department of health services is exempt from the rulemaking requirements of title 41, chapter 6, Arizona Revised Statutes, for eighteen months after the effective date of this section, except that the department shall provide public notice and an opportunity for public comment on proposed rules at least sixty days before the rules are amended or adopted.

Sec. 10. Appropriation; department of insurance and financial institutions; exemption

A. The sum of $250,000 and one FTE position are appropriated from the state general fund in fiscal year 2020-2021 to the department of insurance and financial institutions to administer title 20, chapter 28, Arizona Revised Statutes, as added by this act.

B. The appropriation made in subsection A of this section is exempt from the provisions of section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations.

Sec. 11. Appropriation; children's behavioral health services fund; exemption

A. The sum of $8,000,000 is appropriated from the state general fund in fiscal year 2020-2021 to the children's behavioral health services fund established by section 36-3436, Arizona Revised Statutes, as added by this act, to pay contractors for services as prescribed in section 36-3436, Arizona Revised Statutes, as added by this act.

B. The appropriation made in subsection A of this section is exempt from the provisions of section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations until June 30, 2022.

Sec. 12. Short title

This act may be cited as "Jake's Law".

APPROVED BY THE GOVERNOR MARCH 3, 2020.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MARCH 3, 2020.