Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

State of Arkansas *As Engrossed: S3/15/07*
86th General Assembly **A Bill**
Regular Session, 2007 SENATE BILL 944

By: Senators Womack, Critcher, Crumbly, Horn, Wilkins, Altes
By: Representatives R. Green, Key, Lamoureux, Ragland, Cooper, Davis

For An Act To Be Entitled

AN ACT TO PROVIDE FOR THE QUALIFICATIONS AND REIMBURSEMENT OF PROVIDERS OF MENTAL HEALTH CARE ASSISTANCE TO INDIGENT PERSONS; TO ESTABLISH CRITERIA FOR THE ADMISSION OF INDIGENT PERSONS TO MENTAL HEALTH CARE PROGRAMS; TO ENSURE NONDISCRIMINATION AND CHOICE; AND FOR OTHER PURPOSES.

Subtitle

TO PROVIDE FOR THE QUALIFICATIONS AND REIMBURSEMENT OF PROVIDERS OF MENTAL HEALTH CARE ASSISTANCE TO INDIGENT PERSONS AND TO ESTABLISH CRITERIA FOR THE ADMISSION OF INDIGENT PERSONS TO MENTAL HEALTH CARE PROGRAMS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 77 is amended to add an additional subchapter to read as follows:

20-77-1801. Legislative findings and intent.

(a) The General Assembly finds that:

(1) Health care providers who serve Medicaid recipients are an indispensable and vital link in serving this state's needy citizens; and

(2) The Department of Health and Human Services already has made great progress in making behavioral health care services more accessible to

this state's citizens who need such services.

(b) The General Assembly intends this subchapter to ensure that the department preserves its gains in the accessibility of cost-effective and high quality behavioral health care services through open competition among providers, freely-exercised consumer choice, and nationally-recognized quality standards for service providers.

20-77-1802. Definitions.

(a) As used in this subchapter:

(1) "Consumer" means an individual who is authorized to consent to treatment and to select a service provider for an eligible recipient;

(2) Consumer entity" means the local school district that arranges for the provision of mental health services for its students or its enrollees by contractual or other arrangement with a qualified program providers;

(3) "Department" means the Department of Health and Human Services;

(4) "Director" means the Director of the Department of Health and Human Services;

(5)(A) "Funding source" means funding for mental health services in an inpatient or an outpatient setting from whatever source derived, including state funds, federal funds, or Medicaid funds.

(B) "Funding source" does not include:

(i) State assistance to a community mental health center;

(ii) A mental health block grant fund that is mandated by federal statute or regulation to be used only for a community mental health center; or

(iii) Acute mental health services per capita funds;

(6) "Government entity" means the State and any agency thereof, a county, a city, any special purpose district, and a school district or local education cooperative; and

(7) "Program provider" means any individual, partnership, corporation, or other entity that:

(A) Provides psychiatric residential treatment services for children or outpatient mental health services for adults or children; and

(B) Is funded in whole or in part by a medical care program for indigents;

(8) "Qualified program provider" means a program provider that is willing and able to meet the terms and conditions for participation in the operation of a medical care program for indigents as established by federal or state law or federal or state regulation;

(9) "Qualified psychiatric residential treatment services provider" means a qualified program provider who provides psychiatric residential treatment services;

(10) "Qualified outpatient mental health provider" means a qualified program provider who provides outpatient mental health services;

(11)(A) "Single point of entry" means any entity, agency, group of individuals, or network that has the intent to act or the effect of acting as the gatekeeper for:

(i) Accessing or coordinating behavioral health services; or

(ii) Influencing the consumer's selection of a qualified program provider,

(B) "Single point of entry" does not include the federally-mandated utilization review process; and

(12) "Agency" means any state, county, or local governmental entity.

20-77-1803. Consumer choice – Nondiscrimination.

(a)(1) Subject only to the minimum federal requirements for utilization review to determine the medical necessity of services, consumers and consumer entities have the right to select the qualified program provider of their choice free from the coercion or influence of any government entity.

(2) No person or agency may issue a policy or promulgate a regulation that has the intent or the effect of:

(A) Limiting , restricting, or influencing the right of a consumer to select a qualified program provider; or

(B) Creating a single point of entry.

(b) No person or agency involved in the operation of a program of indigent medical care for mental health services may engage in any of the following discriminatory practices:

(1) Distributing a funding source to an individual program provider or to an identifiable class of program providers in a manner that favors or disfavors any program provider or identifiable class of program providers;

(2) Promulgating any regulation which has the effect of favoring or disfavoring any particular program provider or identifiable class of program providers;

(3) Distributing a funding source in a manner that enables or allows a government entity to compete with a privately-owned qualified program provider unless mandated by federal law or federal regulation;

(4) Requiring a consumer or a consumer entity to access services through a single point of entry other than the minimum federally-mandated requirements established for utilization review to establish medical necessity; or

(5) Requiring a qualified program provider to be a member of any network as a condition of participation in a program for medical care for indigents.

(c) A qualified program provider shall have access to all funding sources on a fee-for-service basis unless otherwise mandated by federal law or federal regulation.

20-77-1804. Program provider reimbursement.

(a) Reimbursement under a program of indigent medical care for mental health services shall only be made to outpatient program providers that have been operating and accredited for one year by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, *or* the Council on Accreditation except for:

(1) Medical doctors or psychologists; and

(2) Providers who have:

(A) Initiated the certification process before the effective date of this act; and

(B) Received full accreditation by July 1, 2008.

(b) A program provider who provides services in reliance on a prior authorization or a continuing care authorization is entitled to payment for its services.

20-77-1805. Treatment decisions.

Unless limited by federal regulation or federal law and subject to medical necessity, a program provider physician or a program provider treatment team member has the right to make all treatment decisions, including the level of intensity, frequency, and type of treatment interventions, that he or she deems to be in the best interest of the patient.

20-77-1806. Qualification for treatment in a psychiatric residential treatment facility.

(a) As used in this section, "medical necessity" means:

(1) The patient experiences significant impairment in psychological, emotional, or behavioral functioning that causes distress or disruption for the individual, family, educational personnel or immediate others;

(2) A condition that warrants an Axis I diagnosis from the Diagnostic and Statistical Manual of Mental Illness, as it existed on January 1, 2007, and

(3) A condition that has not been or cannot be ameliorated with less restrictive interventions."

(b) Prior authorization for admission into an in-state qualified psychiatric residential treatment services provider shall require:

(1) A finding that medical necessity criteria are met; and

(2)(A) That the child should have been engaged in at least one (1) month of outpatient counseling with a therapist who provided a written or verbal assurance to the admitting facility that his or her client needed residential treatment; or

(B) A finding that the child will be endangered in the absence of residential treatment admission.

(c) Continuing care authorization in an in-state qualified psychiatric residential treatment services provider shall require:

(1) A finding that services are medically necessary and

(2)(A) That the child's current level of functioning will continue to disrupt normal activities of daily living for the individual, family, educational personnel, or immediate others; or

(B) The patient will regress in a less restrictive

setting.

(d) A participant in the Medicaid program is entitled to receive services from any willing in-state provider who is approved to participate in the program of indigent medical care for mental health services.

(e) A child who meets the definition of medical necessity shall not be denied prior or continuing care authorization if there is:

(1) Drug or alcohol use or abuse that is:

(A) Secondary to a psychological or emotional impairment; or

(B) A form of self-medication used to alleviate psychological distress;

(2) Evidence of developmental delay that contributes to symptoms of an Axis I psychiatric condition;

(3) A legal involvement which appears to be symptomatic of an Axis I psychiatric condition;

(4) A lack of parenting skills or functional abilities that interfere with lesser restrictive therapeutic improvements;

(5) A lack of current outpatient counseling attributable to the existence of barriers that prevent the juvenile from attending or progressing at an outpatient level of care; or

(6) A lack of a therapist referral attributable to the refusal of the therapist to cooperate or to provide a referral.

(f) If a juvenile is ordered by a court to receive psychiatric residential treatment, a program provider may make a request for prior and continuing care authorization for treatment in the following manner:

(1) The request for prior and continuing care authorization shall be reviewed within five (5) days after its submission and shall be granted if the criteria for a medical necessity are met, pending a determination of the eligibility of the recipient for the indigent care program; and

(2) If the applicant is found to be eligible for the indigent care program, payment for services shall be authorized from the date of preauthorization except no payment for services shall be made in the event the resident is found ineligible for participation in the indigent care program; and

(3) The provider who requests the authorization for a patient

who is not yet determined to be eligible for the indigent care program shall repay Medicaid the rate contracted with the utilization review provider for the prior authorization review if:

(A) Treatment is determined not medically necessary; or

(B) The patient is determined ineligible to participate in the indigent care program.

(g) The department shall maintain records which indicate the number of patients placed for treatment in a psychiatric residential treatment facility outside the borders of the state and shall separately note all such placements in which the facility is located more than fifty (50) miles from the patient's residence.

20-77-1807. Conflict resolution.

In the event that any provision of this subchapter conflicts with any portion of the Arkansas Medicaid State Plan or any waivers approved by the federal government, the affected state agencies shall immediately seek to resolve the conflict by amending the Medicaid State Plan or by seeking federal approval for a change in any conflicting agreement to prevent or minimize any loss of federal funding as a result of the conflict.

20-77-1808. Construction of subchapter.

Nothing in this subchapter shall be construed to prevent the sale, merger, or transfer of stock or control of a company operating an outpatient mental health care program, or limit its right to continuously contract with Medicaid without interruption.

SECTION 2. EMERGENCY CLAUSE. It is found and determined by the General Assembly of the State of Arkansas that the regulatory process applicable to program providers in its present form is not sufficiently delineated, and that this uncertainty creates a condition in which delay in the effective date of this act beyond the date approved by the Governor could work irreparable harm upon the proper administration and provision of essential government programs. Therefore, an emergency is hereby declared to exist and this act being immediately necessary for the preservation of the public peace, health, and safety shall become effective on:

(1) The date of its approval by the Governor;

(2) If the bill is neither approved nor vetoed by the Governor, the expiration of the period of time during which the Governor may veto the bill; or

(3) If the bill is vetoed by the Governor and the veto is overridden, the date the last house overrides the veto.

/s/ Womack