SENATE HEALTH & WELFARE COMMITTEE
Wednesday, January 27, 2016

ATTACHMENT 2

IDAHO ASSOCIATION OF COMMUNITY PROVIDERS, INC.
4477 W. Emerald St, Suite C100
Boise, ID 83706

Docket Number 16.0715.1501

Presented to the House and Senate Health & Welfare Committees

Mr. (Madam) Chairman, and members of the committee. My name is Greg Dickerson and I am a Mental Health Director and Treasurer of the Idaho Association of Community Providers (IACP). The IACP is the result of a merger between the Mental Health Provider Association of Idaho, The Idaho Association of Developmental Disability Agencies, the Case Management Association of Idaho, the Idaho Residential Support Association, and Advocates for Addiction Counseling and Treatment.

I am here today to represent our associations' opposition to the proposed rules describing "State Approval of Behavioral Health Programs" in Docket 16.0715.1501. This initiative is not in alignment with Idaho Statute and its intent and will create additional costs for the State of Idaho than stated in the fiscal impact statement.

During the 2010 and 2011 Legislative sessions, the Department and the Mental Health Provider Association worked with the House and Senate committees in identifying alternative cost savings to the proposed elimination of whole categories of Medicaid funded services. One of the suggestions providers introduced was to replace the Department Credentialing program by requiring mental health providers to become Nationally Accredited. At that time, the Department acknowledged that its minimal credentialing program for mental health providers cost the State $779,300 per year. The result of that work was captured in House Bill 260 of the 2011 Legislative session. This language is currently in Title 56, Chapter 2 Medicaid Managed Care Plan. (Please refer to Handouts 1 & 2a. and b.)

Not only did the legislation direct the Department to develop a Medicaid Managed Care Plan, but also directed that Mental Health services be "delivered by providers that meet national accreditation standards". To date, this docket of rules, along with the Departments' "Behavioral Health Standards Manual" is the first indication of efforts to implement this directive. These "standards" were copied from the major national accreditation bodies, yet do not contain all of the standards a provider would need to adopt to achieve national accreditation. In its introduction, the main function of these standards are stated to *"Serve as a guide for practitioners and agencies to provide best practice Behavioral Health and Recovery Support Service in Idaho. Contractors may use any portion(s) of this manual for auditing purposes".* Over the past 5 years, several providers across the state have achieved national accreditation in compliance with the statute, while others have waited for the Department to implement its provisions. (Please refer to handouts 3a., b., & c.)

The Fiscal Impact Statement of these rules states: "The fiscal impact for this rule change is anticipated to be cost neutral for state general funds and all other funds". The section goes on to describe the $100 fee per treatment facility and $50 fee for recovery support services. This is an inaccurate assessment of the costs of any credentialing effort. The real costs of credentialing comes from the process by which the authority conducts site visits and confirms that providers' are conforming to the standards. Since most of the standards described in these rules are based on national accreditation guidelines, a reasonable comparison of the ultimate costs of this program may be drawn from the actual costs of national accreditation processes.

The agency I work for underwent its 4th CARF accreditation review earlier this year. CARF surveys are for the purposes of verifying conformance with the standards and are provided at rate that allows CARF to break even in offsetting its costs. Each survey team is assigned based on the size of the agency, the number of locations surveyed, and the number of programs that are surveyed. From this formula, CARF charges are based on the number of surveyor days. For this agency with 2 locations and 3 program areas surveyed, it required 2 surveyors for 3 days each. At the rate charged of $1,550.00 per surveyor day, our accreditation review cost $9300.00. To make this a fair comparison, a part of these fees are used to compensate the travel expenses of the surveyors. However, the surveyors are not compensated as employees of the Department or as its' potential contractor will be for performing these same functions. The point is that the minimal fees described in the rule will most certainly be insufficient to meet these costs.

It is unlikely to say the least that the Department of Health & Welfare or its managed care contractors will replicate the value that National Accreditation Bodies such as CARF or the Joint Commission have brought to a wide range of health care facilities over the past several decades. (Please refer to handouts 4 a & b)

Our request is that the committee please reject these rules, and instead direct the department to follow through with the intent of the legislature when it approved HB260. In this way the State will externalize the cost of providers achieving national accreditation, and will instead focus our limited resources on direct services to meet the needs of the citizens of Idaho. I thank you for your consideration of this request, and I will stand for any questions.

Gregory Dickerson, MSW, MBA
Mental Health Provider Type Director & Treasurer,
Idaho Association of Community Providers, Inc.
(208)321-0160

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ATTACHMENT 2 – HANDOUT 1

Mental Health Providers Association of Idaho

These proposals are designed to provide savings that will not impact actual participant services.

1. Eliminate credentialing and replace it with accreditation, which eliminates the cost of credentialing staff. **Savings: $1 million**

2. For credentialing that is already scheduled conduct only one survey per agency to look at both clinic and PSR programs. **Savings: $1 million**

3. Eliminate the requirement for participants to be seen annually by the agency's supervising physician. Federal rules only require one time. **Savings: $500,000**

4a. Carve Mental Health Services out of the Healthy Connections Services, eliminating visits required by rule but unnecessary to the participant's health as well as transportation costs. OR **Savings: $1.5 Million**

4b. Alternately, instead of #4a, accept the Healthy Connection Physician Referral as evidence of Medical necessity and in lieu of the History and Physical. **Savings: $1.5 Million**

5. Return to the pre-2010 rule on assessments which allows accessing or developing a reference diagnosis and then completing a comprehensive assessment with bachelor level PSR's rather than requiring 2 full assessments: the Comprehensive Diagnostic Assessment and the Functional Assessment. **Savings: $4 Million**

6. After the initial assessment, allow an update rather than a full-blown assessment each year. Currently the rules would allow this but the Prior Authorization unit requires it. **Savings: depends on the extent of the update**

7. For adults only: Since treatment plans are reviewed every 120 days, remove the requirement to completely rewrite the plan every year and require it to be updated as needed. **Savings: $1.5 Million**

8. If a client is qualified for both Adult Mental Health Service Coordination and PSR services and are receiving both services from the same agency, use the PSR Comprehensive Assessment (see #6) as the assessment for both services instead of developing a separate assessment for each service. Also, write the service coordination services into the PSR treatment plan instead of developing 2 separate treatment plans. **Savings: $4 Million**

9. Since Mental Health service provision in the private sector is significantly less expensive than direct services provided by DHW staff, immediately refer all mental health treatment being provided by DHW staff to the private sector. Contract for indigent, uninsured individuals at the Medicaid rate. We do not have enough information to quantify the savings that could be realized by implementing this idea.

10. This suggestion may increase other expenditures, such as hospitalizations and incarcerations as needs above 5 hours per week are addressed only when the participant is in crisis and is, therefore, only recommended with great reservation: Reduce PSR services (skills training and community integration) from 10 hours per week to a maximum of 5 hours per week which would eliminate the Prior Authorization unit. Existing staff in each region could process crisis service requests. Savings would include all PSR hours currently authorized over 5 per week (Savings Unknown) plus the expense of operating the Prior Authorization Unit. **Savings: $1 Million**

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ATTACHMENT 2 – HANDOUT 2a

Division of Medicaid/Mental Health Provider Meeting
6/15/2010

Attendance: Paula Marcotte – Provider Association, Lee Barton – Provider Association, Randy May - DHW, Tom Nielsen - DHW, Pat Guidry - DHW and Paul Leary – DHW

The focus of the meeting was to review the saving proposal from the Mental Health Provider Association that was presented to the Department in a meeting during the legislative session. The following is a summary of the discussion around each recommendation:

- The projected savings that were included in the Association's proposal were a guesstimate. The first two items in the proposal point to inaccurate estimates.
    - Currently the State cost for accreditation is $779,300 – so unsure how these two suggestions would save the projected $2,000,000.
    - If national accreditation was required the State would have some responsibilities related to complaint investigation – so would need to retain some staff and operational function in the Department.
- **Recommendation #1** - The Department supports moving the accreditation process from the state to a nationally recognized accrediting body as is evidence in our current administrative rules that allow national accreditation in lieu of state accreditation.
    - Only 3 of approximately 400 mental health agencies have chosen national accreditation instead of state accreditation. This is most likely due to the cost of national accreditation compared to no agency cost for state accreditation.
- **Recommendation #2** – Both the provider association and the Department are committed to streamlining the accreditation process while assuring that all needed information is obtained in the most efficient manner for the provider and the Department.
- **Recommendation #3** – The State has no flexibility in this area as long as Mental Health clinics are authorized in the clinic section of the Medical Assistance State Plan. This is a federal requirement of all clinics that operate under this authority.
    - The option would be to move Mental Health clinic from the clinic section to the rehabilitation section of the State Plan.
    - Would require federal approval which may present some of its own challenges.
- **Recommendation #4** – Idaho Medicaid is committed to the Primary Care Case Management model and is interested in strengthening and not weakening that model of care. Indeed there is a national push to move toward Medical Homes (called Health Homes in the Patient Protection and Affordable Care Act) – not to further fractionate the health care system.
    - The provider perception is that the Department – through this rule - has made them responsible to make sure that the primary physician is doing the history and physical.
    - The intent of the rule is to assure that the patients symptoms are truly a mental health and not a physical health issue. The department had several examples of individuals that were receiving mental health services when in fact their symptoms were related to a metabolic condition.

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ATTACHMENT 2 – HANDOUT 2b

- Both the provider association and the Department are in agreement with the intent of this rule – both are committed to working together to minimize the burden on the mental health provider while still meeting the intent of this rule.

- **Recommendation #5** – All in attendance felt that the "2010" rule has resulted in higher quality assessments of participants and that we should not revert back to the pre-2010 assessment rules. There was also strong agreement that the move to a single comprehensive assessment for an individual that is used by all services is a move in the right direction.
  - Commitment from both the provider association and the Department to work on a single assessment tool.
  - Tool should assess the individual's needs – not the needs of any one specific service.
  - This work will align with legislative intent stated in HB 701.
  - Pat will include both Lee and Paula in the assessment work group.
- **Recommendation #6** – Current rules (IDAPA 16.03.10.114) allow for providers to determine whether or not a full diagnostic assessment or an update is appropriate. Issue that has been seen by the Department is that some updates that have been received have contained insufficient information for the care manager to make a decision about authorization. Both Paula and Lee expressed that they have not had any issues gaining authorization based on updates.
  - Since the rules already allow for updates it may be more of an educational issue than a policy issue.
  - This is an opportunity for the Department and the provider association to work together in educating providers about what information is needed in order for the care managers to make prior authorization decisions.
- **Recommendation #7** – this recommendation is supported by both the provider association and the Department. It offers the opportunity to eliminate some billing for services that have minimal if any affect on patient outcome. Pat is going to research further to make sure there is not a federal requirement.
  - If there is nothing to impede this recommendation from occurring – Pat will work with providers to put a process together that assures that the participant's treatment plan is updated appropriately and matches the current functioning and status of the participant.
- **Recommendation #8** – See recommendation #5
- **Recommendation #9** – This recommendation is being addressed in the Division of Behavioral Health. It appears that there may be movement in this direction coming out of the Governor's Behavioral Health Work Group.
- **Recommendation #10** – The Department concurs with this recommendation but must retain a UM function over this service. All were in agreement that it would be a positive outcome to increase the UM function of the department in this area to assure that participants are getting the services that they need – and that providers that are misusing the services are brought in line.

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ATTACHMENT 2 – HANDOUT 3a

INTRODUCTION

The Division of Behavioral Health has begun an ongoing process of developing best practice standards, which are anticipated to improve behavioral health services provided in the state of Idaho. The standards carry the intention of serving as a consistent base for the provision of high quality behavioral health care in Idaho, by providing increased awareness, understanding and utilization of best-practice service and treatment modalities.

The first release of standards (known presently as the "Core 18") includes principles that are intended to apply to all behavioral health treatment and recovery support service providers in Idaho. Additional standards will be developed according to priority and system need, and may apply to only those entities that offer the services or serve the populations identified in the standards.

Throughout the development process, careful consideration has been paid to: a) evidence-based behavioral health practices; b) widely accepted standards of behavioral health care; c) Idaho Administrative Rule (program specific); d) State contractual requirements; e) current practice; f) need throughout the state; and g) input from community providers, consumers, and stakeholders. Using the following guiding principles, a research team from Division of Behavioral Health has developed best practice standards for implementation by behavioral health providers across the state of Idaho.

Guiding Principles:
As an effort to produce standards that are unique to Idaho's behavioral health infrastructure, 11 guiding principles were established as the foundation for standards development and decision-making. These guiding principles define the qualities that are essential to the improvement of behavioral health service delivery in Idaho.

- ✓ Provide effective direction for the state of Idaho's evolving behavioral health system.
- ✓ Practice responsible management of finances and resources.
- ✓ Place a heavy emphasis on providing exceptional customer service to participants and their families, providers and stakeholders, by modeling professional and ethical behavior.
- ✓ Demonstrate respect for and encouragement of diversity and cultural awareness.
- ✓ Strive for continuous enhancement of Idaho's Best Practice Standards.
- ✓ Foster recovery, resiliency and independence by providing strengths-based, person-centered and family-focused care.
- ✓ Endorse comprehensive and integrated healthcare whereby both mental health and substance use disorders care is coordinated with primary care.
- ✓ Provide guidance for programming that is innovative and evidence-based/best practices, through decision-making that is guided by research and data analysis.
- ✓ Promote ongoing quality improvement based on participation and collaboration in development of services, policy, and planning from providers, stakeholders and participants.
- ✓ Encourage preemptive and valuable staff training and education.
- ✓ Prevention and intervention services are outcomes-based, established to minimize risks and support recovery.

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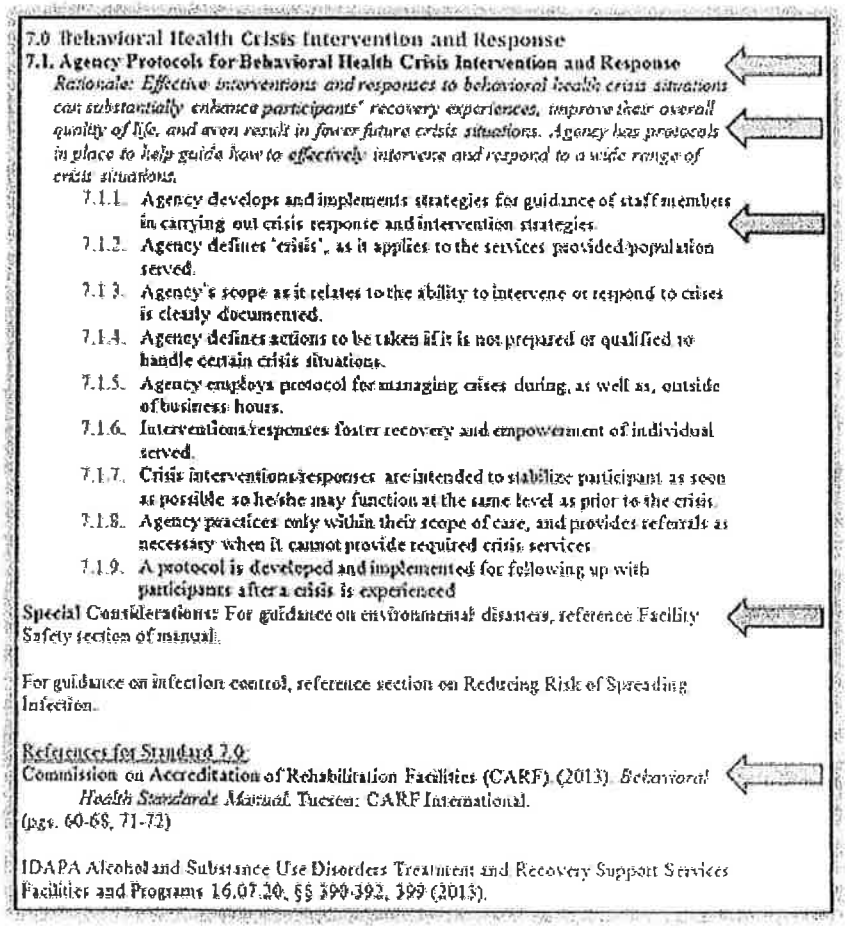
ATTACHMENT 2 – HANDOUT 3b

What is the main function of standards?
Serve as a guide for practitioners and agencies to provide best practice Behavioral Health and Recovery Support Service in Idaho. Contractors may use any portion(s) of this manual for auditing purposes.

How do I use this manual?
This manual is intended to serve as a user-friendly reference guide for providers, consumers, and stakeholders; it offers guidelines on the provision of behavioral health care in Idaho. It is fully searchable by simply using the keyword search box. The guidelines contained within these standards are to be interpreted as benchmarks rooted in up-to-date evidence for not only community providers, but funding contractors as well.

What are the expectations for implementation?
Currently, the basis for implementation of these standards is opt-in, but the Department will be integrating them into current practices, and suggests that partners and stakeholders begin to do so also.

Anatomy of a Standard:



7.0 Behavioral Health Crisis Intervention and Response
7.1. Agency Protocols for Behavioral Health Crisis Intervention and Response
Rationale: Effective interventions and responses to behavioral health crisis situations can substantially enhance participants' recovery experiences, improve their overall quality of life, and even result in fewer future crisis situations. Agency has protocols in place to help guide how to effectively intervene and respond to a wide range of crisis situations.
7.1.1. Agency develops and implements strategies for guidance of staff members in carrying out crisis response and intervention strategies.
7.1.2. Agency defines 'crisis', as it applies to the services provided/population served.
7.1.3. Agency's scope as it relates to the ability to intervene or respond to crises is clearly documented.
7.1.4. Agency defines actions to be taken if it is not prepared or qualified to handle certain crisis situations.
7.1.5. Agency employs protocol for managing crises during, as well as, outside of business hours.
7.1.6. Interventions/responses foster recovery and empowerment of individual served.
7.1.7. Crisis interventions/responses are intended to stabilize participant as soon as possible so he/she may function at the same level as prior to the crisis.
7.1.8. Agency practices only within their scope of care, and provides referrals as necessary when it cannot provide required crisis services.
7.1.9. A protocol is developed and implemented for following up with participants after a crisis is experienced.
Special Considerations: For guidance on environmental disasters, reference Facility Safety section of manual.

For guidance on infection control, reference section on Reducing Risk of Spreading Infection.

References for Standard 7.0:
Commission on Accreditation of Rehabilitation Facilities (CARF) (2013). *Behavioral Health Standards Manual.* Tucson: CARF International.
(pgs. 60-68, 71-72)

IDAPA Alcohol and Substance Use Disorders Treatment and Recovery Support Services Facilities and Programs 16.07.20, §§ 390-392, 399 (2015).

The sub-standards are short subtitles that introduce the key components of each standard.

The "Rationale" describes the logical foundation for each sub-standard.

Below the rationale section, you will see application guidelines that specifically discuss how the agency is to carry out or evidence compliance with standards.

Sub-standards may include a category for Special Considerations. This category is designed to include any caveats that may apply to the sub-standard to which it is attached.

References are located at the end of the respective standard.

►**Future Section:** After each standard, there is a Question/Answer section that is to be continuously updated with answers to questions asked by community providers, consumers and stakeholders regarding that specific standard.
**The Question/Answer sections will be added after the initial public comment period, as questions pertaining to specific standards are submitted.*

3b.

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ATTACHMENT 2 – HANDOUT 3c

How will the manual be distributed?
For ease of access and to ensure the most recent copy available at all times, this manual will be published electronically. Please sign up on our website to receive email updates when changes to the eManual are made.

How often will the manual be updated?
This manual will be updated on an annual basis or more frequently, according to factors including: public comment, frequently asked questions addition/changes, behavioral health field and evidence base enhancement, implementation of new services, rule/statute changes, and other identified needs.

How can I provide input?
Public input is always welcome and solicited for a period of at least 30 days prior to publication of any new standards. Comments and feedback are collected via our website (mentalhealth.idaho.gov). Please sign up on our website to receive email updates when comment periods open on proposed standards. If you have a specific comment or question, please email us at BHSurvey@dhw.idaho.gov.

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ATTACHMENT 2 – HANDOUT 4a

Payers choose CARF to reduce risk and raise accountability

Payers -- whether a third-party funder, referral agency, insurance company, or governmental regulator -- look for CARF-accredited service providers to lessen risk and provide greater accountability.

Payers prefer CARF International as an independent accrediting body of health and human service providers. Our accredited providers have applied a comprehensive set of standards for quality to their business and service delivery practices. Because CARF accreditation signals a provider's demonstrated conformance to internationally accepted standards, it can significantly reduce governmental monitoring and help to streamline regulation processes.

In addition, CARF accreditation confirms that a program or service is committed to continuous quality improvement, accountability for its performance through outcomes evidence, and monitoring the satisfaction of the persons served. Countries, states, territories, and provinces on five continents recognize one or more of CARF International's areas of accreditation, and many mandate CARF exclusively in at least one area of accreditation.

As a third-party payer, referral source, insurer, or governmental regulator, you have access to searches and lists of CARF-accredited service providers and current CARF standards manuals and monographs. Login here or request a new payer account.

About CARF movie

View the About CARF movie (Flash, 3 min.) for an introduction to CARF International. Or view the script.

Aging services lenders

Lenders seeking to invest in the senio housing and services sector may have questions about accreditation and how it helps identify an organization that is prepared to meet the terms of a lending arrangement.

Visit www.carf.org/lenders to get started.

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ATTACHMENT 2 – HANDOUT 4b

Topic Details

Tuesday 1:20 CST, January 19, 2016

Topic Library Item

Facts about Behavioral Health Care Accreditation

November 30, 2015

In 1969, The Joint Commission began accrediting providers of programs/services for persons with intellectual and developmental disabilities, and expanded in 1972 to include the evaluation and accreditation of organizations providing mental health and chemical dependency services. Today, The Joint Commission accredits more than 2,200 organizations under the *Comprehensive Accreditation Manual for Behavioral Health Care*. Accreditation is available to organizations that provide a wide range of services and programs within a variety of settings across the continuum of care (see box).

Standards

Joint Commission standards address the behavioral health care organization's performance in specific areas, and specify requirements to ensure that care, treatment and services are provided in a safe manner. A trauma-informed, recovery/resilience-oriented philosophy and approach to care, treatment and services is embedded in the requirements. The Joint Commission develops its standards in consultation with behavioral health care experts, providers, measurement experts, as well as individuals and their families. The *Comprehensive Accreditation Manual for Behavioral Health Care* is available for purchase in both hardcover and electronic format. There are additional requirements specific to the unique needs of medication-assisted opioid treatment programs, foster care programs and certification requirements for health homes.

Accreditation process

The Joint Commission's accreditation process concentrates on operational systems critical to the safety and quality of care, treatment or services provided to the individual. Surveys are conducted by experienced and licensed behavioral health care professionals, including psychologists, social workers, professional counselors, behavioral health care nurses and administrators. Many Joint Commission surveyors are actively working in a range of behavioral health care settings.

Benefits of accreditation

Joint Commission behavioral health care accreditation provides a framework to help manage risk and enhance the quality and safety of care, treatment and services. Recognized by more than 198 state authorities, accreditation can be a useful tool to demonstrate compliance with state regulations or licensure requirements. Joint Commission accreditation also is a condition of reimbursement for certain insurers, including Medicaid and commercial payers. The process provides a customized, intensive review, and enhances staff recruitment and development.

Optional certification

Behavioral Health Home Certification is an optional certification to recognize organizations that coordinate and integrate all health care needs of a population served. The optional certification goes above and beyond what is required for accreditation and provides additional recognition as a health home.

Cost of accreditation

The on-site survey fee is paid at the end of the on-site survey and covers survey-related direct costs. The on-site fee for a small organization starts at $3,020. The annual fee, which is based on an organization's volume and type of services provided, is due each January and covers Joint Commission accreditation related services. Annual fees for behavioral health care organizations start at $1,820 and are adjusted based on the number of individuals served, the types of services and programs provided, and sites of care, treatment or services. The Joint Commission Connect extranet includes a fee calculator to help estimate annual subscription billing costs for current customers. For more information about pricing, contact The Joint Commission's Pricing Unit at 630-792-5115 or pricingunit@jointcommission.org.

Read more about behavioral health care accreditation

(4b1)

Joint Commission Accredited Behavioral Healthcare Providers in Idaho

Organization	Address	
CenterPointe, Inc.	915 Park Centre Way, Suite 7	Nampa, ID 83651
Community Health Clinics, Inc. DBA: Terry Reilly Health Services	1224 1st S. Suite 302	Nampa, ID 83651
Community Health Clinics, Inc. DBA: Terry Reilly - Caldwell Elgin	1411 Hope Ln	Caldwell, ID 83605
Terry Reilly Health Services DBA: Terry Reilly Medical - Nampa 16th Ave	223 16th Ave, N.	Nampa, ID 83653
DBA: Terry Reilly Medical / Mental Health/ SANE Solutions - Boise	300 S. 23rd Street	Boise, ID 83702
DBA: Terry Reilly Medical / Mental Health - Caldwell	2005 Arlington	Caldwell, ID 83605
Terry Reilly Health Services DBA: Terry Reilly Medical / Mental Health - Homedale	116 E. Idaho	Homedale, ID 83628
Terry Reilly Health Services DBA: Terry Reilly Medical / Mental Health - Marsing	201 Main Street	Marsing, ID 83639
Terry Reilly Health Services DBA: Terry Reilly SANE Solutions - Boise	408 N. Allumbaugh	Boise, ID 83704
Terry Reilly Health Services DBA: Terry Reilly Medical / Dental / Mental Health - Middleton	201 S. First Ave. E	Middleton, ID 83644
Terry Reilly Health Services DBA: Terry Reilly - Boise Latah	848 LaCassia	Boise, ID 83705
Lewiston Community Based Outpatient Clinic DBA: VA Lewiston Community Based Outpatient Clinic	1630 23rd Ave. Suites 302 & 401 Bldg. 2	Lewiston, ID 83501
Community Based Outpatient Clinic	915 W. Emma Avenue	Coeur D Alene, ID 83814
Northpoint Recovery	10787 W. Ustick Road	Boise, ID 83713
Project PATCH Ranch	25 Miracle Lane	Garden Valley, ID 83622

CARF Accredited Behavioral Healthcare Providers in Idaho

A to Z Family Services	Blackfoot
A to Z Family Services	Pocatello
A to Z Family Services	American Falls
A to Z Family Services	Malad
A to Z Family Services	Idaho Falls
Boise VA Medical Center	Boise
Human Supports of Idaho	Boise
Human Supports of Idaho	Caldwell
Idaho Behavioral Health	Boise
Idaho Behavioral Health	Caldwell
Idaho Behavioral Health	Mountain Home
Joshua D. Smith & Associates	Idaho Falls
Joshua D. Smith & Associates	Pocatello
The Walker Center	Gooding
The Walker Center	Twin Falls
Easter Seals Goodwill	Boise
Easter Seals Goodwill	Caldwell
Easter Seals Goodwill	Moscow
Easter Seals Goodwill	Couer d Alene
Easter Seals Goodwill	Lewiston
Easter Seals Goodwill	Ponderay
Center for Behavioral Health	Boise
Center for Behavioral Health	Meridian
Raise The Bottom Training & Counseling Center	Boise

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ATTACHMENT 2 – HANDOUT 5

HOUSE BILL NO. 260

The purpose of this legislation is to reduce health care costs in the Medicaid budget and improve the healthcare delivery system in Medicaid. The proposed changes to the law will implement policies that should be changed or deleted temporarily because of the current economic situation, with the possibility of being continued later, because they are found to be excellent business practices; permanently discontinue policies when they are poor business practices; discontinue benefit programs when the preponderance of scientific evidence does not support the outcomes; re-design certain optional programs to reflect those basic needs that are necessary to prevent elevated costs in other areas; propose to eliminate the fee-for-service healthcare delivery to a managed care approach which will focus on improved healthcare outcomes; remove all forms of self-referral by certain healthcare providers; maximimze co-pays to the extent allowed under federal law to encourage personal responsibility; provide structural support to implement changes.

(d) Mental health services delivered by providers that meet national accreditation standards, including:
(i) Inpatient psychiatric facility services whether in a hospital, or for persons under age twenty-two (22) years in a freestanding psychiatric facility, as permitted by federal law, in excess of those limits in department rules on inpatient psychiatric facility services provided under subsection (5) of this section;
(ii) Outpatient mental health services in excess of those limits in department rules on outpatient mental health services provided under subsection (5) of this section; and
(iii) Psychosocial rehabilitation for reduction of mental disability for children under the age of eighteen (18) years with a serious emotional disturbance (SED) and for severely and persistently mentally ill adults,. Individuals aged eighteen (18) years or older, to age twenty-one (21) years with severe and persistent mental illness shall have access to benefits up to a weekly cap of five (5) hours while adults over the age of twenty-one (21) years with severe and persistent mental illness shall have access to benefits up to a weekly cap of four (4) hours

TITLE 56
PUBLIC ASSISTANCE AND WELFARE
CHAPTER 2
PUBLIC ASSISTANCE LAW

56-255. MEDICAL ASSISTANCE PROGRAM -- SERVICES TO BE PROVIDED.

(ix) Behavioral health services, including:
1. Outpatient behavioral health services that are appropriate, delivered by providers that meet national accreditation standards and may include community-based rehabilitation services and case management; and
2. Inpatient psychiatric facility services whether in a hospital, or for persons under the age of twenty-two (22) years in a freestanding psychiatric facility as permitted by federal law;

TITLE 56
PUBLIC ASSISTANCE AND WELFARE
CHAPTER 2
PUBLIC ASSISTANCE LAW

56-263. MEDICAID MANAGED CARE PLAN.

(c) Managed care contracts to pay for behavioral health benefits as described in executive order number 2011-01 and in any implementing legislation. At a minimum, the system should include independent, standardized, statewide assessment and evidence-based benefits provided by businesses that meet national accreditation standards.