Senate Bill 1258 – Key Provisions

1. Legislative Intent: to create a management structure that places responsibility for MH and SA treatment services within a single entity and contains a **flexible funding** arrangement;

2. Further Legislative Intent: to allow a transition period and demonstration sites so that **the publicly funded MH and SA treatment system can evolve into a single, well-integrated behavioral health system**;

3. Further Legislative Intent: to support the testing and critical review of new ideas and technologies.

4. Financing Intent: the strategies will be the first phase of transferring the management of MH and SA treatment services from traditional fee-for-service and unit cost contracting methods to **risk-sharing** arrangements.

5. The Act permits: DCF and ACHA to contract for the establishment of two behavioral health service delivery strategies to test methods and techniques for coordinating, integrating and managing the delivery of MH and SA services

6. Overall Goal: to provide a design for an effective coordination, integration and management approach for delivering effective behavioral health services

7. Additional stated goals: a) improve **accountability** for a local system of care that meets performance outcomes; b) assure clinical **continuity of care**; c) provide **early diagnosis and treatment** interventions that enhance recovery and prevent hospitalization; d) improve **assessment of local needs**; e) improve quality through the use of **best practice models**; f) demonstrate **improved service integration** between BH programs and education, vocational rehabilitation, child welfare, health care, emergency services and criminal justice; g) test **creative and flexible financing** strategies; h) enhance **individualized treatment** and support services; i) control the cost of services without sacrificing quality; j) **coordinate admissions and discharges** from **state hospitals and residential** treatment centers; k) improve the **use of data for planning**; promote BH services to **residents of assisted living facilities**; l) **reduce admissions and length of stay for dependent children in residential** treatment; and m) provide **court-ordered treatment to abused and neglected children and their families.**

8. Implicit goals that appear in the Act: **redirect service delivery dollars, and reward cost-effective and appropriate care patterns**

9. Requires: **a managing entity** for each service delivery strategy

10. Allows: DCF and ACHA to contract for the provision or management of behavioral health services with a managing entity in at least two geographic areas (at least one must be the service area of G. Pierce Wood Memorial Hospital)

11. Strategy # 1: DCF may contract with an (ACHA contracted) pre-paid health plan to be the managing entity. Competitive procurement is not required.

12. Specific Provision: any contract in ACHA's area 6 may be entered into with the existing SA treatment provider network if an administrative service organization (ASO) is part of its network.

13. Strategy # 2: DCF and ACHA shall competitively procure a contract with a managing entity.

14. Definition of a managing entity: "an entity that manages delivery of behavioral health services". The managing entity may be:

    A network of existing providers with an ASO, that can function independently
    An ASO that is independent of local provider agencies, or
    An entity of state or local government

15. Role of the managing entity: The managing entity:

    Improves coordination of care
    Improves access to care
    Contains costs
    Improves quality of care
    Arranges and coordinates all publicly funded services

16. Services to be delivered: The managing entity provides or manages:

    Diagnostic and assessment services
    The emergency BH care system
    Acute care
    Rehabilitative services
    Support services
    Continuing care services

17. Requirement for provider participation in the "network panel": the managing entity shall assure the provision of comprehensive services and statutory compliance with existing Medicaid regulations. Providers will include:

    Mental health centers
    Substance abuse treatment providers
    Hospitals
    Licensed psychiatrists
    Licensed psychiatric nurses, and
    Licensed mental health professionals

18. Population to be served: persons who meet the financial criteria for publicly funded MH and SA treatment services, or are Medicaid eligible. Cliients may reside in their own home or in settings such as assisted living facilities, skilled nursing facilities, foster homes or group homes.

19. Funding for treatment services: all state, federal and Medicaid funds in the geographic area, including federal block grant funds

20. Funding for the managing entity: limited to ten percent (10%) of services funding

21. Powers given to DCF and ACHA: DCF and ACHA may:

    Establish benefit packages
    Align and/or integrate procedure codes and standards
    Use pre-paid per capita and prepaid fixed-sum payment mechanisms, in addition to fee for service reimbursement
    Increase clinical flexibility
    Encourage use of the most effective interventions
    Support rehabilitation activities, i.e.re-engineer the system

22. Other provisions: SB1258 requires that national accreditation be accepted by DCF and ACHA in lieu of licensure on-site review requirements and as a substitute for DCF administrative and program monitoring requirements. Accredited networks of providers qualify. A provider organization that is a part of an accredited network qualifies as the result of network membership. There are provisions that allow DCF and ACHA to adopt rules that establish additional standards; require monitoring of accredited MH ambulatory facilities for continued compliance every 24-36 months, and every 12-24 months for residential MH facilities; and that maintain DCF licensure inspections of accredited SA facilities every 3 years.