Legislative Analysis

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BEHAVIORAL HEALTH AMENDMENTS

House Bill 4925 (proposed substitute H-1)
Sponsor: Rep. Mary Whiteford

House Bill 4926 (proposed substitute H-1)
Sponsor: Rep. Abdullah Hammoud

House Bill 4927 (proposed substitute H-1)
Sponsor: Rep. Phil Green

House Bill 4928 (proposed substitute H-1)
Sponsor: Rep. Sue Allor

House Bill 5894 as introduced
Sponsor: Rep. Felicia Brabec

Committee: Health Policy
Complete to 3-17-22

SUMMARY:

House Bill 4925 would amend the Mental Health Code to authorize the Department of Health and Human Services (DHHS) to contract with administrative services organizations (ASOs) to assist in performing certain of its functions and duties. The bill also would amend provisions concerning recipient rights and certain powers and duties of DHHS and would create the Behavioral Health Oversight Council in DHHS to advise DHHS in developing and executing public behavioral health policies, programs, and services. The other four bills would amend other acts to account for changes proposed by HB 4925.

House Bill 4925 would revise provisions detailing DHHS's mandate, powers, and duties. Currently, the code states that DHHS should shift primary responsibility for the services from the state to a community mental health services program (CMHSP) if the program has adequate willingness and capacity (the bill would add "ability"). The bill would additionally allow DHHS to provide, directly or through a contract, any service or set of services and supports to ensure that Michigan has an adequate network of public behavioral health services in accordance with state and federal requirements.

The bill would provide that, if DHHS contracts with an ***administrative services organization*** (as described below), DHHS would have to provide operational oversight of the ASO through contract, policy, administrative rules, or other authorized means, including at a minimum developing a comprehensive plan for monitoring its performance, establishing policies to coordinate public behavioral health benefits with other benefits received under Medicaid, and developing consumer and provider appeal procedures.

> ***Administrative services organization*** would mean a third-party organization with special expertise in managing public behavioral health and intellectual disability or developmental disability that contracts with DHHS to assist in the administration of the public behavioral health system, including Medicaid specialty supports and

services. An ASO that contracts with DHHS under the bill would not provide clinical services.

DHHS would have to develop equitable public behavioral health reimbursement policies, procedures, and rates necessary to ensure that Michigan has an adequate network of public behavioral health services in accordance with state and federal requirements. All policies and procedures and related documents would have to be posted and maintained on its website. DHHS would have to use payment models that promote value over volume and also would have to do all of the following to promote value over volume:

- Develop and fully fund ***certified community behavioral health clinics*** at all eligible sites that meet DHHS certification criteria and use a ***prospective payment system*** to reimburse them for eligible services.
- Develop and fully fund ***Medicaid health homes*** at all eligible sites that meet DHHS requirements for beneficiaries with a mental illness, emotional disturbance, intellectual or developmental disability, or substance use disorder.
- Apply for all applicable federal and private funding opportunities, seek appropriate changes or waivers to the Medicaid state plan, and apply for any necessary waivers and approvals from the Centers for Medicare and Medicaid Services (CMMS) or any other appropriate federal agency.

Certified community behavioral health clinic would mean an entity certified by DHHS in accordance with federal criteria and the federal Protecting Access to Medicare Act or an appropriate change or waiver to the Medicaid state plan.

Prospective payment system would mean a payment methodology that reimburses a certified community behavioral health clinic for the anticipated costs of providing core certified community behavioral health clinic services as determined by DHHS in accordance with federal criteria.

Medicaid health homes would mean an optional Medicaid state plan benefit authorized under section 1945 of the federal Social Security Act.

DHHS would have to do all of the following to promote ***self-directed services***:

- Contract with a contractor with experience and expertise in managing self-determination contracts between an individual served and a financial services manager to ensure network adequacy, equitable access, and choice of self-directed services consistent with DHHS guidelines.
- Provide technical assistance for local self-directed service programs.
- Measure the performance of the relevant entities.
- Annually assess implemented self-directed services to ensure that they are provided in accordance with DHHS policies.

DHHS could provide for the use of a contractor described above to carry out the management of a self-determination contract if a CMHSP did not demonstrate the willingness, capacity, or ability to do so.

Self-directed services would mean that a participant or, if applicable, the participant's representative has decision-making authority over certain services and takes direct

responsibility to manage the participant's services with the assistance of a system of available supports. The self-directed service delivery model is an alternative to traditionally delivered and managed services, such as an agency delivery model.

In addition, the code currently states that DHHS must direct services to individuals who have a serious mental illness, developmental disability, or serious emotional disturbance. The bill would add intellectual disabilities and substance use disorders to the list of service recipients and remove the word both instances of the word "serious" from the description. It also would rearrange slightly the description of services provided and allow DHHS to promulgate rules to carry out the requirements and further describe priority populations to be served.

Contracting with an ASO

To assist in executing its powers and duties, DHHS could enter into a contract, through a request for proposal, with a single ASO. An ASO so selected would be bound by the same federal and state laws, regulations, and policies as DHHS, and its employees would have the same immunity provided for governmental employees under 1964 PA 170. The ASO would not serve in a fiduciary role or capacity in carrying out its functions. The bill states that DHHS would retain its ultimate duty, authority, and accountability in executing its powers and responsibilities.

DHHS would have to ensure that a selected ASO meets at least all of the following:

- It has a full-time chief executive officer, chief financial officer, and medical or clinical director.
- It is not organized as a for-profit entity.
- It is not a CMHSP, a group of CMHSPs under the Urban Cooperation Act, or any other group or confederation of CMHSPs.

The contract would have to require the ASO to assist DHHS in performing all of the following functions and duties:

- Eligibility verification.
- Utilization management.
- Intensive care management.
- Quality management.
- Coordination of physical, behavioral, and social health services, including at least coordination with health plans, primary care providers, peers, community health workers, and social service agencies.
- Provider network development and management.
- Critical incident, grievance, and appeals monitoring and reporting.
- Customer services.
- Coordination with recipient rights
- Corporate compliance that includes adherence to all applicable state and federal civil rights statutes and regulations.
- Clinical management services not retained by DHHS.

An ASO would have to authorize services based on DHHS policy and guidelines, although exceptions could be made when requested by a recipient of services or a recipient's legal guardian or services provider and determined by the ASO to be in the recipient's best interest. DHHS would have to make decisions regarding the interpretation of guidelines. An ASO could

not have any financial incentive to approve, deny, or reduce services. ASOs would have to ensure that service providers and individuals seeking services have timely access to information and timely responses to inquiries, including those concerning clinical guidelines and expected outcomes.

An ASO would have to use the Michigan Crisis and Access Line (MiCAL)[1] to support the duties and functions described above. (MiCAL is the statewide crisis and access line accepting all calls and dispatching support based on the assessed need of the caller.)

Subject to DHHS approval, an ASO would have to establish regional or satellite divisions to ensure geographic and demographic equity in executing the duties and functions described above.

Incorporating ASOs throughout the code

The bill also would incorporate throughout the code ASOs and their proposed ability to assist DHHS in providing services, generally by adding DHHS to places where the code now requires that functions be performed by a DHHS-designated community mental health entity. Under the bill, if DHHS were to assume responsibility for those functions, it could contract with an ASO for assistance.

Functions of a CMHSP

The bill would add all of the following to the mental health crisis emergency services that must be provided by a CMHSP:

- Coordination with MiCAL.
- Providing crisis intervention and stabilization services, such as mobile crisis teams, to any individual in need of those services from any referral source.
- Providing crisis stabilization units that serve everyone in need from all referral sources.

Currently, part of those emergency services is providing inpatient or other protective environment for treatment. The bill would specify that the environment is for treatment provided by DHHS, CMHSPs, and approved service programs.

In addition, the array of mental health services a CMHSP must offer now includes planning, linking, coordinating, follow-up, and monitoring to assist the recipient in gaining access to services. The bill would instead require a CMHSP to provide ***case management***, which DHHS must ensure is provided independently of individuals and entities that provide or pay for other services and supports.

> ***Case management*** would mean assistance and advocacy in assessing, planning, facilitating, coordinating, monitoring, and evaluating services and supports for a recipient.

CMHSPs would be required to include the choice for self-directed services.

DHHS could promulgate rules or establish Medicaid policy, or both, to carry out the provisions of section 206 of the code, which prescribes the purpose and requirements of CMHSPs.

[1] House Fiscal Agency analysis of 2020 PA 12 (HB 4051), which created the Michigan Crisis and Access Line: http://www.legislature.mi.gov/documents/2019-2020/billanalysis/House/pdf/2019-HLA-4051-EE6CC87D.pdf

The bill also would provide that, in contracting with entities to provide substance use disorder prevention, treatment, and rehabilitation services, priority must be given to CMHSPs that are able and willing to provide such services.

Recipient rights

The bill would provide that an individual qualifying for publicly funded mental health services, the individual's guardian if applicable, or the individual's designated representative must be informed verbally and in writing of the following rights:

- With regard to ***self-direction*** options and processes, the rights to do the following:
  - Learn about self-direction options and processes.
  - Seek to develop a self-directed service and support arrangement.
  - Use a service payer or provider other than the involved service payer or provider to file a grievance or appeal the unsatisfactory structuring of a self-directed arrangement.
- With regard to ***person-centered planning***, the rights to do the following:
  - Engage in person-centered planning.
  - Have the person-centered planning process independently facilitated.
  - Designate an individual to assist or represent the individual in the person-centered planning process.
  - For children, youth, or families, ensure that the needs of the youth and their family are considered in the development of the individual plan of service and are ***family-driven*** and ***youth-guided***.
  - Use a service payer or provider other than the involved service payer or provider to file a grievance or appeal the service offered after the person-centered planning process.
  - Be informed about utilization management practices that are used to make determinations about supports and services identified through the person-centered planning process, including written information about policies, procedures, and methods used to make those determinations.

Self-direction would mean the act of selecting, directing, and managing one's services and supports as a method of moving away from professionally managed models of supports and services.

Person-centered planning would mean a collaborative, person-directed process designed to assist an individual to plan the individual's life and supports.[2]

Family-driven would mean an approach that recognizes that services and supports affect the entire family, not just the identified child or youth receiving mental health services. In the case of minors, the child, youth, and family would be the focus of service planning. Family members would be integral to a successful planning process.

Youth-guided would mean a process in which a young individual has the right to be empowered, educated, and given a decision-making role in his or her own life as well

[2] The bill would amend the current definition of ***person-centered planning***, which is "a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires."

as the policies and procedures governing all care for all youth in the community, state, and nation. As the child or youth matures toward transition age, the focus of the treatment planning, services, and supports would have to be youth-driven, young-driven, or adult-driven to accommodate the youth as the youth gains skills toward independence.

The rights listed above could be temporarily suspended during a period of a psychiatric crisis if the individual has no guardian, legal representative, or advance psychiatric directive that can safely be implemented during the crisis. The temporary suspension would have to end when the psychiatric crisis is stabilized.

The bill states that utilization management is not a substitute for, and should not supplant, the individual plan of service developed through person-centered planning.

Service authorizations would have to be completed within time frames as specified in 42 CFR 438.210.[3]

Within one business day of a decision to deny a service authorization request or to authorize a service in an amount, scope, and duration that are less than requested, the recipient of services and the requesting provider would have to be notified in writing of that decision.

Recipient rights concerning minors

For minors accepted for publicly funded mental health services, DHHS would have to ensure that the family-driven and youth-guided approach is used in making decisions about services and supports and in choosing, implementing, and evaluating them. Outcomes for the individual plan of service would have to be determined by the child, youth, and family through the selection of supports and services that meet the goals of the individual plan of service.

DHHS would have to ensure that the publicly funded mental health system has adequate resources and training programs for effective use of family-driven and youth-guided planning among diverse cultural groups.

DHHS would have to have in place policies and procedures for conducting family-driven and youth-guided planning, to which minors and their families have contributed, and would have to periodically review and adjust them as necessary.

A minor or the minor's parent could request and receive independent facilitation of family-driven and youth-guided planning and could designate an individual to represent or assist the minor and family in the process.

A minor or the minor's parent would have to have available mechanisms to use a service payer or provider other than the involved service manager, service payer, or provider to file a grievance or appeal perceived problems with family-driven and youth-guided planning processes.

The bill states that utilization management is not a substitute for, and should not supplant, the outcomes of family-driven and youth-guided planning.

[3] https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438/subpart-D/section-438.210

Service authorizations would have to be completed within time frames as specified in 42 CFR 438.210.

Within one business day of a decision to deny a service authorization request or to authorize a service in an amount, scope, and duration that are less than requested, the minor and the minor's family receiving services and the requesting provider would have to be notified in writing of that decision.

Behavioral Health Oversight Council

The bill would create the Behavioral Health Oversight Council in DHHS. The council would have to equitably reflect the geographic and demographic characteristics of individuals served by the public behavioral health system. At least 33% of its members would have to be primary recipients of the system, their families, or individuals in recovery from behavioral health conditions served by the system. The council also would have to reflect experience and expertise in administering and delivering public-funded behavioral health services to children and adults with mental illness, emotional disturbance, intellectual or developmental disability, or substance use disorder. The council would have to include a behavioral health or physical health medical professional. The council would consist of the following members:

- Fifteen voting members:
  - Five members who are recipients of the public behavioral health system, their families, or former recipients in recovery. (At least three would have to be current recipients.)
  - One member from each of the ten prosperity regions identified by the Department of Technology, Management, and Budget (DTMB).
- Up to four nonvoting members appointed by the DHHS director to represent DHHS and departmental agencies related to delivering public behavioral health and intellectual or developmental disability services.

The governor and the majority and minority leaders of the House and Senate would each appoint three of the voting members and would have to do so within 60 days after the bill's effective date. Members would serve three-year terms or until appointment of a successor, whichever is later, and could serve up to two terms. Council members would serve without compensation but could be reimbursed for actual and necessary expenses incurred in the performance of their official duties. The bill provides for the filling of vacancies and removal of members for such issues as incompetence and dereliction of duty.

The DHHS director or his or her designee would have to call the first meeting of the council within 90 days after the bill's effective date. The council would elect a chairperson and officers at its first meeting and would meet at least quarterly thereafter. (It could meet more frequently at the call of the chair or if requested by at least two-thirds of its members.) A majority of the members would constitute a quorum for the transaction of business at a meeting, and a majority of the members present and serving would be required for official action. Meetings would have to be held in compliance with the Open Meetings Act, and council documents would have to be made available to the public in compliance with the Freedom of Information Act.

The council would have to make specific recommendations on matters related to the planning and execution of public behavioral health services, including doing each of the following:

- Review of services under the chapters of the code that govern county community mental health programs and substance use disorder services and any other pertinent law or regulation for the provision of public behavioral health services.
- Review of periodic reports on the program activities, finances, and outcomes, including reports on achievement of service delivery system goals.
- Report annually to the legislature regarding the council's activities and the ASO that includes service outcomes for individuals served.

Council committees

The council would have to establish standing and ad hoc committees to carry out its duties, including a substance use disorder oversight policy committee, a clinical oversight committee, a financial oversight committee, and a consumer oversight committee. The committees and subcommittees would have to meet the same geographic and demographic equity requirements that apply to the council as a whole.

The substance use disorder oversight policy committee would provide advice and recommendations regarding the dissemination of funding by DHHS for substance use disorder treatment, prevention, or recovery services in the context of state, federal, and local laws or regulations. The committee also would provide advice and recommendations to ensure an adequate network of substance use disorder treatment, prevention, or recovery providers.

The clinical oversight committee would have to consist of an independent expert panel including at least independent experts in psychiatry, pediatrics, and internal medicine, and representatives from the consumer oversight committee. The clinical oversight committee would have to perform the following functions:

- Based on a review of the current literature, develop treatment protocols for the diagnoses or conditions being treated by the local behavioral health service providers to ensure that quality care is available to all consumers.
- Provide oversight regarding required clinical and person-centered outcomes that are to be included in service delivery models.
- Along with DHHS, and after a review of the current literature and consultation with national experts as needed, develop a model for front-line integration of physical and behavioral health care.
- Provide advice and recommendations regarding integrated care.
- Present the committee's report to the legislature. The report must include the treatment protocols and model of integration, as well as the outcome measures and recommendations for improvements if needed.

Repealers

Finally, the bill would repeal seven sections of the code, briefly described as follows:

- Section 110, which created the Citizens Mental Health Advisory Council.
- Section 204b, which allows the creation of a regional entity (a combination of community mental health organizations or authorities).
- Section 232b, which establishes standards for specialty prepaid health plans.
- Section 287, which contains requirements for DHHS-designated community mental health entities, specifically in regard to substance use disorder services and funding.

- Section 753, which requires DHHS review of recipient rights systems under specified standards.
- Section 755, which requires each CMHSP and licensed hospital to establish an office or recipient rights.
- Section 758, which generally requires a licensed hospital to appoint a recipient rights advisory committee.

House Bill 4925 would not take effect unless HB 4926 were also enacted.

MCL 300.100a et seq.

House Bill 4926 would amend the Social Welfare Act to mirror the description of DHHS's provision of behavioral health services in HB 4925.

Currently, the act requires DHHS to support the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries with *serious* mental illness, developmental disability, *serious* emotional disturbance, or substance use disorder. The bill would add intellectual disability to this list and remove both instances of the word "serious" (italicized above).

The bill would retain the provision that, generally, Medicaid-covered specialty services and supports be managed and delivered by specialty prepaid health plans chosen by DHHS. However, it would provide that, within one year of the bill's effective date, DHHS would have to use a self-insured financing and delivery system structure to provide or arrange for the delivery and integration of those services for eligible Medicaid beneficiaries with the specified conditions. These specialty services and supports would have to be carved out from the basic Medicaid health care benefits package. Medicaid beneficiaries currently receiving limited behavioral health services through the basic Medicaid health care benefits package could continue to do so or choose to receive behavioral health services through the self-insured financing and delivery system structure.

Within 180 days after the bill's effective date, DHHS would have to create an implementation plan and timeline to execute the above provisions and report that plan and timeline to the legislature for review. Upon legislative review, and no later than three years after the bill's effective date, DHHS would have to fully implement the above provisions in accordance with the implementation plan.

House Bill 4926 would not take effect unless HB 4925 were also enacted.

MCL 400.109f

House Bill 4927 would amend the Public Health Code. Currently, before imposing sentence or entering a juvenile disposition for a controlled substance offense, the court may order the individual to undergo screening and assessment by a person or agency as designated by a DHHS-designated community mental health entity or by a CMHSP program under the Mental Health Code to determine whether the individual would benefit from rehabilitative services. The bill would instead require the screening and assessment to be conducted by a person or

agency as designated by *DHHS*, a DHHS-designated community mental health entity, or a CMHSP.

MCL 333.7408a

House Bill 4928 would amend the Michigan Liquor Control Code. Currently, a minor who purchases, consumes, or possesses alcohol, attempts to do so, or has any bodily alcohol content must undergo screening and assessment by a person or agency as designated by the DHHS-designated community mental health entity to determine whether the minor would benefit from rehabilitative services. The bill would instead require the screening and assessment to be conducted by a person or agency as designated by *DHHS or* the DHHS-designated community mental health entity.

MCL 436.1703

House Bill 5894 would amend the Foster Care and Adoption Services Act to revise a citation to provisions of the Mental Health Code that would be renumbered by House Bill 4925. The bill would not take effect unless House Bill 4925 were also enacted.

722.954c

FISCAL IMPACT:

These bills would have a significant fiscal impact on the state and local units of government by increasing access to, and corresponding utilization of, specialty behavioral health supports and services and by reducing administrative costs by moving to an ASO instead of utilizing 10 prepaid inpatient health plans (PIHPs) for Medicaid-funded specialty behavioral health supports and services.

Local PIHPs and their network of CMHSPs currently manage Medicaid-funded specialty behavioral health supports and services. With an ASO assisting DHHS with administering specialty behavioral health supports and services, the local CMHSPs would no longer be responsible for, and no longer be reimbursed for the administrative costs of, managing Medicaid-funded specialty behavioral health supports and services.

After a first year that may cost the state $3.0 million gross ($1.0 million GF/GP) due to transitional costs for DHHS to enter into a contract with an ASO to assist with Medicaid-funded specialty behavioral health supports and services, along with policy planning and any possible rule promulgation, the second year may see implementation costs for staffing, IT, and transitional costs that would be moderate to significant, and the third year would see a significant reduction in administrative costs, with the following years' administrative costs remaining fairly static. In general, ASOs have lower administrative costs than managed care organizations (such as PIHPs). This fiscal analysis assumes that administrative costs will be reduced by at least 2.0 percentage points, reducing administrative costs paid through the state Medicaid program by approximately $70.0 million Gross ($20.0 million GF/GP) on an ongoing basis.

These bills would increase access to specialty behavioral health supports and services by no longer specifically providing that supports and services are available to individuals with

"serious" mental illness, developmental disability, emotional disturbance, or substance use disorder, but instead allowing those services and supports to be available to any individuals with mental illness, emotional disturbance, intellectual or developmental disability, or substance use disorder. This change would allow an individual with mild to moderate mental illness to access specialty behavioral health supports and services as long as a medical provider determines that the services are medically necessary. This fiscal analysis assumes that, after a year of administrative planning and contracting with an ASO to assist with Medicaid-funded specialty behavioral health supports and services, the average annual growth in Medicaid behavioral health utilization and its related costs would increase by 0.5 to 1.0 percentage points or from $18.0 million Gross ($5.0 million GF/GP) to $36.0 million Gross ($10.0 million GF/GP) annually. This increase in Medicaid behavioral health utilization would gradually return to historic averages over a number of years, once provider capacity and behavioral health utilization requests equalize. Medicaid is a state and federally administered health care program, with the federal government reimbursing the state for approximately 75% of the gross cost.

These bills could also impact the amount of revenue the state receives from the Insurance Provider Assessment (IPA). Depending on the level at which the ASO "assists" DHHS in managing Medicaid-funded specialty behavioral health supports and services, the state may no longer be able to utilize the ASO, which could replace the PIHPs, as an entity that could be assessed the IPA. As the bills are permissive in the scale at which the ASO "assists" DHHS, the fiscal impact is indeterminate, but could be significant.

The Behavioral Health Oversight Council would have a negligible fiscal impact.

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■ This analysis was prepared by nonpartisan House Fiscal Agency staff for use by House members in their deliberations and does not constitute an official statement of legislative intent.