SUBSTITUTE FOR

SENATE BILL NO. 597

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

by amending sections 105d and 109f (MCL 400.105d and 400.109f), section 105d as amended by 2018 PA 208 and section 109f as amended by 2017 PA 224.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

1 Sec. 105d. (1) The department shall seek a waiver from the
2 United States Department of Health and Human Services to do,
3 without jeopardizing federal match dollars or otherwise incurring
4 federal financial penalties, and upon approval of the waiver shall
5 do, all of the following:
6 (a) Enroll individuals eligible under section
7 1396a(a)(10)(A)(*i*)(VIII) of title XIX who meet the citizenship

provisions of 42 CFR 435.406 and who are otherwise eligible for the medical assistance program under this act into a contracted health plan that provides for an account into which money from any source, including, but not limited to, the enrollee, the enrollee's employer, and private or public entities on the enrollee's behalf, can be deposited to pay for incurred health expenses, including, but not limited to, co-pays. The account shall be administered by the department and can be delegated to a contracted health plan or a third party administrator, as considered necessary.

(b) Ensure that contracted health plans track all enrollee co-pays incurred for the first 6 months that an individual is enrolled in the program described in subdivision (a) and calculate the average monthly co-pay experience for the enrollee. The average co-pay amount shall be adjusted at least annually to reflect changes in the enrollee's co-pay experience. The department shall ensure that each enrollee receives quarterly statements for his or her account that include expenditures from the account, account balance, and the cost-sharing amount due for the following 3 months. The enrollee ~~shall be required to~~ **must** remit each month the average co-pay amount calculated by the contracted health plan into the enrollee's account. The department shall pursue a range of consequences for enrollees who consistently fail to meet their cost-sharing requirements, including, but not limited to, using the MIChild program as a template and closer oversight by health plans in access to providers.

(c) Give enrollees described in subdivision (a) a choice in choosing among contracted health plans.

(d) Ensure that all enrollees described in subdivision (a) have access to a primary care practitioner who is licensed,

registered, or otherwise authorized to engage in his or her health care profession in this state and to preventive services. The department shall require that all new enrollees be assigned and have scheduled an initial appointment with their primary care practitioner within 60 days of initial enrollment. The department shall monitor and track contracted health plans for compliance in this area and consider that compliance in any health plan incentive programs. The department shall ensure that the contracted health plans have procedures to ensure that the privacy of the enrollees' personal information is protected in accordance with the health insurance portability and accountability act of 1996, Public Law 104-191.

(e) Require enrollees described in subdivision (a) with annual incomes between 100% and 133% of the federal poverty guidelines to contribute not more than 5% of income annually for cost-sharing requirements. Cost-sharing includes co-pays and required contributions made into the accounts authorized under subdivision (a). Contributions required in this subdivision do not apply for the first 6 months an individual described in subdivision (a) is enrolled. Required contributions to an account used to pay for incurred health expenses shall be 2% of income annually. Except as otherwise provided in subsection (20), notwithstanding this minimum, required contributions may be reduced by the contracting health plan. The reductions may occur only if healthy behaviors are being addressed as attested to by the contracted health plan based on uniform standards developed by the department in consultation with the contracted health plans. The uniform standards ~~shall~~ **must** include healthy behaviors such as completing a department approved annual health risk assessment to identify unhealthy

1 characteristics, including alcohol use, substance use disorders,
2 tobacco use, obesity, and immunization status. Except as otherwise
3 provided in subsection (20), co-pays can be reduced if healthy
4 behaviors are met, but not until annual accumulated co-pays reach
5 2% of income except co-pays for specific services may be waived by
6 the contracted health plan if the desired outcome is to promote
7 greater access to services that prevent the progression of and
8 complications related to chronic diseases. If the enrollee
9 described in subdivision (a) becomes ineligible for medical
10 assistance under the program described in this section, the
11 remaining balance in the account described in subdivision (a) shall
12 be returned to that enrollee in the form of a voucher for the sole
13 purpose of purchasing and paying for private insurance.
14 (f) Implement a co-pay structure that encourages use of high-
15 value services, while discouraging low-value services such as
16 nonurgent emergency department use.
17 (g) During the enrollment process, inform enrollees described
18 in subdivision (a) about advance directives and require the
19 enrollees to complete a department-approved advance directive on a
20 form that includes an option to decline. The advance directives
21 received from enrollees as provided in this subdivision shall be
22 transmitted to the peace of mind registry organization to be placed
23 on the peace of mind registry.
24 (h) Develop incentives for enrollees and providers who assist
25 the department in detecting fraud and abuse in the medical
26 assistance program. The department shall provide an annual report
27 that includes the type of fraud detected, the amount saved, and the
28 outcome of the investigation to the legislature.
29 (i) Allow for services provided by telemedicine from a

1 practitioner who is licensed, registered, or otherwise authorized
2 under section 16171 of the public health code, 1978 PA 368, MCL
3 333.16171, to engage in his or her health care profession in the
4 state where the patient is located.
5 **(j) Allow for services to be provided by a specialty**
6 **integrated plan as described in section 109f(3).**
7 (2) For services rendered to an uninsured individual, a
8 hospital that participates in the medical assistance program under
9 this act shall accept 115% of Medicare rates as payments in full
10 from an uninsured individual with an annual income level up to 250%
11 of the federal poverty guidelines. This subsection applies whether
12 or not either or both of the waivers requested under this section
13 are approved, the patient protection and affordable care act is
14 repealed, or the state terminates or opts out of the program
15 established under this section.
16 (3) Not more than 7 calendar days after receiving each of the
17 official waiver-related written correspondence from the United
18 States Department of Health and Human Services to implement the
19 provisions of this section, the department shall submit a written
20 copy of the approved waiver provisions to the legislature for
21 review.
22 (4) The department shall develop and implement a plan to
23 enroll all existing fee-for-service enrollees into contracted
24 health plans if allowable by law, if the medical assistance program
25 is the primary payer and if that enrollment is cost-effective. This
26 includes all newly eligible enrollees as described in subsection
27 (1)(a). The department shall include contracted health plans as the
28 mandatory delivery system in its waiver request. The department
29 also shall pursue any and all necessary waivers to enroll persons

1 eligible for both Medicaid and Medicare into the 4 integrated care
2 demonstration regions. The department shall identify all remaining
3 populations eligible for managed care, develop plans for their
4 integration into managed care, and provide recommendations for a
5 performance bonus incentive plan mechanism for long-term care
6 managed care providers that are consistent with other managed care
7 performance bonus incentive plans. The department shall make
8 recommendations for a performance bonus incentive plan for long-
9 term care managed care providers of up to 3% of their Medicaid
10 capitation payments, consistent with other managed care performance
11 bonus incentive plans. These payments ~~shall~~ **must** comply with
12 federal requirements and ~~shall~~ **must** be based on measures that
13 identify the appropriate use of long-term care services and that
14 focus on consumer satisfaction, consumer choice, and other
15 appropriate quality measures applicable to community-based and
16 nursing home services. Where appropriate, these quality measures
17 ~~shall~~ **must** be consistent with quality measures used for similar
18 services implemented by the integrated care for duals demonstration
19 project. This subsection applies whether or not either or both of
20 the waivers requested under this section are approved, the patient
21 protection and affordable care act is repealed, or the state
22 terminates or opts out of the program established under this
23 section.
24 (5) The department shall implement a pharmaceutical benefit
25 that utilizes co-pays at appropriate levels allowable by the
26 Centers for Medicare and Medicaid Services to encourage the use of
27 high-value, low-cost prescriptions, such as generic prescriptions
28 when such an alternative exists for a branded product and 90-day
29 prescription supplies, as recommended by the enrollee's prescribing

1 provider and as is consistent with section 109h and ~~sections 9701~~
2 ~~to 9709~~ **part 97** of the public health code, 1978 PA 368, MCL
3 333.9701 to 333.9709. This subsection applies whether or not either
4 or both of the waivers requested under this section are approved,
5 the patient protection and affordable care act is repealed, or the
6 state terminates or opts out of the program established under this
7 section.
8 (6) The department shall work with providers, contracted
9 health plans, and other departments as necessary to create
10 processes that reduce the amount of uncollected cost-sharing and
11 reduce the administrative cost of collecting cost-sharing. To this
12 end, a minimum 0.25% of payments to contracted health plans shall
13 be withheld for the purpose of establishing a cost-sharing
14 compliance bonus pool beginning October 1, 2015. The distribution
15 of funds from the cost-sharing compliance pool shall be based on
16 the contracted health plans' success in collecting cost-sharing
17 payments. The department shall develop the methodology for
18 distribution of these funds. This subsection applies whether or not
19 either or both of the waivers requested under this section are
20 approved, the patient protection and affordable care act is
21 repealed, or the state terminates or opts out of the program
22 established under this section.
23 (7) The department shall develop a methodology that decreases
24 the amount an enrollee's required contribution may be reduced as
25 described in subsection (1)(e) based on, but not limited to,
26 factors such as an enrollee's failure to pay cost-sharing
27 requirements and the enrollee's inappropriate utilization of
28 emergency departments.
29 (8) The program described in this section is created in part

1 to extend health coverage to the state's low-income citizens and to
2 provide health insurance cost relief to individuals and to the
3 business community by reducing the cost shift attendant to
4 uncompensated care. Uncompensated care does not include courtesy
5 allowances or discounts given to patients. The Medicaid hospital
6 cost report shall be part of the uncompensated care definition and
7 calculation. In addition to the Medicaid hospital cost report, the
8 department shall collect and examine other relevant financial data
9 for all hospitals and evaluate the impact that providing medical
10 coverage to the expanded population of enrollees described in
11 subsection (1)(a) has had on the actual cost of uncompensated care.
12 This shall be reported for all hospitals in the state. By December
13 31, 2014, the department shall make an initial baseline
14 uncompensated care report containing at least the data described in
15 this subsection to the legislature and each December 31 after that
16 shall make a report regarding the preceding fiscal year's evidence
17 of the reduction in the amount of the actual cost of uncompensated
18 care compared to the initial baseline report. The baseline report
19 shall use fiscal year 2012-2013 data. Based on the evidence of the
20 reduction in the amount of the actual cost of uncompensated care
21 borne by the hospitals in this state, the department shall
22 proportionally reduce the disproportionate share payments to all
23 hospitals and hospital systems for the purpose of producing general
24 fund savings. The department shall recognize any savings from this
25 reduction by September 30, 2016. All the reports required under
26 this subsection shall be made available to the legislature and
27 shall be easily accessible on the department's website.
28 (9) The department of insurance and financial services shall
29 examine the financial reports of health insurers and evaluate the

1 impact that providing medical coverage to the expanded population
2 of enrollees described in subsection (1)(a) has had on the cost of
3 uncompensated care as it relates to insurance rates and insurance
4 rate change filings, as well as its resulting net effect on rates
5 overall. The department of insurance and financial services shall
6 consider the evaluation described in this subsection in the annual
7 approval of rates. By December 31, 2014, the department of
8 insurance and financial services shall make an initial baseline
9 report to the legislature regarding rates and each December 31
10 after that shall make a report regarding the evidence of the change
11 in rates compared to the initial baseline report. All the reports
12 required under this subsection shall be made available to the
13 legislature and shall be made available and easily accessible on
14 the department's website.
15 (10) The department shall explore and develop a range of
16 innovations and initiatives to improve the effectiveness and
17 performance of the medical assistance program and to lower overall
18 health care costs in this state. The department shall report the
19 results of the efforts described in this subsection to the
20 legislature and to the house and senate fiscal agencies by
21 September 30, 2015. The report required under this subsection shall
22 also be made available and easily accessible on the department's
23 website. The department shall pursue a broad range of innovations
24 and initiatives as time and resources allow that shall include, at
25 a minimum, all of the following:
26 (a) The value and cost-effectiveness of optional Medicaid
27 benefits as described in federal statute.
28 (b) The identification of private sector, primarily small
29 business, health coverage benefit differences compared to the

medical assistance program services and justification for the differences.

(c) The minimum measures and data sets required to effectively measure the medical assistance program's return on investment for taxpayers.

(d) Review and evaluation of the effectiveness of current incentives for contracted health plans, providers, and beneficiaries with recommendations for expanding and refining incentives to accelerate improvement in health outcomes, healthy behaviors, and cost-effectiveness and review of the compliance of required contributions and co-pays.

(e) Review and evaluation of the current design principles that serve as the foundation for the state's medical assistance program to ensure the program is cost-effective and that appropriate incentive measures are utilized. The review shall include, at a minimum, the auto-assignment algorithm and performance bonus incentive pool. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(f) The identification of private sector initiatives used to incent individuals to comply with medical advice.

(11) By December 31, 2015, the department shall review and report to the legislature the feasibility of programs recommended by multiple national organizations that include, but are not limited to, the ~~council of state governments, the national conference of state legislatures, and the American legislative exchange council,~~ **Council of State Governments, the National**

Conference of State Legislatures, and the American Legislative Exchange Council, on improving the cost-effectiveness of the medical assistance program.

(12) The department in collaboration with the contracted health plans and providers shall create financial incentives for all of the following:

(a) Contracted health plans that meet specified population improvement goals.

(b) Providers who meet specified quality, cost, and utilization targets.

(c) Enrollees who demonstrate improved health outcomes or maintain healthy behaviors as identified in a health risk assessment as identified by their primary care practitioner who is licensed, registered, or otherwise authorized to engage in his or her health care profession in this state. This subsection applies whether or not either or both of the waivers requested under this section are approved, the patient protection and affordable care act is repealed, or the state terminates or opts out of the program established under this section.

(13) The performance bonus incentive pool for contracted health plans that are not specialty prepaid health plans **or specialty integrated plans** shall include inappropriate utilization of emergency departments, ambulatory care, contracted health plan all-cause acute 30-day readmission rates, and generic drug utilization when such an alternative exists for a branded product and consistent with section 109h and ~~sections 9701 to 9709~~ **part 97** of the public health code, 1978 PA 368, MCL 333.9701 to 333.9709, as a percentage of total. These measurement tools ~~shall~~ **must** be considered and weighed within the 6 highest factors used in the

1 formula. This subsection applies whether or not either or both of
2 the waivers requested under this section are approved, the patient
3 protection and affordable care act is repealed, or the state
4 terminates or opts out of the program established under this
5 section.
6 (14) The department shall ensure that all capitated payments
7 made to contracted health plans are actuarially sound. This
8 subsection applies whether or not either or both of the waivers
9 requested under this section are approved, the patient protection
10 and affordable care act is repealed, or the state terminates or
11 opts out of the program established under this section.
12 (15) The department shall maintain administrative costs at a
13 level of not more than 1% of the department's appropriation of the
14 state medical assistance program. These administrative costs shall
15 be capped at the total administrative costs for the fiscal year
16 ending September 30, 2016, except for inflation and project-related
17 costs required to achieve medical assistance net general fund
18 savings. This subsection applies whether or not either or both of
19 the waivers requested under this section are approved, the patient
20 protection and affordable care act is repealed, or the state
21 terminates or opts out of the program established under this
22 section.
23 (16) The department shall establish uniform procedures and
24 compliance metrics for utilization by the contracted health plans
25 to ensure that cost-sharing requirements are being met. This shall
26 include ramifications for the contracted health plans' failure to
27 comply with performance or compliance metrics. This subsection
28 applies whether or not either or both of the waivers requested
29 under this section are approved, the patient protection and

1 affordable care act is repealed, or the state terminates or opts
2 out of the program established under this section.
3 (17) The department shall withhold, at a minimum, 0.75% of
4 payments to contracted health plans, except for specialty prepaid
5 health plans **or specialty integrated plans**, for the purpose of
6 expanding the existing performance bonus incentive pool.
7 Distribution of funds from the performance bonus incentive pool is
8 contingent on the contracted health plan's completion of the
9 required performance or compliance metrics. This subsection applies
10 whether or not either or both of the waivers requested under this
11 section are approved, the patient protection and affordable care
12 act is repealed, or the state terminates or opts out of the program
13 established under this section.
14 (18) The department shall withhold, at a minimum, 0.75% of
15 payments to specialty prepaid health plans **or specialty integrated**
16 **plans** for the purpose of establishing a performance bonus incentive
17 pool. Distribution of funds from the performance bonus incentive
18 pool is contingent on the specialty prepaid health plan's **or**
19 **specialty integrated plan's** completion of the required performance
20 of compliance metrics that shall include, at a minimum, partnering
21 with other contracted health plans to reduce nonemergent emergency
22 department utilization, increased participation in patient-centered
23 medical homes, increased use of electronic health records and data
24 sharing with other providers, and identification of enrollees who
25 may be eligible for services through the United States Department
26 of Veterans Affairs. This subsection applies whether or not either
27 or both of the waivers requested under this section are approved,
28 the patient protection and affordable care act is repealed, or the
29 state terminates or opts out of the program established under this

1 section.

2 (19) ~~The~~ **Except as otherwise required under section 109f, the**
3 department shall measure contracted health plan, ~~or~~ specialty
4 prepaid health plan**, or specialty integrated plan** performance
5 metrics, as applicable, on application of standards of care as that
6 relates to appropriate treatment of substance use disorders and
7 efforts to reduce substance use disorders. This subsection applies
8 whether or not either or both of the waivers requested under this
9 section are approved, the patient protection and affordable care
10 act is repealed, or the state terminates or opts out of the program
11 established under this section.

12 (20) By October 1, 2018, in addition to the waiver requested
13 in subsection (1), the department shall seek an additional waiver
14 from the United States Department of Health and Human Services that
15 requires individuals who are between 100% and 133% of the federal
16 poverty guidelines and who have had medical assistance coverage for
17 48 cumulative months beginning on the date of their enrollment into
18 the program described in subsection (1) by the date of the waiver
19 implementation to choose 1 of the following options:

20 (a) Complete a healthy behavior as provided in subsection
21 (1)(e) with intentional effort given to making subsequent year
22 healthy behaviors incrementally more challenging in order to
23 continue to focus on eliminating health-related obstacles
24 inhibiting enrollees from achieving their highest levels of
25 personal productivity and pay a premium of 5% of income. A required
26 contribution for a premium is not eligible for reduction or refund.

27 (b) Suspend eligibility for the program described in
28 subsection (1)(a) until the individual complies with subdivision
29 (a).

(21) The department shall notify enrollees 60 days before the enrollee would lose coverage under the current program that this coverage is no longer available to them and that, in order to continue coverage, the enrollee must comply with the option described in subsection (20)(a).

(22) The medical coverage for individuals described in subsection (1)(a) shall remain in effect for not longer than a 16-month period after submission of a new or amended waiver request under subsection (20) if a new or amended waiver request is not approved within 12 months after submission. The department must notify individuals described in subsection (1)(a) that their coverage will be terminated by February 1, 2020 if a new or amended waiver request is not approved within 12 months after submission.

(23) If a new or amended waiver requested under subsection (20) is denied by the United States Department of Health and Human Services, medical coverage for individuals described in subsection (1)(a) shall remain in effect for a 16-month period after the date of submission of the new or amended waiver request unless the United States Department of Health and Human Services approves a new or amended waiver described in this subsection within the 12 months after the date of submission of the new or amended waiver request. A request for a new or amended waiver under this subsection must comply with the other requirements of this section and must be provided to the chairs of the senate and house of representatives appropriations committees and the chairs of the senate and house of representatives appropriations subcommittees on the department budget, at least 30 days before submission to the United States Department of Health and Human Services. If a new or amended waiver request under this subsection is not approved within

1 the 12-month period described in this subsection, the department
2 must give 4 months' notice that medical coverage for individuals
3 described in subsection (1)(a) shall be terminated.
4 (24) If a new or amended waiver requested under subsection
5 (20) is canceled by the United States Department of Health and
6 Human Services or is invalidated, medical coverage for individuals
7 described in subsection (1)(a) shall remain in effect for 16 months
8 after the date of submission of a new or amended waiver unless the
9 United States Department of Health and Human Services approves a
10 new or amended waiver described in this subsection within the 12
11 months after the date of submission of the new or amended waiver. A
12 request for a new or amended waiver under this subsection must
13 comply with the other requirements of this section and must be
14 provided to the chairs of the senate and house of representatives
15 appropriations committees and the senate and house of
16 representatives appropriations subcommittees on the department
17 budget at least 30 days before submission to the United States
18 Department of Health and Human Services. If a new or amended waiver
19 under this subsection is not approved within the 12-month period
20 described in this subsection, the department must give 4 months'
21 notice that medical coverage for individuals described in
22 subsection (1)(a) shall be terminated.
23 (25) If a new or amended waiver request under subsection (23)
24 or (24) is approved by the United States Department of Health and
25 Human Services but does not comply with the other requirements of
26 this section, medical coverage for individuals described in
27 subsection (1)(a) shall be terminated 4 months after the new or
28 amended waiver has been determined to be in noncompliance. The
29 department must notify individuals described in subsection (1)(a)

1 at least 4 months before the termination date that enrollment shall
2 be terminated and the reason for termination.
3 (26) Individuals described in 42 CFR 440.315 are not subject
4 to the provisions of the waiver described in subsection (20).
5 (27) The department shall make available at least 3 years of
6 state medical assistance program data, without charge, to any
7 vendor considered qualified by the department who indicates
8 interest in submitting proposals to contracted health plans in
9 order to implement cost savings and population health improvement
10 opportunities through the use of innovative information and data
11 management technologies. Any program or proposal to the contracted
12 health plans must be consistent with the state's goals of improving
13 health, increasing the quality, reliability, availability, and
14 continuity of care, and reducing the cost of care of the eligible
15 population of enrollees described in subsection (1)(a). The use of
16 the data described in this subsection for the purpose of assessing
17 the potential opportunity and subsequent development and submission
18 of formal proposals to contracted health plans is not a cost or
19 contractual obligation to the department or the state.
20 (28) This section does not apply if either of the following
21 occurs:
22 (a) If the department is unable to obtain either of the
23 federal waivers requested in subsection (1) or (20).
24 (b) If federal government matching funds for the program
25 described in this section are reduced below 100% and annual state
26 savings and other nonfederal net savings associated with the
27 implementation of that program are not sufficient to cover the
28 reduced federal match. The department shall determine and the state
29 budget office shall approve how annual state savings and other

1 nonfederal net savings shall be calculated by June 1, 2014. By
2 September 1, 2014, the calculations and methodology used to
3 determine the state and other nonfederal net savings shall be
4 submitted to the legislature. The calculation of annual state and
5 other nonfederal net savings shall be published annually on January
6 15 by the state budget office. If the annual state savings and
7 other nonfederal net savings are not sufficient to cover the
8 reduced federal match, medical coverage for individuals described
9 in subsection (1)(a) shall remain in effect until the end of the
10 fiscal year in which the calculation described in this subdivision
11 is published by the state budget office.
12 (29) The department shall develop, administer, and coordinate
13 with the department of treasury a procedure for offsetting the
14 state tax refunds of an enrollee who owes a liability to the state
15 of past due uncollected cost-sharing, as allowable by the federal
16 government. The procedure shall include a guideline that the
17 department submit to the department of treasury, not later than
18 November 1 of each year, all requests for the offset of state tax
19 refunds claimed on returns filed or to be filed for that tax year.
20 For the purpose of this subsection, any nonpayment of the cost-
21 sharing required under this section owed by the enrollee is
22 considered a liability to the state under section 30a(2)(b) of 1941
23 PA 122, MCL 205.30a.
24 (30) For the purpose of this subsection, any nonpayment of the
25 cost-sharing required under this section owed by the enrollee is
26 considered a current liability to the state under section 32 of the
27 McCauley-Traxler-Law-Bowman-McNeely lottery act, 1972 PA 239, MCL
28 432.32, and shall be handled in accordance with the procedures for
29 handling a liability to the state under that section, as allowed by

1 the federal government.
2 (31) By November 30, 2013, the department shall convene a
3 symposium to examine the issues of emergency department
4 overutilization and improper usage. The department shall submit a
5 report to the legislature that identifies the causes of
6 overutilization and improper emergency service usage that includes
7 specific best practice recommendations for decreasing
8 overutilization of emergency departments and improper emergency
9 service usage, as well as how those best practices are being
10 implemented. Both broad recommendations and specific
11 recommendations related to the Medicaid program, enrollee behavior,
12 and health plan access issues shall be included.
13 (32) The department shall contract with an independent third
14 party vendor to review the reports required in subsections (8) and
15 (9) and other data as necessary, in order to develop a methodology
16 for measuring, tracking, and reporting medical cost and
17 uncompensated care cost reduction or rate of increase reduction and
18 their effect on health insurance rates along with recommendations
19 for ongoing annual review. The final report and recommendations
20 shall be submitted to the legislature by September 30, 2015.
21 (33) For the purposes of submitting reports and other
22 information or data required under this section only, "legislature"
23 means the senate majority leader, the speaker of the house of
24 representatives, the chairs of the senate and house of
25 representatives appropriations committees, the chairs of the senate
26 and house of representatives appropriations subcommittees on the
27 department budget, and the chairs of the senate and house of
28 representatives standing committees on health policy.
29 (34) As used in this section:

(a) "Patient protection and affordable care act" means the patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152.

(b) "Peace of mind registry" and "peace of mind registry organization" mean those terms as defined in section 10301 of the public health code, 1978 PA 368, MCL 333.10301.

(c) "State savings" means any state fund net savings, calculated as of the closing of the financial books for the department at the end of each fiscal year, that result from the program described in this section. The savings shall result in a reduction in spending from the following state fund accounts: adult benefit waiver, non-Medicaid community mental health, and prisoner health care. Any identified savings from other state fund accounts shall be proposed to the house of representatives and senate appropriations committees for approval to include in that year's state savings calculation. It is the intent of the legislature that for fiscal year ending September 30, 2014 only, $193,000,000.00 of the state savings shall be deposited in the roads and risks reserve fund created in section 211b of article VIII of 2013 PA 59.

(d) "Telemedicine" means that term as defined in section 3476 of the insurance code of 1956, 1956 PA 218, MCL 500.3476.

Sec. 109f. (1) The department shall support the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries with a serious mental illness, developmental disability, serious emotional disturbance, or substance use disorder. ~~Medicaid-covered~~ **Until specialty integrated plans are available to provide the specialty services and supports for all eligible Medicaid beneficiaries in accordance with the plan**

developed under subsection (3), Medicaid-covered specialty services and supports shall be managed and delivered by specialty prepaid health plans chosen by the department ~~. The specialty services and supports~~ **and** shall be carved out from the basic Medicaid health care benefits package.

(2) Specialty prepaid health plans are Medicaid managed care organizations as described in section 1903(m)(1)(A) of title XIX, 42 USC 1396b, and are responsible for providing defined inpatient services, outpatient hospital services, physician services, other specified Medicaid state plan services, and additional services approved by the Centers for Medicare and Medicaid Services under section 1915(b)(3) of title XIX, 42 USC 1396n.

(3) ~~This section does not apply to a pilot project authorized under section 298(3) of article X of 2017 PA 107.~~**The department shall establish a competitive contract and procurement process that outlines the eligibility requirements for entities to apply to operate as a specialty integrated plan. By not later than January 1, 2023, the department shall develop and begin implementation of a plan to fully integrate the administration of physical health care services and behavioral health specialty services and supports for eligible Medicaid beneficiaries with a serious mental illness, developmental disability, serious emotional disturbance, or substance use disorder and eligible Medicaid beneficiaries who are children in foster care. The plan required under this section shall provide for full integration and administration of physical health care services and behavioral health specialty services and supports through specialty integrated plans by 2030.**

(4) The department must use a procurement process for contracting with eligible specialty integrated plans to administer

the integrated and comprehensive Medicaid health care benefit package. The request for proposal must incorporate, but is not limited to, requirements pertaining to all of the following:

(a) Network adequacy.

(b) Staffing.

(c) Financial plans and risk-sharing.

(d) Quality improvement, quality assessment programs, or both.

(e) Care management, care coordination programs, or both.

(f) Five years of behavioral health experience.

(g) Five years of managed care experience.

(5) The plan developed under this section must also satisfy each of the following:

(a) Provide eligible Medicaid beneficiaries with the option to choose from at least 2 specialty integrated plans, unless a rural exemption has been granted by the Centers for Medicare and Medicaid Services.

(b) Require a specialty integrated plan to contract with each community mental health services program within its service area for the provision of behavioral health specialty services and supports, including, but not limited to, specialized residential services, respite care, community living supports, peer supports, and other services.

(c) Require a community mental health services program to contract with each specialty integrated plan within its service area to provide behavioral health specialty services and supports, including, but not limited to, specialized residential services, respite care, community living support services, peer supports, and other services. Community mental health services program reimbursement for contracted services shall be at the standardized

1 fee schedule established in subdivision (o) with the opportunity
2 for additional payments under value-based contracting incentive
3 arrangements.
4 (d) Require that the physical health care services and
5 behavioral health specialty services and supports provided by a
6 specialty integrated plan be person-centered.
7 (e) Include a process to ensure the readiness of all specialty
8 integrated plans, at each phase of the transition under subsection
9 (6), to administer the services previously funded through specialty
10 prepaid health plans for all of the eligible Medicaid beneficiaries
11 transitioning under that phase of the plan.
12 (f) Reduce inefficiencies in funding, coordination of care,
13 and service delivery.
14 (g) Generate uniformity with benefits, contracts, training
15 reciprocity, outcome measurement, care coordination, and
16 utilization management such as screenings and authorizations.
17 (h) Allow for portability throughout this state without a
18 change in access or benefits.
19 (i) Increase eligible Medicaid beneficiary choice of service
20 provider and delivery method.
21 (j) Allow for increased resources to be directed back into
22 care delivery and services through the reduction of administrative
23 layers and cost, including reinvestment of realized savings into
24 the integrated behavioral health system to further promote and
25 expand access to clinically integrated services and locations. At a
26 minimum, during the implementation time frame, savings shall be
27 actualized through the use of the risk corridor, and any amount of
28 money that is returned from the specialty integrated plan to the
29 state as part of the corridor reconciliation process is considered

1 savings.
2 (k) Allow for increased coordination, including data and
3 information sharing, with other providers, agencies, and
4 organizations that are part of an eligible Medicaid beneficiary's
5 plan of care.
6 (*l*) Standardize and centralize accountability for administering
7 and managing physical health care services and behavioral health
8 specialty services and supports services.
9 (m) Increase transparency and budget predictability.
10 (n) Establish a 2-way risk corridor for the plan implemented
11 under this section under which specialty integrated plans
12 participate in a payment adjustment system through December 31,
13 2025. In establishing the 2-way risk corridor under this
14 subdivision, medical expenses used in the risk corridor shall
15 include covered services and approved in-lieu-of services, benefit
16 expenses including incurred but not reported expenses within a time
17 frame developed by the department, as well as health care quality
18 improvement expenses as defined in 42 CFR 438.8(e)(3).
19 (o) Establish a Medicaid loss ratio that is based on
20 actuarially sound capitation rates and built on a standardized fee
21 schedule for all covered Medicaid behavioral health services.
22 (p) Ensure that any non-Medicaid general fund money, which the
23 department may choose to award to a specialty integrated plan
24 through a directed payment arrangement, is dispersed to the
25 community mental health service providers or other providers as
26 determined by the department, at 100% of the intended award. No
27 administrative fees are permitted.
28 (6) During development of the plan described in subsection
29 (5), the department shall consider incorporating the collaborative

1 care model into the benefit delivery system for specialty
2 integrated plans.
3 (7) The plan required under subsection (3) must provide for
4 the phased-in transition and enrollment of all eligible Medicaid
5 beneficiaries from a specialty prepaid health plan into a specialty
6 integrated plan within the following timeline:
7 (a) Within 2 years after the effective date of the amendatory
8 act that added this subsection, all eligible Medicaid beneficiaries
9 with a serious mental illness or serious emotional disturbance who
10 are considered children as provided within their respective
11 Medicaid program, including children in foster care, must be
12 enrolled in a specialty integrated plan.
13 (b) Within 2 years after the successful transition and
14 enrollment of those individuals described under subdivision (a),
15 all eligible Medicaid beneficiaries with a serious mental illness
16 or serious emotional disturbance that were not enrolled as part of
17 the populations described in subdivision (a) must be enrolled in a
18 specialty integrated plan.
19 (c) Within 2 years after the successful transition and
20 enrollment of those individuals described under subdivision (a),
21 all eligible Medicaid beneficiaries with a substance use disorder
22 must be enrolled in a specialty integrated plan.
23 (d) Within 2 years after the successful transition and
24 enrollment of those individuals described under subdivision (b),
25 all eligible Medicaid beneficiaries with a developmental disability
26 must be enrolled in a specialty integrated plan. Individuals with a
27 dual diagnosis must be enrolled during the time frame individuals
28 are enrolled under this subdivision.
29 (8) The department, in consultation with 1 representative from

1 **each of the interested parties, shall develop key metrics to be**
2 **used in determining whether or not each phase of the implementation**
3 **under subsection (7) for the transition and enrollment of those**
4 **eligible Medicaid beneficiaries into a contracted specialty**
5 **integrated plan has been successful. In developing the key metrics,**
6 **the department and representatives of the interested parties, must**
7 **ensure that the metrics are or do all of the following:**
8 **(a) Are tailored to each of the populations included in the**
9 **specific phase of implementation.**
10 **(b) Take into consideration lessons learned from any past**
11 **implementation efforts of other phases as described in subsection**
12 **(7) that may be applicable.**
13 **(c) Are developed and made publicly available at least 6**
14 **months before the phase of implementation.**
15 **(9) The department shall not consider the implementation of a**
16 **phase successful unless, based on the key metrics established under**
17 **this section, the implementation resulted in statistically**
18 **significant improvements in service delivery, health outcomes, and**
19 **access for those eligible Medicaid beneficiaries. At a minimum, the**
20 **key metrics must do all of the following:**
21 **(a) Focus on assessing individuals with behavioral health**
22 **diagnoses or physical and behavioral health comorbidities.**
23 **(b) Include measures related to patient-centered care,**
24 **including shared decision-making, patient education, provider-**
25 **patient communication, and patient or family experiences of care.**
26 **(c) Include evidence-based metrics to assess health outcomes,**
27 **coordination and continuity of care, utilization, cost, efficiency,**
28 **patient safety, and access to care.**
29 **(d) Include measures that utilize real-time performance data**

1 **of specialty integrated plans.**
2 **(e) Leverage standards from national resources, including, but**
3 **not limited to, the Centers for Medicare and Medicaid Services,**
4 **National Committee for Quality Assurance, Substance Abuse and**
5 **Mental Health Services Administration, and Agency for Healthcare**
6 **Research and Quality.**
7 **(10) During each implementation phase described in subsection**
8 **(7), the department, in consultation with the behavioral health**
9 **accountability council, must routinely monitor the progress of the**
10 **integration effort. The behavioral health accountability council is**
11 **responsible for completing a formal evaluation of each**
12 **implementation phase described in subsection (7) no later than 18**
13 **months after the effective date for each phase. At the time when**
14 **the formal evaluation is completed for each phase, the behavioral**
15 **health accountability council is responsible for providing an**
16 **evaluation on the status of the implementation and proposed**
17 **recommendations for the next steps to the department. The**
18 **department must use the behavioral health accountability council's**
19 **evaluation and recommendation as part of the process to assess and**
20 **determine the success of each implementation phase described in**
21 **subsection (7). The department must complete a formal evaluation of**
22 **each implementation phase described in subsection (7) no later than**
23 **20 months after the effective date for each phase. The department**
24 **must, at a minimum, use the predefined key metrics to assess the**
25 **current state of the integration phase and evaluate the**
26 **effectiveness of the integration effort. Within 60 days following**
27 **the evaluation required under this subsection, the department must**
28 **submit a report to the legislature with the findings, and include**
29 **with the report an assessment of whether the phase is considered**

1 **successful, unsuccessful, or undetermined. If the evaluation is**
2 **considered unsuccessful or undetermined, the department must**
3 **include a recommendation to do any of the following:**
4 **(a) Continue the integration phase as intended.**
5 **(b) Extend the duration of the phase to allow for further**
6 **evaluation time of that phase.**
7 **(c) Propose to reform, modify, or terminate the current phase**
8 **before the 2-year phase comes to an end. If this recommendation is**
9 **used, the department must work in coordination with the behavioral**
10 **health accountability council to determine the best option to use**
11 **to reform, modify, or terminate the phase.**
12 **(11) Except in a case of malfeasance or misfeasance, the**
13 **department shall require the prepaid inpatient health plan system**
14 **to maintain all current provider contractual arrangements**
15 **throughout the duration of the transition period. A prepaid**
16 **inpatient health plan shall not reduce provider choice within the**
17 **service networks by restructuring delegated services or altering**
18 **reimbursement rates during the transition period. A prepaid**
19 **inpatient health plan that reduces choice within the current**
20 **provider network or otherwise tampers with the structure of the**
21 **current network or its ability to continue providing services is**
22 **subject to economic sanctions, up to and including disqualification**
23 **from participating in a specialty integrated plan.**
24 **(12) The department shall ensure that all capitated payments**
25 **made to specialty integrated plans are actuarially sound as**
26 **provided under section 1903(m)(2)(A)(*iii*) of title XIX, 42 USC 1396b.**
27 **(13) The department must establish an annual reporting**
28 **requirement for specialty integrated plans. The reporting**
29 **requirement must be posted publicly and provided to the legislature**

1 in order to annually evaluate the success and efficacy of the
2 specialty integrated plan implementation. Five years after
3 implementation of the program, the legislature may review the
4 program's success and efficacy to determine if the program shall
5 continue.
6 (14) As used in this section:
7 (a) "Collaborative care model" means the evidence-based,
8 integrated behavioral health service delivery method that includes
9 a formal collaborative arrangement among a primary care team
10 consisting of a primary care provider, a care manager, and a
11 psychiatric consultant, and includes, but is not limited to, the
12 following elements:
13 (*i*) Care directed by the primary care team.
14 (*ii*) Structured care management.
15 (*iii*) Regular assessments of clinical status using validated
16 tools.
17 (*iv*) Modification of treatment as appropriate.
18 (b) "Community mental health services program" means that term
19 as defined in section 100a of the mental health code, 1974 PA 258,
20 MCL 330.1100a.
21 (c) "Foster care" means that term as defined in section 115f.
22 (d) "Integrated care network" means a public or private entity
23 that is composed of a network of organizations that provide or
24 arrange to provide a coordinated continuum of physical health care
25 services and behavioral health specialty services and supports for
26 a defined population and that are willing to be held clinically and
27 fiscally accountable for the outcomes and health status of that
28 defined population.
29 (e) "Interested parties" means the behavioral health advisory

1 **council established within the department, Arc Michigan,**
2 **Association for Children's Mental Health, Blue Cross Blue Shield of**
3 **Michigan, Community Mental Health Association of Michigan, Mental**
4 **Health Association of Michigan, MI Care Council, Michigan**
5 **Association of Alcoholism and Drug Abuse Counselors, Michigan**
6 **Association of Health Plans, Michigan Health and Hospital**
7 **Association, Michigan Primary Care Association, Michigan Protection**
8 **and Advocacy Service, Inc., Michigan Psychological Association,**
9 **Michigan State Medical Society, Michigan Psychiatric Society, and**
10 **National Alliance on Mental Illness-Michigan.**
11 **(f) "Specialty integrated plan" means a managed care**
12 **organization or a person operating a system of health care delivery**
13 **and financing as provided under section 3573 of the insurance code**
14 **of 1956, 1956 PA 218, MCL 500.3573, designated by the department as**
15 **a specialty integrated plan to provide or arrange for the**
16 **integration and delivery of comprehensive physical health care**
17 **services and the full array of behavioral health specialty services**
18 **and supports for eligible Medicaid beneficiaries with a serious**
19 **mental illness, developmental disability, serious emotional**
20 **disturbance, or substance use disorder and eligible Medicaid**
21 **beneficiaries who are children in foster care.**