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BILL ANALYSIS

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Senate Bill 597 (Substitute S-2 as reported)
Senate Bill 598 (Substitute S-2 as reported)
Sponsor: Senator Mike Shirkey (S.B. 597)
Senator John Bizon, M.D. (S.B. 598)

Date Completed: 11-19-21

## INTRODUCTION

This analysis represents the Senate Fiscal Agency's (SFA's) examination of the changes that Senate Bills 597 (S-2) and 598 (S-2) would make to current law regarding the provision of behavioral health services and supports, as well as their fiscal impact on State and local government. As discussed in greater detail below (see **CONTENT**), the bills would require the Department of Health and Human Services (DHHS) to develop and begin implementation of a phased-in plan to integrate the administration and provision of Medicaid physical health care services and behavioral health specialty services for behavioral health populations through the creation of specialty integrated plans (SIPs), beginning on January 1, 2023, and extending through 2030, and would make various changes to the Social Welfare Act and the Mental Health Code to effectuate those changes.

This analysis also includes a section (see **BACKGROUND**) presenting a discussion of the history regarding the provision of behavioral health services, an overview of arguments advanced in debates on these issues, and a summary of other states' approaches to the provision of these services. Lastly, the analysis includes a section (see **FISCAL IMPACT**) discussing the impact of the legislation on State and local government, including (among other things) the bills' prospective impacts on the Insurance Provider Assessment (IPA), State and local spending on various behavioral services users, and Headlee Amendment ramifications.

## CONTENT

**Senate Bill 597 (S-2) would amend the Social Welfare Act to do the following:**

- **Require the DHHS, by January 1, 2023, to develop and begin implementation of a phased-in plan to integrate the administration and provision of Medicaid physical health care services and behavioral health specialty services for behavioral health populations through the creation of SIPs.**
- **Require the plan to provide for full integration and administration of physical health care services and behavioral health specialty services and supports through SIPs by 2030.**
- **Require the integration plan to meet certain criteria, such as requiring a SIP to contract with each community mental health services program (CMHSP) within its service area to provide behavioral health specialty services, and requiring a CMHSP to contract with each SIP in its service area to provide behavioral health specialty services.**

**-- Require the integration plan to provide for the phased-in transition and enrollment of all eligible Medicaid beneficiaries from a specialty prepaid health plan (i.e., a public prepaid inpatient health plans (PIHP)) into a SIP within the timeline prescribed in the bill.**
**-- Require the DHHS, in consultation with one representative from each of the interested parties (listed in the bill), to develop key metrics used to determine whether an implementation phase was successful.**
**-- Require the DHHS, in consultation with the Behavioral Health Accountability Council, to monitor each implementation phase and to complete a formal evaluation of each phase within 20 months after its effective date.**
**-- Specify that the DHHS, except in a case of malfeasance or misfeasance, would have to require the PIHP system to maintain all current provider contractual arrangements throughout the transition phase.**
**-- Specify that a provision requiring Medicaid-covered specialty services and supports to be delivered by PIHPs chosen by the DHHS would apply until SIPs were available to provide the specialty services for all eligible Medicaid beneficiaries in accordance with the integration plan.**
**-- Require the DHHS to seek a waiver from the Federal government to allow and, if the waiver were granted, to allow for services to be provided by a SIP**
**-- Modify the Act's provisions pertaining to performance bonus incentive pools to exclude or include SIPs, as applicable.**

**<u>Senate Bill 598 (S-2)</u> would amend the Mental Health Code to do the following:**

**-- Specify that a SIP would not be responsible for duties set forth in the bill until after completion of a successful transition, as determined at each integration phase by the Behavioral Health Accountability Council.**
**-- Specify that a SIP would be a separate entity that operated as a CMHSP and either was a managed care organization or a specified system of health care delivery and financing.**
**-- Eliminate language that requires a DHHS-designated community mental health entity to coordinate the provision of substance use disorder (SUD) services in its region and to ensure those services are available for individuals with SUD.**
**-- Make multiple changes to the Code to include SIPs as well as local public behavioral health entities as eligible providers of publicly funded behavioral health services.**
**-- Require a SIP (or a CMHSP, as currently required) to participate in the development of school-to-community transition services for individuals with serious mental illness (SMI), serious emotional disturbance (SED), or developmental disability (DD).**
**-- Require a multidisciplinary council to be established to select a Director of the Office of Recipient Rights on the date a SIP was implemented.**
**-- Establish the Office of the Behavioral Health Ombudsman as an autonomous entity within the DHHS and prescribe the duties of the Ombudsman.**
**-- Create the Behavioral Health Accountability Council within the Office of the Behavioral Health Ombudsman and prescribe its membership and duties.**

Senate Bill 598 (S-2) is tie-barred to Senate Bill 597. Senate Bill 598 (S-2) also would repeal Section 269 of the Mental Health Code, which allows the Department-designated community mental health entity and its CMHSP provider network to contract for and spend funds for the prevention of SUD and for the counseling and treatment of individuals with SUD.

## **Senate Bill 597 (S-2)**

Definitions

"Specialty integrated plan" would mean a managed care organization or a person operating a system of health care delivery and financing as provided under Section 3573 of the Insurance Code, designated by the Department as a specialty integrated plan to provide or arrange for the integration and delivery of comprehensive physical health care services and the full array of 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.

(Section 3573 of the Insurance Code allows a person that proposes to operate a system of health care delivery and financing in exchange for a fixed payment and to be organized so that providers and the organization are at risk for the cost of services in a manner similar to a health maintenance organization (HMO), but that fails to meet the requirements of the Code for an HMO, may operate the system if the Director of the Department of Insurance and Financial Services (DIFS) finds that the proposed operation will benefit individuals who will be served by it.)

"Community mental health services program" would mean that term as defined in Section 100a of the Mental Health Code: a program operated under Chapter 2 (County Community Mental Health Programs) as a county community mental health agency, a community mental health authority, or a community mental health organization.

Integration of Physical Health Care Services & Behavioral Health Specialty Services

The bill would amend the Act to require the DHHS to establish a competitive contract and procurement process that outlined the eligibility requirements for entities to apply to operate as a SIP. By January 1, 2023, the DHHS would have to develop and implement a plan to fully integrate the administration of physhs health care services and behavioral health specialty services and supports for eligible Medicaid beneficiaries with a SMI, DD, SED, or SUD and eligible Medicaid beneficiaries who were children in foster care. The plan would have to provide for full integration and administration of physical health care services and behavioral health specialty services and supports through SIPs by 2026.

Medicaid services for SMI, DD, SED, SUD, and foster care behavioral health clients presently are covered by Medicaid health plans for physical health care services and local public PIHPs for behavioral health services. Under the bill, both physical health care and behavioral health Medicaid coverage for these populations eventually would be exclusively covered by the SIPs. The Medicaid health plans would continue to cover physical health services for the large majority of the Medicaid population who did not have an SMI, DD, SED, SUD, or were in foster care. The function of the PIHPs would be phased out as responsibility for Medicaid behavioral health services for these populations would be transferred to the SIPs. However, PIHPs would appear to be eligible to apply to become a SIP.

The Department would have to use a procurement process for contracting with eligible SIPs to administer the integrated and comprehensive Medicaid health care benefit package. The request for proposal would have to include 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; and g) five years of managed care experience.

The plan also would have to do each of the following:

-- Provide eligible beneficiaries with the option to choose from at least two SIPs, unless a rural exemption had been granted by the Centers for Medicare and Medicaid Services (CMS); currently, the State has a rural exemption for physical health Medicaid that applies to the Upper Peninsula.
-- Require a SIP to contract with each CMHSP within its service area (and vice versa) for the provision of behavioral health specialty services and supports, including specialized residential services, respite care, community living supports, peer supports, and other services; CMHSP reimbursement for contracted services would be at the standardized fee schedule with the opportunity for additional payments under value-based contracting incentive arrangements.
-- Allow a SIP to contract directly with local public CMHSPs, any other behavioral health providers, as long as that provider meets standards established by the DHHS to ensure adequate and timely access to care, or an integrated care network.
-- Require that the physical health care services and behavioral health specialty services and supports provided by a SIP be person-centered.
-- Include a process to ensure the readiness of all SIPs, at each phase of the transition, to administer the services previously funded through the local public PIHPs for all of the eligible Medicaid beneficiaries transitioning under that phase of the plan.
-- Reduce inefficiencies in funding, coordination of care, and service delivery.
-- Generate uniformity with benefits, contracts, training reciprocity, outcome measurement, care coordination, and utilization management such as screenings and authorizations.
-- Allow for portability of coverage throughout the State without a change in access or benefits.
-- Increase eligible Medicaid beneficiary choice of service provider and delivery method.
-- Allow for increased resources to be directed back into care delivery and services through the reduction of administrative layers and cost, including reinvestment of realized savings into the integrated behavioral health system to further promote and expand access to clinically integrated services and locations; during the implementation time frame savings would have to be actualized through the use of the risk corridor, and any amount of money returned from the SIP to the State as part of the corridor reconciliation process would be considered savings.
-- Allow for increased coordination with other agencies and organizations that were part of an eligible Medicaid beneficiary's plan of care.
-- Standardize and centralize accountability for administering and managing physical health care services and behavioral health specialty services and supports services.
-- Increase transparency and budget predictability.
-- Establish a two-way risk corridor for the plan under which SIPs participated in a payment adjustment system through December 31, 2025 (see below); in doing so, medical expenses used in the corridor would have to include covered services and approved in-lieu-of services, benefit expenses including incurred but not reported expenses within a time frame developed by the DHHS, and health care quality improvement expenses as defined under Federal regulations.
-- Establish a Medicaid loss ratio based on actuarially sound capitation rates and built on a standardized fee schedule for all covered Medicaid behavioral health services (a medical loss ratio reflects the portion of premium revenue spent on care or quality improvement measures and effectively identifies the portion of revenue spent on nonadministrative costs).
-- Ensure that any non-Medicaid General Fund money, which the DHHS could award to a SIP through a directed payment arrangement, was dispersed to the CMHSP or other provider as determined by the DHHS, at 100% if the intended award.

(Managed care providers generally are at full financial risk (absorbing all excess costs and keeping all surpluses) unless risk corridors or other risk abatement strategies are employed. A two-way risk corridor would limit financial risk both for the State and the SIPs in case of unexpectedly high or low costs. Specialty integrated plan costs above a certain point relative to the established payment rates would be partially or fully covered by the State and savings below a certain point would partially or fully accrue to the State).

During development of the plan, the DHHS would have to consider incorporating the collaborative care model into the benefit delivery system for SIPs. "Collaborative care model" would mean the evidence-based, integrated behavioral health service delivery method that includes a formal collaborative arrangement among a primary care team consisting of a primary care provider, a care manager, and a psychiatric consultant, and includes the following elements: a) care directed by the primary care team, b) structured care management, c) regular assessments of clinical status using validated tools, and d) modification of treatment as appropriate.

The plan would have to provide for the phased-in transition and enrollment of all eligible Medicaid beneficiaries from a specialty prepaid health plan into a SIP within the following timeline:

-- Within two years after the bill's effective date, all eligible beneficiaries with a SMI or SED and eligible beneficiaries who were considered children as provided within their respective Medicaid program, including children in foster care would have to be enrolled in a SIP.
-- Within two years after the successful transition and enrollment of the above beneficiaries, all eligible Medicaid beneficiaries with a SMI or SED who were not enrolled above
-- Within two years after the successful transition and enrollment of the beneficiaries with a SMI or SED, all eligible Medicaid beneficiaries with a SUD would have to be enrolled in a SIP.
-- Within two years after the successful transition and enrollment of the beneficiaries with a SUD, all eligible Medicaid beneficiaries with a DD or a dual diagnosis of DD and either SMI or SED would have to be enrolled in a SIP.

The Department, in consultation with one representative from each interested party, would have to develop key metrics to be used to determine whether each phase of the implementation for the transition and enrollment of eligible beneficiaries into a contracted SIP had been successful. In developing these metrics, the DHHS and interested parties would have to ensure that the metrics were tailored to each population included in the specific implementation phase, took into consideration lessons learned from past implementation phases, and were developed and made available publicly at least six months before the implementation phase. ("Interested parties" would mean the Behavioral Health Advisory Council established within the Department, Arc Michigan, Association for Children's Mental Health, Blue Cross Blue Shield of Michigan, Community Mental Health Association of Michigan, Mental Health Association of Michigan, MI Cares Council, Michigan Association of Alcoholism and Drug Abuse Counselors, Michigan Association of Health Plans, Michigan Health and Hospital Association, Michigan Primary Care Association, Michigan Protection and Advocacy Service, Inc., Michigan Psychological Association, Michigan State Medical Society, Michigan Psychiatric Society, and National Alliance on Mental Illness-Michigan.)

The DHHS could not consider the implementation successful unless, based on the established key metrics, the implementation resulted in statistically significant improvements in service delivery, health outcomes, and access for eligible beneficiaries. The key metrics, at a minimum, would have to do all of the following:

-- Focus on assessing individuals with behavioral health diagnoses or physical and behavioral health comorbidities.
-- Include measures related to patient-centered care, including shared decision-making, patient education, provider-patient communication, and patient or family experiences of care.
-- Include evidence-based metrics to assess health outcomes, coordination and continuity of care, utilization, cost, efficiency, patient safety, and access to care.
-- Include measures that utilize real-time performance data of SIPs.
-- Leverage standards from national resources, including, but not limited to, the CMS, National Committee for Quality Assurance, Substance Abuse and Mental Health Services Administration, and Agency for Healthcare Research and Quality.

During the implementation phase, the DHHS, in consultation with the Behavioral Health Accountability Council, would have to monitor the progress of the integration effort. The Council would have to complete a formal evaluation of each phase within 18 months after the effective date for each phase. When the evaluation was completed for each phase, the Council would have to provide an evaluation on the status of the implementation and proposed recommendations for the next steps to the DHHS. The DHHS would have to use the Council's evaluation and recommendations as part of the process to assess and determined the success of each implementation phase.

The DHHS would have to complete a formal evaluation of each implementation phase within 20 months after each phase's effective date. The DHHS, at a minimum, would have to use the predefined key metrics to assess the state of the integration phase and evaluate the effort's effectiveness. Within 60 days after the evaluation, the DHHS would have to submit a report to the Legislature with the findings, including an assessment of whether the phase was considered successful, unsuccessful, or undetermined. If the evaluation were considered unsuccessful or undetermined, the DHHS would have to include a recommendation to continue the phase as intended, extend the duration of the phase to allow for further evaluation, or propose to reform, modify, or terminate the current phase before the two-year phase came to end. If the latter recommendation were used, the DHHS would have to work with the Council to determine the best option to reform, modify, or terminate the phase.

Except in a case of malfeasance or misfeasance, the DHHS would have to use the PIHP system to maintain all current provider contractual arrangements during the transition period. A PIHP would be prohibited from reducing provider choice within the service networks by restructuring delegated services or altering reimbursement rates during the transition period. A PIHP that did so would be subject to economic sanctions, including disqualification from participating in a SIP.

The DHHS would have to ensure that all capitated payments made to SIPs were actuarially sound. The Department also would have to establish an annual reporting requirement for SIPs. The requirement would have to be posted publicly and provided to the Legislature in order to evaluate annually the success and efficacy of the SIP implementation. Five years after implementation of the program, the Legislature could review the program's success and efficacy to determine if the program would continue.

<u>Medicaid-Covered Services & Supports; SIPs</u>

The Act requires the DHHS to support the use of Medicaid funds for specialty services and supports for eligible Medicaid beneficiaries with SMI, DD, SED, or SUD.

Under the Act, Medicaid-covered specialty services and supports must be managed and delivered by specialty prepaid health plans chosen by the DHHS and must be carved out from

the basic Medicaid health care benefits package. Under the bill, this would apply until SIPs were available to provide the specialty services and supports for all eligible Medicaid beneficiaries in accordance with the plan developed as described above.

The Act specifies that these provisions do not apply to a pilot program under Section 209(3) of Article X of Public Act 107 of 2017 (which required the DHHS to implement up to three pilot projects to achieve fully integrated Medicaid behavioral health and physical health benefit and financial integration models). The bill would eliminate this provision (which applied to integration pilots that were never implemented).

Financial Incentives

The Act requires the DHHS in collaboration with the contracted health plans and providers to create financial incentives for all of the following:

-- Contracted health plans that meet specified population improvement goals.
-- Providers who meet specified quality, cost, and utilization targets.
-- Enrollees who demonstrate improved health outcomes or maintain healthy behaviors as identified in a health risk assessment as identified by their primary care practitioner.

The performance bonus incentive pool for contracted health plans that are not PIHPs must 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 applicable provisions of the Public Health Code as a percentage of total. Under the bill, this would apply for contracted health plans that were not PIHPs or SIPs.

The Act requires the DHHS to withhold, at least 0.75% of payments to contracted health plans, except for PIHPs, for the purpose of expanding the existing performance bonus incentive pool. Distribution of funds from pool is contingent on the contracted health plan's completion of the required performance or compliance metrics. The DHHS also must withhold, at a minimum, 0.75% of payments to PIHPs to establish a performance bonus incentive pool. Distribution of funds from the pool is contingent on the PIHP's completion of the required performance of compliance metrics that must include, at a minimum, partnering with other contracted health plans to reduce nonemergent emergency department utilization, increased participation in patient-centered medical homes, increased use of electronic health records and data sharing with other providers, and identification of enrollees who may be eligible for services through the United States Department of Veterans Affairs. Under the bill, where the Act refers to PIHPs, the bill also would refer to SIPs.

Federal Waiver; SIPs

The Act specifies that the DHHS must seek a waiver from the United States Department of Health and Human Services to do, without jeopardizing Federal match dollars or otherwise incurring Federal financial penalties, and after approval of the waiver must do specified tasks. Under the bill, this would include allowing for services to be provided by a SIP, as specified above.

## Senate Bill 598 (S-2)

Powers & Duties of DHHS; SIPs

Under Section 116 of the Mental Health Code, consistent with the Michigan Constitution, the DHHS must "continually and diligently endeavor to ensure that adequate and appropriate

mental health services are available" to Michigan residents. Accordingly, the Department has the general powers and duties prescribed in Section 116. In particular, the DHHS must administer the provisions of Chapter 2 to promote and maintain an adequate and appropriate system of CMHSPs throughout the State.

In doing so, the Department's objective is to shift primary responsibility for the direct delivery of public mental health services from the State to a CMHSP whenever the program has demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area. Under the bill, the Department's objective would be to shift primary responsibility for the direct delivery of public *non-Medicaid-funded* mental health services from the State to a CMHSP *or a SIP* whenever the program had demonstrated a willingness and capacity to provide an adequate and appropriate system of mental health services for the citizens of that service area. This provision would permit SIPs to provide some or all of the non-Medicaid public behavioral health services currently provided exclusively by local CMHSPs. The DHHS would have to contract with licensed SIPs for financial and service delivery management of Medicaid-funded behavioral health services.

The bill would change numerous provisions in the Mental Health Code that refer to local public mental health services to reflect implementation of integration through the SIPs by including references to SIPs along with references to CMHSPs.

The Department must submit to the members of the House and Senate standing committees and appropriations subcommittees with legislative oversight of mental health matters an annual report summarizing its assessment of mental health needs of the State, incorporating information received from the CMHSPs. Under the bill, the report also would have to incorporate information received from SIPs.

Also, the DHHS must review and evaluate the relevance, quality, effectiveness, and efficiency of mental health services being provided by the Department and ensure the review and evaluation of mental health services provided by CMHSPs. The bill also would require the DHHS to ensure the review and evaluation of mental health services provided by SIPs.

The bill specifies that, throughout Chapter 2, a SIP would not be responsible for the duties prescribed in Chapter 2 until after completion of a successful transition under the Social Welfare Act. After a SIP had completed a successful transition, it would have to take over the prescribed duties and the CMHSP no longer would be responsible for them. The Council would have to determine the successful transition at each integration phase establishing when the SIP was responsible and the CMHSP was no longer responsible.

Inpatient Psychiatric Bed Registry

The DHHS must establish and administer an electronic inpatient psychiatric bed registry. The registry must be a web-based resource to identify available psychiatric beds in Michigan categorized by patient gender, acuity, age, and diagnosis. The registry must be accessible on the DHHS website. The registry must be made accessible to PIHPs, licensed health plans, CMHSPs, acute care hospitals, psychiatric facilities, and employees and caregivers with other appropriate providers. Under the bill, the registry also would have to be made available to SIPs, as applicable.

Promulgation of Rules

The DHHS must promulgate rules for the placement of adults who have SMI or DD into community-based dependent living settings by DHHS agencies, CMHSPs, and by agencies under contract to the DHHS or to a CMHSP. Under the bill, the rules also would have to pertain

to the placement of those adults into community-based dependent living settings by agencies under contract to a SIP.

The Code also requires the DHHS to promulgate rules for the certification of specialized programs offered in an adult foster care facility to individuals with SMI or DD. After receiving a request from an adult foster care facility for certification of a specialized program, the DHHS must inspect the facility to determine whether the proposed specialized program conforms with the Code and rules promulgated under the Code. In carrying out the inspection and certification requirements, the DHHS may contract with a CMHSP, specialty integrated program, or any other agency. Under the bill, the DHHS also could contract with a SIP.

Michigan Crisis and Access Line

Subject to appropriation, the DHHS must establish and make available to the public a mental health telephone access line known as the Michigan crisis and access line. The Department must contract for the design, operation, and maintenance of the access line. A contractor operating or maintaining the access line, among other things, must refer and connect individuals requiring mental health or SUD services to mental health professionals, including CMHSPs and PIHPs, using telecommunications and digital communications methods commonly in use, such as a telephone call, text message, email, and internet chat. Under the bill, in addition to CMHSPs and PIHPs, a contractor also could refer an individual to a SIP for these purposes.

SIPs; State Support

Under the Code, the State must financially support, in accordance with Chapter 3, CMHSPs that have been established and that are administered under Chapter 2. A CMHSP must determine an individual's eligibility for a private health insurer, Medicaid, or Medicare and must bill the private health insurer, Medicaid, or Medicare first before spending money from the State General Fund for providing treatment and services under the Code to that individual. Where these provisions refer to CMHSPs, the bill also would refer to SIPs.

SIP Operating as CMHSP

Under the Code, a CMHSP established under Chapter 2 must be a county community mental health agency, a community mental health organization, or a community mental health authority. A county community mental health agency is an official county agency. A community mental health organization or a community mental health authority is a public governmental entity separate from the county or counties that establish it. Under the bill, a SIP would be a separate entity that operated as a CMHSP under Chapter 2 and was either a managed care organization or a person operating a system of health care delivery and financing as provided under Insurance Code. Procedures and policies for a SIP operating as a CMHSP would have to be set by June 1, 2022.

Regional Entities

The Code allows a combination of community mental health organizations or authorities to establish a regional entity by adopting bylaws that satisfy the Code's requirements. A community mental health agency may combine with a community mental health organization or authority to establish a regional entity if the board of commissioners of the county or counties represented by the community mental health agency adopts bylaws that satisfy the Code.

Except as otherwise stated in the bylaws, a regional entity has all of the powers specified in the Code, including the power to enter into a contract with a participating CMHSP for any service to be performed for, by, or from the participating CMHSP. Under the bill, a regional entity also would have the power to enter into a contract with a participating SIP under the Medicaid managed care program.

Purpose of SIP & Services

The purpose of a CMHSP is to provide a comprehensive array of mental health services appropriate to conditions of individuals who are located within its geographic service area, regardless of an individual's ability to pay. Under the bill, this also would apply to SIP. A SIP would have to offer the same array of services for Medicaid beneficiaries enrolled in the SIP.

A CMHSP must deliver services in a manner that demonstrates they are based upon recipient choice and involvement and must include wraparound services when appropriate. Each CMHSP must provide services designed to divert individuals with SMI, SED, or DD from possible jail incarceration when appropriate. These services must be consistent with policy established by the DHHS. Under the bill, these requirements also would apply to a SIP.

Interagency Agreements

The Code requires each county to have a written interagency agreement in place for a collaborative program to provide mental health treatment and assistance, if permitted by law and considered appropriate, to individuals with SMI who are considered at risk for entering the criminal justice system, not receiving needed mental health treatment services while incarcerated in a county jail or upon release or discharge, or being committed to the jurisdiction of the Department of Corrections.

Parties to the agreement must include, at a minimum, all of the following:

-- The county sheriff's department.
-- The county prosecutor's office.
-- The CMHSP that provides services in that county.
-- The county board of commissioners.
-- A district court judge who serves in that county or, if there is more than one district in the county, a district court judge who serves in the county who is designated either by the chief judge of a district court within that county or a chief judge with authority over a district court in that county.
-- A circuit court judge who serves in that county who is designated either by the chief judge of the circuit court or by a chief judge with authority over the circuit court in that county.

Under the bill, the Medicaid health plan serving individuals in that county also would have to be a party to the agreement.

Prerelease Plan

Section 209a of the Code specifies that the appropriate CMHSP, with the assistance of the State facility or licensed hospital under contract with a CMHSP, or the State facility must develop an individualized prerelease plan for appropriate community placement and a prerelease plan for aftercare services appropriate for each resident, and prescribes requirements for CMHSP release plans. Section 209b pertains to prerelease and postrelease plans and placement of individual in supervised community living arrangement Under the bill, where Sections 209a and 209b refer to a CMHSP, the bill also would refer to a SIP.

Duties of a CMHSP Board

The board of a CMHSP, among other things, must conduct an annual needs assessment to determine the mental health needs of the residents of the county or counties that it represents. The assessment must include information gathered from all appropriate sources, including community mental health waiting list data and school districts providing special education services. Under the bill, the assessment would have to include information gathered from all appropriate sources, including community mental health waiting list data, *SIP data*, and school districts providing special education services, *consistent with and necessary to complete the needs assessment as specified by the DHHS*.

The bill also would require a CMHSP board to report monthly to the Ombudsman and the Council on the progress of the *SIPs*.

Provision of SUD Services

A DHHS-designated community mental health entity must ensure that funding dedicated to SUD services is retained for those purposes and not diverted to fund services that are not for SUDs. Under the bill, this requirement also would apply to a SIP.

A DHHS-designated community mental health entity designated by the Director to assume the responsibilities of providing SUD services for a county or region must retain the existing providers who are under contract to provide SUD treatment and prevention services for two years after December 28, 2012. This provision reflected the integration of SUD services with mental health services provided by local public mental health entities. Under the bill, beginning no later than January 1, 2026, or after implementation of a SIP, whichever was sooner, the Director could designate a SIP to assume the responsibilities of providing SUD services for a county or region.

The DHHS and its designated community mental health entity must continue to use the allocation formula based on Federal and State data sources to allocate and distribute nonmedical assistance SUD services funds. Under the bill, this requirement also would apply to a SIP.

Department-designated community mental health entities are SUD coordinating agencies for the purpose of receiving funds required to be distributed to SUD coordinating agencies. Under the bill, beginning no later than January 1, 2026, or after implementation of a SIP, whichever was sooner, SIPs would be coordinating agencies for this purpose.

Preadmission Screening Units & SIPs

The Code requires each CMHSP to establish one or more preadmission screening units with 24-hour availability to provide assessment and screening services for individuals being considered for admission into hospitals, assisted outpatient treatment programs, or crisis services on a voluntary basis. Under the bill, a SIP would have to establish or contract with a CMHSP for a preadmission screening unit in each CMHSP location that it served.

Each CMHSP must provide the address and telephone number of its preadmission screening unit or units to law enforcement agencies, the DHHS, the court, and hospital emergency rooms. Also, a screening unit must assess an individual being considered for admission into a hospital operated by the DHHS or under contract with the CMHSP. Under the bill, where the Code refers to CMHSP, the bill also would refer to SIP.

If the screening unit denies hospitalization, the individual or the person making the application may request a second opinion from the executive director of the CMHSP. The executive director must arrange for an additional evaluation by a psychiatrist, other physician, or licensed psychologist to be performed within three days, excluding Sundays and legal holidays, after the executive director receives the request. If the conclusion of that opinion is different from the screening unit's conclusion, the executive director, in conjunction with the medical director, must make a decision based on all clinical information available. The executive director's decision must be confirmed to the individual who requested the second opinion, and the confirming document must include the signatures of the executive director and medical director or verification that the decision was made in conjunction with the medical director. If an individual is assessed and found not to be clinically suitable for hospitalization, the preadmission screening unit must provide appropriate referral services. Under the bill, if the screening unit denied hospitalization, a second opinion could be requested from the executive director of the CMHSP or the nurse case manager of the SIP, as applicable.

If an individual chooses a hospital not under contract with a CMHSP, and the hospital agrees to the admission, the screening unit must refer the individual to the requested hospital. Any financial obligation for services the hospital provides must be satisfied from funding sources other than the CMHSP, the DHHS, or other State or county funding. Where the Code refers to a CMHSP, the bill also would refer to a SIP.

Recipient Rights

If an applicant for community mental health services has been denied mental health services, the applicant, his or her guardian if one has been appointed, or the applicant's parent or parents if the applicant is a minor may request a second opinion of the executive director. The executive director must secure the opinion from a physician, licensed psychologist, registered professional nurse, or master's level social worker, or master's level psychologist. Where the Code refers to executive director, the bill also would refer to the nurse case manager of the SIP, as applicable.

If the individual providing the second opinion determines that the applicant has a SMI, SED, or a DD, or is experiencing an emergency situation or urgent situation, the CMHSP must direct services to the applicant. Under the bill, this requirement also would apply to a SIP.

The DHHS, each CMHSP, each licensed hospital, and each service provider under contract with the DHHS, a CMHSP, or a licensed hospital must establish written policies and procedures concerning recipient rights and the operation of an office of recipient rights. The policies and procedures must provide a mechanism for prompt reporting, review, investigation, and resolution of apparent or suspected violations of the rights guaranteed by Chapter 7 (Rights of Recipients of Mental Health Services) and must be designed to protect recipients from, and prevent repetition of, violations of rights guaranteed by Chapters 7 and 7a (Dispute Resolution). The policies and procedures must include, at a minimum, all of the items prescribed in the Code. The Code also requires each CMHSP to establish an office of recipient rights.

Under the bill, each SIP would have to establish written policies and procedures concerning recipient rights and the operation of an office of recipient rights, as prescribed above, and would have to create an office of recipient rights.

The Code requires the DHHS to establish a State Office of Recipient Rights subordinate only to the Director of DHHS. After consulting with the State Recipient Rights Advisory Committee, the DHHS Director must select a Director of the State Office of Recipient Rights who has the education, training, and experience to fulfill the responsibilities of the office. The DHHS

Director may not replace or dismiss the Director of the State Office of Recipient Rights without first consulting the State Recipient Rights Advisory Committee. The Director of the State Office of Recipient Rights must report directly and solely to the DHHS Director. The DHHS Director may not delegate his or her responsibility with respect to these provisions.

Under the bill, the State Office of Recipient Rights would be established within the Office of the Behavioral Health Ombudsman and would be subordinate, and would have to report directly, to the Ombudsman. The DHHS Director could not replace or dismiss the Director of the State Office of Recipient Rights without first consulting the State Recipient Rights Advisory Committee and the Ombudsman. The Ombudsman could not delegate his or her responsibilities with respect to these provisions.

The bill would require, on the date a SIP was implemented, a multidisciplinary council to be established to select a Director of the Office of Recipient Rights. The Director would have to be a member of the Council established under the DHHS subordinate to the Ombudsman.

Office of the Behavioral Health Ombudsman

The bill would establish the Office of the Behavioral Health Ombudsman as an autonomous entity within the DHHS. The principal executive officer of the Office would be the Behavioral Health Ombudsman, who would have to be appointed by the Governor with the advice and consent of the Senate. The Ombudsman would serve at the pleasure of the Governor and would have to be qualified by training and experience to perform the duties of the office.

The Ombudsman would have to establish procedures for approving the Office's budget, for spending Office funds, and for the employment of Office personnel. The Ombudsman also would have to establish procedures for receiving and processing complaints from complainants and individuals not meeting the definition of complainant, conducting investigations, holding informal hearings, and reporting findings and recommendations resulting from investigations.

Behavioral Health Accountability Council

The bill would create the Behavioral Health Accountability Council within the Office of the Behavioral Health Ombudsman. The Council could have to consist of the following:

-- The Ombudsman, who would have to serve as chair of the Council.
-- The Director of the Office of Recipient Rights.
-- An individual from each of the entities that were awarded the request for proposal for the SIPs.
-- One individual representing the CMHSPs.
-- One individual representing an organization or institution with experience in research on physical health and behavioral health.
-- Five individuals representing recipients of mental health services throughout Michigan, including northern Michigan or the Upper Peninsula.
-- One individual representing a private provider or agency of SUD services.
-- Three individual representing private providers of mental health services throughout Michigan, including northern Michigan or the Upper Peninsula.
-- Individuals appointed by the Senate Majority Leader, the Senate Minority Leader, the Speaker of the House of Representatives, and the House Minority Leader.

The Council would have to perform its business at a public meeting held in compliance with the Open Meetings Act. The Council also would have to monitor the progress of the SIPs. The Council would have to complete a formal evaluation of each phase within 18 months after the

effective date for each phase. When the evaluation was completed for each phase, the Council would have to provide an evaluation on the status of the implementation and proposed recommendations for the next steps to the DHHS. The DHHS would have to use the Council's evaluation and recommendations as part of the process to assess and determined the success of each implementation phase. For each implementation phase, the DHHS would have to complete a formal evaluation of that phase 20 months after the phase was implemented.

The DHHS, at a minimum, would have to use the predefined key metrics to assess the current state of the integration phase and evaluate the effort's effectiveness. The key metrics, at a minimum, would have to do all of the following:

-- Focus on assessing individuals with behavioral health diagnoses or physical and behavioral health comorbidities.
-- Include measures related to patient-centered care, including shared decision-making, patient education, provider-patient communication, and patient or family experiences of care.
-- Include evidence-based metrics to assess health outcomes, coordination and continuity of care, utilization, cost, efficiency, patient safety, and access to care.
-- Include measures that utilize real-time performance data of SIPs.
-- Leverage standards from national resources, including, but not limited to, the CMS, National Committee for Quality Assurance, Substance Abuse and Mental Health Services Administration, and Agency for Healthcare Research and Quality.

Within 60 days after the 20-month evaluation, the DHHS would have to submit a report to the Legislature with the findings and include with it an assessment of whether the implementation phase was considered successful, unsuccessful, or undetermined. If the evaluation yielded a finding of unsuccessful or undetermined, the DHHS would have to include a recommendation to do any of the following:

-- Continue the integration phase as intended.
-- Extend the duration of the phase to allow for further evaluation time of the phase.
-- Propose to reform, modify, or terminate the current phase before the two-year phase comes to an end.

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**BACKGROUND**

Introduction

In discussing any proposal for changes to the way the State of Michigan delivers Medicaid behavioral health services, it is useful to look at the history of how the delivery of Medicaid behavioral health services has evolved since the late 1990s.

In fiscal year (FY) 1998-99, the State of Michigan shifted from a fee for service model to a managed care model for Medicaid behavioral health services. Those services have been provided by PIHPs, which are groupings of local county-based community mental health boards (CMHs). The State also moved, over several years before FY 1998-99, to a managed care model for Medicaid physical health care, generally delivered by Medicaid HMOs, also known as Medicaid health plans (MHPs).

Michigan's approach, in which Medicaid behavioral health services are delivered separately from Medicaid physical health services, is known as a "carve-out"; i.e., the Medicaid

behavioral health services are "carved out" from the rest of Medicaid services. Many states have moved to a more unified model, in which managed care entities handle both physical health and behavioral health for much or all of the behavioral health population (see below for a discussion of approaches taken by other states).

The Reasons for the Move to Managed Care

Most Medicaid clients in Michigan receive their services via a managed care model. Over the years, the delivery of most health care services in the United States has shifted from a fee-for-service model to managed care.

Under fee-for-service, a person obtains health care services, such as a doctor visit, a hospital stay, or a prescription, and the provider bills the person's insurance company (or the person himself or herself if the person is uninsured). The insurer reimburses the provider the insurer's going rate for the given service (for instance, $50 for a routine physician office visit, $3,000 for a cardiac catheterization, or $10 to fill an amoxicillin prescription).

In the case of fee-for-service Medicaid, this meant that the State's Medicaid program played the role of fee-for-service insurer. Therefore, after a Medicaid patient visited a doctor, the doctor would bill Medicaid, and the Medicaid program, assuming the billing was determined to be legitimate, would reimburse the doctor at the Medicaid payment rate for the given service. The fee-for-service model theoretically puts cost risks on the insurer (such as Medicaid) and effectively places responsibility to control costs on the insurer as well. Insurers reimburse any legitimate provider for a legitimate claim, so there is limited leverage in negotiating payment rates with providers.

Over time, a new model known as managed care began to emerge. Health maintenance organizations became prominent in the health insurance field. There are three key aspects to managed care that affect delivery of and payment for services as described below.

First, the HMO assumes most of the financial risk. In other words, the employer or program contracting with an HMO pays the HMO "capitation" payments for each employee, employee dependent, or recipient served. The capitation payment is determined based on the projected costs for a person based on demographic characteristics and cost experience. (For instance, there may be a specific capitation payment for a man between ages 18 and 25 and a different one for a woman between ages 55 and 64, based on actuarially determined average health care cost estimates; total capitation payments to the HMO are based on the number of people enrolled and their age/gender demographics.) The HMO receives money for the people it covers, then the HMO handles reimbursement of health care costs and effectively assumes the risk of costs (within negotiated limits). Since HMOs have a strong incentive to limit costs, it is believed that they work to root out inappropriate services as well as fraud. They also face financial risk in case some people incur higher-than-expected costs.

Second, HMOs create provider networks. By creating networks of individual providers (i.e., doctors) and institutional providers (hospitals), HMOs are able to limit costs. Costs are limited because an HMO can negotiate with the providers seeking to be part of its network. The key is that the network generally does not include every provider in a given area. If a provider is an oncologist, for example, and the provider is "in network" with a major HMO, while others are not "in network", the provider is likely to get more patients from that HMO insurer than under a fee-for-service model. Having more patients means that average fixed costs for the provider are reduced, so overall reimbursement to that provider may be lower without the provider being any worse off. This leads to cost restraint.

Third, HMOs, because of their rational self-interest in restraining costs, are believed to be more aggressive in finding methods to reduce costs. These methods include utilization review, an emphasis on preventive care, and incentives to ensure that individuals use the most effective care.

Michigan & Medicaid Managed Care

Michigan's Medicaid program covers all health care costs outside of nominal cost sharing, but it has long been split into two realms: physical health and behavioral health ("behavioral health" being a catchall term to describe mental health and SUD services). For decades, the Medicaid physical health services were provided mostly via a fee-for-service model through mostly private providers (whether individual providers or institutional providers). There was a relatively small HMO line item in the budget for those who voluntarily opted to be in a Medicaid HMO; but, to cite one example, managed care represented perhaps 7.0% of total Medicaid spending in FY 1993-94.

The Medicaid behavioral health services were provided on a fee-for-service basis through the local county-run CMH boards. A CMH, just like a doctor or a hospital, would provide a Medicaid-covered service to a Medicaid client and bill the State for reimbursement. Community mental health boards also would contract with doctors and hospitals to provide mental health services and reimburse them, so they did act somewhat like an insurer.

In the late 1990s, the State sought and received a Federal waiver and began to move toward mandatory physical health managed care for most Medicaid clients. The State sought bids from private HMOs and other private managed care entities. (Some hospitals set up "clinic plans" that were HMOs by another name.) The State began to enroll the majority of Medicaid clients into managed care for their physical health needs. This meant that the State was contracting with private, often for-profit, HMOs to provide Medicaid services.

Only a few populations were exempt from mandatory Medicaid-managed care for physical health; those exempt generally were clients who had other insurance (such as people who were dually eligible for Medicare and Medicaid, that is, low-income mostly elderly people). Also exempt (until relatively recently) were pregnant women. People who had enrolled in Medicaid but had not yet chosen or been assigned to an HMO also were covered on a fee-for-service basis until enrolling in an HMO.

This process had a number of fits and starts, but eventually things began running smoothly, and most would agree that the Medicaid physical health managed care program in Michigan has been a success, with restrained cost growth, fairly high levels of client satisfaction, and relatively few controversies. The fact that these HMOs are private, and many are for-profit has not been controversial, at least not for well over a decade.

In 1998, the State also moved to shift behavioral health services to a managed care model. In this case, there was no attempt to bid out the services to private managed care entities. The behavioral health services were "carved out" from regular Medicaid and contracted to a separate group of managed care entities.

The State directed that groupings of multiple CMHs boards and some large individual CMHs, called PIHPs, serve as the managed care entities for Medicaid behavioral health. The groupings of CMHs were deemed necessary by the Federal government because some CMH boards covered such small populations that their fixed costs would be rather high. At first there were 18 PIHPs (compared to the current 46 CMH boards); at present there are 10 PIHPs.

It should be noted that much of the PIHP spending is not for "typical" health care services. Over 40% of the PIHP spending is on services for the developmentally disabled, in particular reimbursement for group homes and day services. These are not services that are typically provided by "regular" health insurers such as HMOs, even ones that cover mental health, because the developmentally disabled population for regular health insurers is very small and housing and day services generally are not covered by health insurance. Similarly, the PIHPs spend a lot of money on services for the severely mentally ill, another population that is not very prevalent in regular health insurance, as many severely mentally ill individuals have low incomes and are on Medicaid.

In 2002, the Engler Administration had to rebid the Medicaid managed care behavioral health services. At the Federal level, the George W. Bush Administration argued that private behavioral health managed care providers, that is, behavioral health HMOs, had to be allowed to bid to provide services. There was strong opposition from the PIHPs and many in the mental health community. Eventually, the Engler Administration negotiated a revised waiver with the Bush Administration that allowed the current PIHPs the "right of first refusal". In other words, the PIHPs would get contracts unless they chose not to participate or unless they were judged unqualified to provide services. To this point, no PIHP has refused the contract and none have been judged unqualified, so Medicaid behavioral health managed care services have continued to be provided by quasi-public PIHPs.

The Situation Leading up to "Section 298"

The public behavioral health system in the State is composed of Medicaid and non-Medicaid services. The PIHPs handle Medicaid services. The CMHs handle non-Medicaid services, which include services to populations not eligible for traditional or expansion Medicaid and services that are not covered by Medicaid (jail diversion and 24-hour wrap-around services, among others). Almost 97% of the behavioral health budget is Medicaid, with only 3.4% or about $125.6 million allocated for non-Medicaid services.

There has been talk over the years, ever since the Engler-era rebid, of allowing private entities to bid to provide Medicaid behavioral health services. There have been other entities, in particular the Medicaid HMOs, that have sought to broaden the spectrum of services that they provide to include the full range of behavioral health services. Other states have implemented integrated approaches (see below for a more extended discussion of approaches that have been taken).

Section 298

Former Governor Snyder's recommendation for the FY 2016-17 DHHS budget included new boilerplate language, Section 298. This section would have required funding and services provided to and by PIHPs be transferred to the Medicaid HMOs by the end of FY 2016-17. The language included provisions that would have required stakeholder development of what was called the "integration plan" and would have required reports on the implementation of the integration plan. It also would have required Medicaid HMOs to contract with existing CMHs to provide specialty services and supports. Section 298, if implemented as written, would have shifted what was then over $2.3 billion in full-year funding from the PIHPs (which effectively would have no longer existed) to the Medicaid HMOs.

Section 298 faced intense opposition from mental health groups. The main concern expressed by those groups was a belief that transferring financial and programmatic responsibility for behavioral health services to private entities that were focused on Medicaid physical health could result in poorer outcomes for Medicaid clients, in particular the seriously mentally ill, those children with SED, and those with intellectual and developmental disabilities (IDD). The

Snyder Administration and other supporters of the proposal countered that the proposal had specific protections for populations built in as well as a provision that would have reinvested any General Fund/General Purpose (GF/GP) savings on Medicaid in the non-Medicaid public mental health system.

A workgroup was created under the direction of former Lieutenant Governor Brian Calley. That workgroup produced a report in March 2017 that included 70 recommendations. The workgroup's report outlined a road map for further exploration of the possibility of further integration of Medicaid physical and behavioral health services. These possible approaches to integration were not limited to financial approaches (in which funding streams could be shifted to one entity or another) but also could include integration at the clinical level. The report suggested continuing current demonstration projects and pilots and to fund new ones, with a multi-year effort including evaluation of such projects by University researchers.

However, a majority of the workgroup "affirmed that model categories that do not align with the policy recommendations should not be evaluated by the workgroup". They claimed that integration proposals similar to Governor Snyder's original proposal for shifting of responsibility for behavioral health services violated the workgroup's interim report's recommendation 1.1. That recommendation stated:

> The State of Michigan should retain system structures for Medicaid funding with (1) separate funding for and management of physical health flowing through the MHP system and (2) separate funding for and management of specialty behavioral health and intellectual/developmental disabilities flowing through the public PIHP/CMHSP system. Michigan should retain a public separately funded and managed system for non-Medicaid specialty behavioral health and intellectual/developmental disability services. CMHSPs should continue to play the central role in the delivery of Medicaid and non-Medicaid specialty behavioral health and intellectual/developmental disabilities services. The recommendation does not preclude the consideration of models of other competent, public, risk-based configurations.

As such, the Section 298 workgroup had officially encouraged a variety of pilots and demonstration projects but effectively argued to bar pilot programs that involved one common set of models (which included the FY 2016-17 proposal of former Governor Snyder): the shifting of financial responsibility for Medicaid behavioral health services to the Medicaid health plans.

This swing of the pendulum, from a shift to full financial integration in former Governor Snyder's FY 2016-17 budget to a ban on any pilot program exploring full financial integration, led to interest from legislators in allowing exploration of all reasonably plausible approaches. Over the next two budget cycles there were attempts to reduce the number of PIHPs and to launch various pilot programs. Groups did work toward establishing various pilot proposals and language was included in a revised Section 298 in the DHHS portion of Public Act 207 of 2018 establishing up to four integration demonstration projects or pilots, with funding to establish and evaluate the demonstration and pilot programs.

There were difficulties in getting these programs off the ground as PIHPs, CMHs, and health plans had to find common ground and that proved to be challenging.

A revised version of Section 298 was included in the FY 2019-20 DHHS budget, outlining a three-pilot project approach, with language stating legislative intent that, if the pilots met outlined performance metrics, full integration would be triggered on October 1, 2023. Governor Gretchen Whitmer vetoed this revised Section 298, expressing concern about a

"one-size-fits all approach". Neither the funding or the language has been reinstated since then and advocates for integration and other approaches have moved away from budgetary boilerplate integration proposals toward trying a statutory approach.

Arguments About Outcomes

The pro and con arguments about Section 298 were about both outcomes (the long-term outlook for services) and process.

The discussion about integration led to one obvious concern: whether recipients would be better off under such an approach. How would continuity in services and, in particular, continuity in service providers and even medications be protected? How would the most unique and costly behavioral health populations, the developmentally disabled and severely mentally ill, be served under the proposed setup? While there were discussions of protections in Section 298 (and required contracting with CMHs for specialty services), the transfer of funding and responsibility would have to occur whether protection concerns were addressed to all parties' satisfaction.

On the other hand, there were concerns, especially from the mental health community, that the current system did not coordinate care: that people facing both behavioral health and physical health issues must go through two different doors to receive services. The issue becomes more confusing because some basic behavioral health services can be covered by Medicaid HMOs or fee-for-service Medicaid (since many behavioral health medications are reimbursed on a fee-for-service basis). Thus, coordination of care, which is one of the strengths of the physical health managed care approach, is more difficult to achieve for Michigan Medicaid clients receiving behavioral health care. Transferring responsibility to one managed care entity could help increase coordination of care. To make matters even more complicated, many mentally ill and developmentally disabled individuals are eligible for Medicare, so their primary insurance is the Federally run Medicare program, not the State-run Medicaid program.

The Use of the Term "Privatization"

The term "privatization" generally is used to describe a process in which public entities provide services through contracts with, or reimbursement to, private sector providers. For instance, trash collection may fairly be described as "privatized" if a city contracts with a private firm to provide the service.

Opponents of transferring financial responsibility to the Medicaid HMOs or the creation of similar integrated models have long argued that the proposal would lead to the "privatization" of Medicaid behavioral health services, due to the shift of such services from quasi-public entities like PIHPs to the private Medicaid HMOs. Opponents also note that some of these private HMOs are for-profit HMOs; thus, their argument is that Section 298 would "privatize" government-funded services by transferring them to entities, some of which are for-profit.

This discussion is a matter of semantics, however, because Medicaid already is a heavily privatized program. Even in the fee-for-service era, Medicaid effectively was a largely privatized program. The State does not employ doctors to provide Medicaid services; instead, it reimburses mostly private doctors who see Medicaid patients. The State has not built State hospitals to provide physical health care to Medicaid patients; instead, it reimburses mostly private hospitals to provide this care. This was true under fee-for-service and it continues to be true under managed care. Furthermore, many CMHs and PIHPs themselves contract out services to private entities, so they engage in "privatization" themselves.

Administrative Costs

Proponents and opponents of behavioral health integration legislation have raised concerns about administrative costs, with integration opponents claiming that PIHP administrative costs are lower on a percentage basis than those of Medicaid HMOs, and proponents noting that the basis for comparison is meaningless because of differing methodologies of calculating administrative costs. The data from the most recent reports provided by the PIHPs and CMHs to the DHHS in the so-called "Section 904 report" indicate administrative costs in FY 2018-19 that were 5.04% of total costs, while Medicaid HMO data submissions to DIFS indicate administrative costs approaching 15.0% of total costs. However, the SFA concludes that these percentages are a clear example of an "apples to oranges" comparison and does not consider them meaningful or conclusive. The Section 904 report does not reflect all administrative costs, such as those for subcontractors, so there is not a clear basis for comparison to the DIFS reports.

A better approach would be to look at medical loss ratio data if such data were fully available. Medical loss ratio (MLR) is defined as the percentage of dollars spent on medical claims and quality improvements, with the remaining spending considered to be administrative. Unfortunately, there are varying definitions of MLR that result in varying estimates of MLR for managed care entities. Even more unfortunately, there are not clear data on MLR for the PIHPs.

The DHHS uses the CMS definition of MLR, which appropriately excludes taxes paid by managed care entities and treats quality improvement expenditures as nonadministrative. Based on experience with the various managed care, insurance, and claims taxes, the SFA believes these taxes should not be included and that quality improvement expenditures should be considered nonadministrative. Based on those assumptions, the FY 2018-19 DHSS estimate of MLR for Medicaid health plans is between 88.0% and 89.0%, which would imply administrative costs of 11.0% to 12.0%.

As noted, there do not appear to be comparable MLR data for the PIHPs but, given the limitations of the Section 904 administrative cost data, the SFA does not believe that the Section 904 5.04% figure is meaningful in comparison to the MLR data for the Medicaid health plans. As such, the claims that either PIHPs or MHPs have lower administrative costs are not claims that the SFA believes are supported by any meaningful evidence.

Approaches in Other States

In researching background for this analysis, the SFA did a cursory review of how every state (as well as Washington, DC) handled Medicaid behavioral health services. When one considers basic approaches as well as carve-outs, there were nearly a dozen different approaches—and the situation is evolving as more states consider more integrated approaches.

There is nearly an even split between states that take a fee-for-service approach to Medicaid behavioral health versus ones that use a managed care approach. It should be noted that, even with the debate over integration, Michigan is in the latter category. Michigan's PIHP system, although run by public mental health entities, is a managed care model.

Based on the most recent available information, 17 states have what amounts to full integration at least for the mentally ill population, with Medicaid health plans whose primary experience is with physical health also handling behavioral health services.

Several other states use a SIP approach that is similar to the one being proposed in Senate Bills 597 and 598. A SIP approach features contracts with specialty managed care entities

that cover all physical and behavioral health services just for a population with serious conditions, such as the seriously mentally ill. This approach differs from the full integration approach because integrated services for the behavioral health populations requiring the most services are bid out to specialty entities, with the rest of the Medicaid population handled as before.

Still other states use an administrative services organization option that is similar to the approach outlined in House Bills 4925 through 4929, in which behavioral health services are supervised by an outside entity that still works with local behavioral health entities. Other models include the aforementioned fee-for-service approach, which is roughly as common as integrated models, and approaches focused on health homes.

The state-by-state examination also revealed differences in the handling of the IDD population. As noted before, expenditures on the IDD population are the largest single component of behavioral health costs. The largest component of the IDD costs is housing and the second largest is day activities. These are not typical health care expenditures, are usually offered under a Federal waiver provision, and are not services with which most typical physical health managed care entities have experience.

A solid majority of states that have taken an integrated approach "carve out" the IDD services, with the IDD services not being part of the integration. This is true both for SIP and full integration models. In this case "carving out" of services to the IDD population means the SIPs or fully integrated health plans do not handle IDD services; usually these services are handled by the State or local public mental health entities. It should be noted that Michigan is among the minority of states with managed care behavioral health that does not carve out IDD services but, unlike the other behavioral health managed care states, Michigan's behavioral health managed care entities are local public behavioral health organizations.

The SFA's examination of the state-by-state data indicate 1) many states have moved to full integration while many others have stayed fee for service; there is no clear pattern, 2) Michigan's current approach with nonintegrated managed care for behavioral health is unusual, and 3) few integrated states have chosen to include services to the IDD population in the integration, apparently due to the bulk of Medicaid spending on that population being for services that are not typically regarded as medical.

Conclusion

Since Michigan began moving toward mandatory managed care for most Medicaid populations in the late 1990s there has been extensive discussion about shifting away from a public behavioral health entity model for Medicaid behavioral health services. This discussion began with the rebid of contracts almost 20 years ago and began to come to general attention again five years ago when former Governor Snyder proposed full financial integration. The issue has been contentious and efforts to set up demonstration and pilot projects to learn more about the strengths and weaknesses of various approaches did not take root. Senate Bills 597 (S-2) and 598 (S-2) (as well as House Bills 4925 through 4929) represent the latest efforts to craft new approaches to the delivery of Medicaid behavioral health services.

## **FISCAL IMPACT**

Introduction

The bills gradually would shift responsibility for the provision of Medicaid mental health and SUD services (known collectively as "behavioral health") to SIPs. This shift would be phased in with at least 24 months between each phase. Services for children with severe emotional

disturbance and those in foster care would be integrated in the first phase, followed by integration of services for seriously mentally ill adults in the second phase, followed by the integration of services for those with SUD needs in the third phase, then integration of services for those with intellectual or developmental disability in the final phase. Progression to each phase would depend on meeting metrics established by the DHHS as determined by evaluations completed by the Behavioral Health Accountability Council and the DHHS. If the DHHS determined that a phase was not successful, the next phase could be delayed and the current phase either could be extended or terminated.

The Senate Fiscal Agency makes the following comments on the legislation and its fiscal impact if it were enacted:

-- There would be minor costs associated with implementation of the bills, including costs for the establishment of a behavioral health ombudsman.
-- There is no compelling evidence that implementation of the bills would lead to a significant change in administrative costs; data presented on this front comparing PIHP administrative costs to Medicaid Health Plan administrative costs are "apples to oranges" comparisons and not particularly revealing.
-- The identification of savings that occur to support expanded behavioral health services, at minimum, would be based on State savings from the two-way risk corridor, with SIP risk corridor savings accruing to the SIPs; this effectively would prevent the State from realizing savings from the integration.
-- The ability to achieve significant savings would be limited for some key behavioral health populations and, because of possible underserving of populations, services could expand, and costs could increase.
-- The rate-setting process could lead to an increase in rates to reflect expanded services that would be sufficient to allow for savings to occur, but the cost would be about $10.0 million GF/GP for each 1.0% increase in overall SIP rates.
-- While there are no explicit financial reserve or capital requirements for the SIPs in the legislation, the SIPs would be more likely to avoid financial problems than PIHPs are currently.
-- After full implementation, the bills (assuming baseline increases in other nonbehavioral health payments to local units of government) would put the State in danger of being below the "Headlee Amendment" minimum for payments to local units of government.
-- There would be a risk that the IPA, which provides a net benefit to the State's bottom line of about $450.0 million per year, would no longer meet a mandatory Federal statistical test and could be invalidated in the short or long term; revisions to the IPA to ensure it continued to meet the Federal statistical test could result in changes in net revenue benefit for the State and to the tax rate applied to private insurers.

General Aspects

The proposed legislation includes a provision allowing "reinvestment of realized savings into the integrated behavioral health system to further promote and expand access to clinically integrated services and locations", which would appear to allow for reinvestment of identified savings into program expansion. The legislation not only would shift provision of Medicaid behavioral health services to the SIPs but would make the SIPs eligible to provide non-Medicaid behavioral health services that community mental health (CMH) boards and SUD coordinating agencies currently provide exclusively. Senate Bill 598 (S-2) Section 203 appears to terminate, upon the final transition to the integrated system, the role of the CMH boards and SUD coordinating agencies for non-Medicaid services as well as Medicaid services. The bills also would create an autonomous Office of the Behavioral Health Ombudsman in the DHHS.

The bills would have an unclear fiscal impact because, under the provision directing that the State's savings from the two-way risk corridor be reinvested in programming, there would appear to be no potential for State savings on services. This provision requiring transfer of identified savings (rather than identified savings reducing State costs) would mean that the bills' fiscal impact either would be neutral or result in increased costs to the State. The bills would lead to increased administrative costs for the DHHS because of the process of implementing integration and creating the Office, with a minimum estimated annual cost for the proposed Office of $100,000 GF/GP. There also could be changes in administrative costs for managed care services tied to the likely shift of responsibility to managed care entities that have more ties to the physical health side, but, as noted in **BACKGROUND**, there are no relevant data indicating a meaningful difference in administrative costs. There also are considerations tied to solvency of current and potential future providers of Medicaid behavioral health services.

General considerations on savings and ways to achieve savings also must be considered. Many other states have partially integrated behavioral health services, with some services fully integrated with physical health and other services still carved out (in particular services to the intellectual/developmentally disabled population). The opportunities for savings may be more limited or more challenging to achieve for some populations. There also is the possibility of increased costs if populations currently covered by PIHPs are underserved. Past experience with the expansion of Medicaid managed care to populations with significant pre-existing conditions indicates that these populations may well be underserved and costs for behavioral health services could increase, with the trade-off being the likelihood of better outcomes and possibly reduced physical health costs. This has been evident in the shift of Children's Special Health Care Services to a mandatory managed care model and the initial shift of Medicaid behavioral health services to a managed care model. In the former case, the growth in cost per case paralleled medical inflation (albeit during a period when Medicaid fee screens were not being increased so cost pressures should have been less than general medical inflation). In the latter case there was significant cost growth from the outset in fiscal year (FY) 1998-99 and FY 1999-2000 before growth rates abated.[1]

There are two key potentially problematic fiscal considerations indirectly related to the legislation, one tied to payments to local units of government and the other related to the continued feasibility of a relatively new insurance provider tax.

Headlee Amendment Considerations. One of the most notable considerations relates to the requirement in the Michigan Constitution (the so-called "Headlee Amendment") that the percentage of State Spending from State Resources paid to local units of government be at least as great as the percentage in FY 1978-79. Shifting spending away from the local PIHPs to the new entities would reduce State payments to local units of government by well over $1.2 billion by the time the population was shifted fully from the PIHPs to the SIPs. This issue is further complicated by the July 2021 ruling by the Michigan Supreme Court in *Taxpayers for Michigan Constitutional Government v. State of Michigan*.[2] In that case, the Court held that payments to public school academies (PSAs, also commonly known as charter schools) should not count as payments to local units of government but also instructed the Court of Appeals to consider whether payments to the subset of PSAs chartered by local school districts or community colleges should be counted as payments to local units of government.

The Supreme Court ruling combined with the eventual shift of spending from PIHPs and non-Medicaid CMHSP and SUD funding to the SIPs could put the State below the Headlee limit by the time the integration legislation was fully implemented. There is still significant uncertainty because full implementation would not occur for several years. Over that time, there could be major changes above or below inflationary baseline to revenue sharing payments, the School Aid foundation allowance, community colleges funding, or local transportation funding that

make any definitive statement on the Headlee impact impossible. The SFA can state, however, that the State's "surplus" in the Headlee calculation (about $2.9 billion in the enacted FY 2021-22 budget before any adjustments for the Supreme Court ruling), barring significantly above-inflation increases in other payments to local units, would nearly or completely disappear (see below for further discussion of this consideration).

Potential IPA Impact. There also is the possibility that the approach integration outlined in the bills could lead to difficulties in maintaining Federal approval of the IPA. Because of the prospective elimination of the PIHPs, the State could no longer be able to design a tax framework that meets the Federal statistical test needed for Federal approval of provider taxes that are not broad-based. If the IPA does not meet the Federal statistical test in any given year, there would be a negative net change to the State's balance sheet of over $450.0 million GF/GP in that year. It also is possible (and arguably likely) that the IPA could be adjusted in ways that would allow the IPA to meet the Federal statistical test, but these adjustments could reduce the State's net benefit from the tax or change the IPA tax rate for private insurance. The magnitude of these possible issues with the IPA is far more significant than any other fiscal issue and could overshadow any of the other cost or savings estimates (see below for further discussion of this consideration).

"Headlee Amendment" Implications

In 1978, Michigan voters adopted Proposal E, commonly known as the "Headlee Amendment" after its primary advocate. Proposal E amended the Michigan Constitution. One of the proposal's provisions requires that the proportion of State spending from State resources paid to local units of government be at least as great as that percentage was in FY 1978-79. That percentage eventually was calculated to be 48.97%. For purposes of ensuring compliance with this 48.97% minimum, each appropriations bill contains a Section 201 that includes estimates of State spending from State resources and the amount of State spending from State resources that is provided in that bill to local units of government. The State has consistently exceeded this 48.97% minimum since the Headlee Amendment was adopted.

School Aid, revenue sharing, payments to community colleges, and local transportation funding are among the largest components of payments to local units. Payments made in the DHHS budget to PIHPs and CMHSPs in the Autism Services, Healthy Michigan Plan—Behavioral Health, Medicaid Mental Health Services, and Medicaid Substance Use Disorder Services line items as well as other line items in the Behavioral Health portion of the DHHS budget are another significant source of these payments. At present, the State amount paid to the PIHPs is less than the long-term baseline because of the pandemic-related enhancement in the Medicaid match rate, which reduced the GF/GP dollars needed to support these line items. The SFA estimates that by FY 2022-23 State spending from State resources for line items that provide funding to PIHPs will be at least $1.29 billion. The SFA estimates that by FY 2022-23 State spending from State resources for line items that provide funding to CMHSPs will be $135.5 million. If the bills were enacted, the $1.29 billion in funding to PIHPs would be shifted to new nonlocal entities over the subsequent few years, which would reduce State spending from State resources paid to local units of government by up to that amount. Furthermore, because Section 203 of Senate Bill 598 (S-2) would eventually put the SIPs in charge of services previously provided by CMHSP, State spending to local units of government would be reduced by another $135.5 million to reflect the transfer of all responsibility and funding for non-Medicaid behavioral health services from local CMHSPs to the SIPs.

In the initial FY 2020-21 budget, State Spending from State Resources was $35.4 billion, with estimated payments to local units of government being $19.9 billion, leaving the State $2.6

billion over the Headlee amendment minimum of 48.97% (the Headlee minimum in this instance is calculated by taking 48.97% of $35.4 billion, which is $17.3 billion; $19.9 billion exceeds $17.3 billion by $2.6 billion).[3] Governor Whitmer's proposed FY 2021-22 budget featured a similar "Headlee surplus" of $2.6 billion. The FY 2021-22 budgets signed by Governor Whitmer in September 2021, thanks to a significant increase in School Aid funding, reflect a Headlee surplus of $2.91 billion. When adjusted for the eventual expiration of the COVID-19-related Federal enhancement of the Medicaid match rate and the official change in the FY 2022-23 Medicaid match rate , the baseline Headlee surplus is about $2.82 billion (see Table 1, "Adjusted for baseline FMAP" column). This $2.82 billion Headlee surplus estimate should not be viewed as a long-term precise number, but rather a best guess estimate of the medium-term baseline Headlee surplus before potential implementation of the bills.

As noted above, this is not the complete picture. The Michigan Supreme Court's ruling in *Taxpayers for Michigan Constitutional Government* could reduce State payments to local units of government by $1.30 billion to $1.49 billion, depending on whether payments to public school academies chartered by local school districts or community colleges would continue to count as payments to local units of government.

Removing this funding from the Headlee surplus reduces the baseline Headlee surplus to $1.33 billion to $1.52 billion. After full implementation, the $1.29 billion baseline State funding to PIHPs would be greatly reduced (and likely would be eliminated), which would reduce the Headlee surplus by a comparable amount and could well put the State close to the Headlee limit. The shift of non-Medicaid behavioral health services from the CMHs and coordinating agencies to the SIPs (which appears to be mandated upon the final phase of integration under the bills) would further reduce payments to locals by $135.5 million, which could put the State below the Headlee limit. The SFA notes that these changes, as may be seen in Table 1, could put the State below the limit because the calculation is a rough estimate and the bills would not be fully implemented for several years. As noted above, the Headlee baseline could be adjusted up or down by hundreds of millions if there were significant above- or below-inflation changes in the school foundation allowance, funding for community colleges, revenue sharing payments, or local transportation funding.

The SFA also notes that the same concerns about the Headlee surplus would apply to the package of behavioral health bills being considered by the House of Representatives (House Bills 4925 through 4929). Because of the more rapid implementation timeline for those bills, there would be a potential Headlee concern much sooner than would be the case with the Senate bills, although the House bills would not transfer responsibility for services currently provided by CMHSPs so the risk of being below the Headlee limit would be less.

Table 1 shows total payments to locals in the State budget, State spending from State resources, the Headlee limit, and the Headlee surplus or deficit in multiple columns. These columns show various adjustments that are made to derive baseline Headlee estimates by the time the bills would be fully implemented. The Headlee limit equals 48.97% of the State spending from State resources and the surplus/deficit is the payments to locals less the Headlee limit.

| Table 1: Impact of Senate Bills 597 (S-2) and 598 (S-2) on Headlee Amendment Calculations (in millions) | | | | | | |
|---|---|---|---|---|---|---|
| | **FY 2021-22 Enacted** | **Expiration of Enhanced FMAP*** | **Adjust for FY 2022-23 FMAP**** | **Adjusted for Baseline FMAP** | **Remove Full Amt for PSAs***** | **Adjusted for PSA Ruling** |
| Payments to Locals ............. | 21,484.4 | 53.9 | 22.4 | 21,560.7 | (1,488.0) | 20,072.7 |
| Total State Spending (TSS).... | 37,930.5 | 240.0 | 100.0 | 38,270.5 | 0.0 | 38,270.5 |
| Headlee Limit (48.97% of TSS) | 18,574.5 | --- | --- | 18,741.0 | --- | 18,741.0 |
| Headlee Surplus/(Deficit)..... | 2,909.9 | --- | --- | 2,819.7 | --- | 1,331.7 |
| | **Adjusted for PSA Ruling** | **Remove Adjusted PIHP Funding** | **Remove Adjusted CMHSP Funding** | **Adjusted for PSA PIHP & CMHSP** | **PSA Fund: K12/CC Chartered ******* | **Adjusted for Minim. PSA/PIHP/ CMHSP** |
| Payments to Locals ............. | 20,072.7 | (1,293.8) | (135.5) | 18,643.4 | 193.4 | 18,836.8 |
| Total State Spending (TSS).... | 38,270.5 | 0.0 | 0.0 | 38,270.5 | 0.0 | 38,270.5 |
| Headlee Limit (48.97% of TSS) | 18,741.0 | --- | --- | 18,741.0 | --- | 18,741.0 |
| Headlee Surplus/(Deficit)..... | 1,331.7 | --- | --- | (97.6) | --- | 95.8 |

* - The Federal government is providing a 6.2% enhancement to the Medicaid match rate in all calendar quarters of the COVID-19 public health emergency. This would presumably expire prior to the full implementation of the bills in 2026 or later.

** - The base Medicaid match rate for FY 2022-23 is now estimated to decrease by 0.77%, which would result in an increase in GF/GP costs.

*** - The full amount of public school academy (PSA) funding counted for Headlee purposes is estimated to be $1,488.0 million.

**** - The amount of K-12/community college chartered PSA funding is estimated to be $193.4 million; courts could rule that some or all of this subset of funding would count for Headlee purposes.

Savings Opportunities & Cost Concerns

One of the arguments made in support of greater behavioral health integration is the potential for efficiencies and other cost savings due to better coordination of care. This potential can vary due to the different types of populations served and their specific coverage situation. Generally speaking the most common behavioral health services are usually provided to five different categories of Medicaid recipients: mentally ill adults (MI-A), mentally ill children (MI-C), individuals with IDD or DD, dually diagnosed MI/IDD, and those facing an SUD. Several years ago, Medicaid began covering autism services as well, though for reporting purposes most of the payments for these services are in the IDD category.

Entities Eligible to Become SIPs

Based on information from other states, it is clear that integrated plans generally are either Medicaid physical health HMOs that expand to include behavioral health services or specialized behavioral health entities that focus on behavioral health services. The legislation includes criteria for the SIP procurement process, including network adequacy, staffing, financial plans and cost sharing, five years of behavioral health experience, and five years of managed care experience. It should be noted that the current PIHPs would appear to be eligible to become SIPs under these criteria (and, to the extent any PIHP won a contract to be a SIP, the Headlee Amendment impact noted above would be lessened).

The term "five years of behavioral health experience" does not specify the type of behavioral health experience. The Medicaid health plans in Michigan deal with what is commonly known as "mild to moderate" behavioral health issues but do not provide the broad spectrum of behavioral health services that specialized entities or PIHPs provide. If the term is intended to be interpreted to treat the "mild to moderate" coverage as the requisite behavioral health experience, then the current Medicaid health plans certainly would be eligible to bid for those contracts.

The Challenge of Identifying Savings

The bills outline a process for identifying savings that is clearer than the process outlined in the bills as introduced. The introduced bills' savings language amounts to a tautology ("reinvestment of realized savings into the integrated behavioral health system to further promote and expand access")—if there were savings, those savings would accrue to the SIP because of lower expenditures and would be available for expansion of services. The substitute bills specify that, at minimum, the State share of savings (if any) from the two-way risk corridor required under the bill would be savings for the purpose of transfer of savings.

A two-way risk corridor, as noted above, usually makes the managed care entity responsible for the first few percent of any costs or savings above or below the capitated rates paid. After that point, the State covers all excess costs and accrue any additional savings. For instance, a hypothetical managed care risk corridor could be designed so that the managed care entity would cover all costs and accrue all savings between 95.0% and 105.0% of the rates, with the State covering any costs above 105.0% and accruing any savings below 95.0%. This would mean, if costs were 107.0% of what was set up under the rates, the managed care entity would have to absorb the first 5.0% of excess costs, with the State covering the remaining 2.0%. Similarly, if costs were 92.0% of what was set up under the rates, the managed care entity would accrue a surplus of the first 5.0% of savings, with the State in theory accruing the remaining 3.0%. Under the substitutes, in the latter situation, the 3.0% savings that the State normally would accrue instead would be invested in the integrated behavioral health system.

The substitutes specify that the savings to be transferred are "at a minimum" the risk corridor savings, which would allow for potential transfer of additional unspecified savings to support services expansions and enhancements. There is a challenge in identifying any savings beyond savings to the State resulting from the risk corridor. The legislation does not outline a specific process for identification of any other savings. Estimating any other savings could prove to be challenging as the populations served are not static and average health care costs for most Medicaid populations tend to increase from year to year, so savings estimates may face a signal-to-noise ratio. The ideal approach would be to have randomly chosen experimental groups and a control groups but the legislation, with a full transfer of responsibility, understandably does not take that approach.

The Section 904 Report

For over two decades the former Department of Community Health and the current DHHS have reported extensive data on services provided by CMHSPs and PIHPs to these populations. The most recent report, covering FY 2018-19, was required by Section 904 of Public Act 67 of 2019 (discussed in **BACKGROUND**).[4] An examination of the data in the Section 904 report provides some insights into savings opportunities, primary services provided to given covered populations, and potential cost concerns.

Administrative Costs

As noted in **BACKGROUND**, the data in the Section 904 report indicate that FY 2018-19 PIHP administrative costs for behavioral health services were about 5.04% of total costs, but this does not reflect a medical loss ratio calculation and thus comparisons to potential SIP or current MHP administrative costs are not particularly valid or meaningful.

Expansion of Services

As previously noted, shifts to managed care for populations with significant pre-existing conditions appear to have led to increases in costs. This should not necessarily be viewed as a negative; these cost increases generally imply that the population is underserved and a broader array of services certainly could be expected to lead to more positive outcomes.

Solvency

Several PIHPs (one in particular) have faced serious financial challenges in recent years. These year-to-year issues with finances and potential for future insolvency create challenges for PIHPs, which has frequently led to discussions of additional funding for those PIHPs as well as disputes over State and local financial responsibility to address these situations. The bills would not establish any specific capital requirements for the SIPs; there would be only a requirement for "financial plans". This could leave SIPs financially vulnerable and could risk creating political pressure for additional financial support from the State. The Michigan Association of Health Plans (MAHP), which has publicly supported the bills, has noted that the definition of eligible providers includes "managed care organizations" or a system of health care delivery as defined under the Insurance Code. The MAHP notes that the latter entities do have some basic requirements for net worth so those latter groups would face a basic capital requirement, though it appears that any entity that bids as a "managed care organization" would not be subject to such a basic capital requirement.

Given that Medicaid health plans and private behavioral health managed care entities generally have greater access to capital than do PIHPs and given the Insurance Code requirements for many of these entities, it appears highly likely that the risk of insolvency for the SIPs under the bills would be less than what is currently the case with PIHPs.

Expenditures for the MI-A Population

The Section 904 report includes extensive data on spending in FY 2018-19 by PIHPs on the mentally ill adult population. Services were provided to over 110,000 individuals, with roughly half living in a family situation and others in more congregate settings ranging from adult foster care to homeless shelters to incarceration. Expenditures on this population were $976.2 million, with over 40% ($415.9 million) of the funding being spent on inpatient and outpatient services and over one quarter ($261.1 million) going to living supports (generally housing), with case management ($142.6 million), day services ($88.6 million), and assertive community treatment ($56.3 million) making up the bulk of the rest of the spending.

The opportunity for savings on these services under any new financial model of course would not be limited to the behavioral health side of services. The challenge and opportunity for any new managed care entity is not simply a matter of finding ways to reduce costs on the behavioral health services that are provided, but rather implementing a prevention-based approach that would provide better coordination of care, especially on the medication side, that could avert both physical and behavioral health issues.

A 2011 study in *World Psychiatry* notes that the prevalence of "modifiable [health] risk factors", in particular, obesity, smoking, diabetes, and hypertension, is greater in adults with schizophrenia and bipolar disorder.[5] These risk factors are clearly associated with higher physical health care expenses, in particular costs related to cardiovascular disease. The study notes that there is some correlation between the use of some antipsychotic medications and obesity. The study states that "an increase in well-established [diabetes] risk factors in these patients partially accounts for much of the increased risk. However, additional factors (disease, treatment) are important as well."

These studies indicate that there is an opportunity to help abate ongoing physical health concerns for individuals with severe mental illness through effective treatment of these risk factors—but it also appears that mental health treatment, particularly medication, can cause or exacerbate some of these risk factors so the opportunities to abate these risk factors and perhaps achieve cost savings on the physical health side would be partially limited.

One of the complications of a coordinated approach is a primary payer issue for a portion of the Medicaid population served by PIHPs. While the Federal Medicare program often is viewed as being strictly a program for the elderly, disabled individuals with a substantial work history become Medicare eligible 24 months after meeting Social Security disability standards and certain disabled children, even in adulthood, can become Medicare eligible based on their parents' work history. The Section 904 report indicates that about 15% of the MI-A population is on Medicare (and thus dually eligible for Medicare and Medicaid; these individuals are known colloquially as "dual eligible"). Medicare is the primary medical payer for most of these individuals, thus the potential for Medicaid savings on the physical health side for the dual eligibles is more limited than one may expect initially: Medicaid serves as gap coverage for behavioral health services for dual eligibles while the cost of their physical health services is really dictated by Medicare policies, policies that cannot be changed at the State level (with the exception of those dually eligible clients who are enrolled in the Michigan dual eligible waiver, known as MiHealthLink).

Expenditures for the MI-C Population

The Section 904 report also includes data on spending for services to the MI-C population (also known as "Children with Serious Emotional Disturbance" or "SED"). Total spending in FY 2018-19 was $261.6 million on 40,000 children, with about one-third of the funding ($87.1 million) going to outpatient services, one-third ($83.3 million) to family support, and the rest split almost evenly between inpatient/crisis services ($38.8 million) and case management ($42.8 million).

One of the concerns over the years regarding services to the MI-C population has been the anecdotal belief that the population is underserved and that children are not receiving sufficiently intense or thorough services, so the potential for savings may be more limited than with the MIA population. The lawsuit *KB v. Lyon* (Eastern District of Michigan, case 2:18-cv-11795-BAF-SDD), which was settled recently by the State of Michigan, would require significant expansion of community-based behavioral health services for children because of concerns that these services had been consistently underfunded. Governor Whitmer's proposed FY 2021-22 budget includes $91.0 million Gross and $30.0 million GF/GP to cover the administration's estimated cost of expanded services under the settlement. Given this and other concerns, meaningful behavioral health savings due to integration of behavioral health services to the MI-C population may not be feasible.

Expenditures for the Population Facing IDD

Expenditures on the IDD population comprise almost half of total PIHP spending, $1.565

billion for about 33,000 individuals. The fact that IDD spending is by far the largest portion of PIHP spending is often not well understood. About half of the cost for the IDD population ($768.7 million) is for living supports. Decades ago, many IDD individuals lived in State facilities and other large congregate settings. The State took action over the years to move IDD individuals who were in these congregate settings into group homes and other community-based settings. While, due to economies of scale, this resulted in an increase in average housing cost per client, most would argue that it was a preferable environment for the individuals being served and that those individuals had a higher quality of life than they did in more congregate settings.[6]

Most of the PIHP expenditures on this population are for the aforementioned living supports, day supports ($339.8 million), and case management ($149.8 million). There is another category of expenditures for the IDD that has grown quickly in recent years, services to individuals with autism, which will be discussed separately below.

Because so much of the cost for the IDD population goes toward housing and day services, and because of research (see next paragraph) indicating that physical health costs for the IDD population (unlike the MI-A and MI-C populations) are similar to those of the general non-IDD population, the opportunities for physical health cost savings for the IDD may be relatively limited. This challenge is even more apparent because over one-third of the IDD population is comprised of dual eligibles and thus Medicare is the primary payer for physical health costs for much of the IDD population.

A recent  examined health care costs for the IDD population in the United States as compared to costs for the non-IDD population.[7] The study found that "per user costs across for services combined were higher in the general [non-IDD] population [than in the IDD population], driven primarily by greater spending for office visits and hospitalizations.[8] The study did note higher medication costs for the IDD population, particularly those under the age of 40, but this is not unexpected given the dually diagnosed mentally ill/IDD population, which is a significant subset of the IDD population. The study also offered a caveat that "lower or equivalent costs could very well be an indicator of unaddressed needs or biases in determining who in the [IDD] population can access services".[9] However, that would indicate the possibility of increased costs under a different model of IDD services rather than the possibility of savings. The possibility of significant Medicaid physical health savings for the IDD population appears to be rather limited.

The other challenge is finding savings opportunities on the behavioral health side for the IDD population. These opportunities exist but may be difficult to achieve; one could produce significant savings by moving individuals with IDD into more congregate settings, shifting back to the old practice of large-scale facilities for many IDD individuals. One could reduce reimbursements to group homes. Or one could reduce reimbursement or access to day activities. Living supports and daytime services represent well over 80% of the nonautism spending on the IDD population, so there are not many other options for savings.

<u>Dually Diagnosed MI/IDD Individuals</u>

Some individuals serviced by the PIHPs, about 16,000, are dually diagnosed with mental illness and intellectual/developmental disabilities. The bills would integrate services for these individuals later in the process, in the final stage with the IDD population rather than with the MI population. The same caveats on the IDD population apply to the potential for savings on the dually diagnosed MI/IDD population.

Expenditures on SUD Services

Medicaid SUD services for the "SUD population" were once provided by substance abuse coordinating agencies, but almost a decade ago these services were effectively transferred to the PIHPs, in large part because of the perceived benefit of integrating mental health and SUD services. The Section 904 report indicates that total spending, split between traditional Medicaid and the Healthy Michigan Plan, was about $125.0 million. About 30% of that was spent on outpatient services, 25% on residential treatment, 20% on methadone treatment, and just under 10% on detoxification. Overall, out of the $125.0 million, over $31.0 million was spent on integrated treatment (in this case, integrated treatment means combined SUD and mental health treatment). Because of the prevalence of limited integrated care that already exists in the SUD population, the opportunities for savings from further integration may be relatively limited.

Expenditures on Autism Services

Autism services expenditures have grown at double digit rates annually since Medicaid autism services were first covered nearly a decade ago (a recent SFA issue paper discussed this growth).[10]

It is likely that expenditures will exceed $300.0 million Gross in FY 2020-21 after being $70 million Gross as recently as FY 2015-16. Section 959 of Public Act 67 of 2019 required a workgroup report on autism spending and included the following statement: "There continues to be a lack in standardization of the diagnostic process and limited access of providing further assessments with complex youth due to the limitations on services from the PIHPs/CMHSPs." There would appear to be fertile ground for a more comprehensive approach that could produce significant savings relative to the baseline expenditure trend and better outcomes in this program.

Non-Medicaid Community Mental Health & SUD Services

Senate Bill 598 (S-2) would amend the Mental Health Code to specify that the SIPs "take over the duties set forth in [Chapter 2 (County Community Mental Health Programs)] and the community mental health services program shall no longer be responsible for those duties." Chapter 2 outlines both Medicaid and non-Medicaid behavioral health services, so the substitute's provision appear to outline the eventual transfer of CMH non-Medicaid and SUD coordinating agency funding from the local public entities such as CMHSPs to the SIPs. This provision would not have a fiscal impact as the non-Medicaid services are not an entitlement and the funding level is set through the appropriations process. Any shift would reduce payments to locals by $135.5 million, which would directly affect the Headlee payments to local calculation.

It should also be noted that the substitute does not speak to the local share of funding for CMHSPs. The Mental Health Code requires counties to pay up to 10.0% of non-Medicaid mental health costs (MCL 330.1302 sets a 10.0% payment). A maintenance of effort provision added in the 1995 Mental Health Code rewrite froze the cost for CMHSPs that become mental health authorities at the amount paid in the year before the CMHSP became an authority (MCL 330.1308). These provisions mean that counties contribute toward the provision of non-Medicaid mental health services in their area. This funding is not reflected in the DHHS budget but is rather a separate payment to CMHSPs appropriated by individual counties. It appears that, if a SIP took over the non-Medicaid services, counties would be required to shift these local share payments from the CMHSPs to the SIPs.

Impact on Current Integration Efforts

The State has established several integration programs that do not clearly mesh with the proposal outlined in the bill. This analysis has already noted the Governor's proposal to fund services related to the *KB v. Lyon* settlement. The State has a Health Homes demonstration project, which works to coordinate physical and behavioral health care for Medicaid beneficiaries who have high rates of hospital utilization, funded at $33.0 million Gross and $2.6 million GF/GP. The State is beginning to implement a Federal demonstration project called the Certified Community Behavioral Health Clinic (CCBHC). The CCBHC would be a two-year demonstration project at 14 sites with comprehensive services including behavioral health and mobile crisis services and supportive services. Governor Whitmer's FY 2021-22 budget would fund CCBHC at $26.5 million Gross and $5.0 million GF/GP and the House and Senate DHHS budget bills also included funding for this initiative.

The goal of both aforementioned demonstration projects is to improve outcomes with the potential of reducing costs. At this point, with the programs not really having started, it is impossible to estimate their fiscal impact let alone their fiscal impact relative to the integration model outlined in Senate Bills 597 (S-2) and 598 (S-2). If the integration process outlined in the bills were more fiscally "effective" than these integration efforts, there would be a net cost reduction, but if a new approach that supersedes current integration efforts were less fiscally effective, net costs could increase.

Transition from Phase to Phase & Legislative Oversight

The legislation would require the DHHS, in consultation with the stakeholders, to create evidence-based metrics to evaluate efficacy of each phase including cost and efficiency. The legislation would direct the Behavioral Health Accountability Council, 18 months into a given 24-month phase, to complete a formal evaluation of the phase. The DHHS then would have complete a formal evaluation 20 months into a given 24-month phase. Within 60 days of that evaluation, the DHHS would have to submit a report to the Legislature determining whether the phase had been successful, unsuccessful, or undetermined. If the evaluation indicated the phase was unsuccessful or had an undetermined outcome, the DHHS would have to recommend continuation of the phase, extension of the duration of the phase for further evaluation, or propose to reform, modify, or terminate the phase. If a phase were unsuccessful but its duration was extended and one of the cost metrics in the evaluation indicated a negative cost (fiscal) impact, that negative fiscal impact could continue indefinitely until the metrics were met.

The legislation also directs that, "five years after implementation of the program, the legislature may review the program's success and efficacy to determine if the program shall continue". This provision is permissive. If the legislation were enacted, the Legislature could attempt to amend or repeal the statute at any time even without the specific five-year review provision.

Summary of Potential Savings & Costs

Some areas of PIHP expenditures are more likely to lead to actual savings under an integration model than others. There would appear to be more opportunities for efficiencies and savings in services to MI adults and autism services than in services to the IDD population. However, the use of the two-way risk corridor to define potential savings that could be transferred would make the potential savings directly affected by the initial rate-setting process. If rates were set high enough to cover potential higher costs, the likelihood of savings occurring would be greater. It should be noted that higher rates would carry a cost to the State—each 1.0%

increase in overall SIP rates would cost about $10.0 million GF/GP (so a 10.0% increase in rates would cost about $100.0 million GF/GP).

Because any identified savings would be transferred to support expansion of integrated behavioral health services, the bills would not lead to savings to the State on behavioral health costs. There is the potential for a net increase in costs to the State if the populations involved were determined, in the rate-setting process, to be effectively underserved, with the corresponding likelihood of a better level of services being provided to clients.

The legislation also likely would reduce potential solvency concerns for the managed care entities because many of the SIP bidders would be subject to the Insurance Code capital reserve requirements and thus likely would have better capital reserves than the PIHPs. At present, there are PIHPs that have clear solvency issues; this risk and potential liability for the State could be alleviated. However, this likely better solvency situation would not be as certain to occur as it would if the legislation included specific capital reserve requirements for all bidders.

Potential Impact on the IPA

The Health Insurance Claims Assessment (HICA) was repealed at the start of 2019 and was effectively replaced by the IPA. The IPA is a multi-tiered tax on health insurers, with significantly higher tax rates on Medicaid health plans than on private insurers and PIHPs. Because of actuarial soundness requirements, the Medicaid health plans' and PIHPs' tax costs are reimbursed so the higher tax rate has no net impact on the Medicaid health plans' and PIHPs' bottom line. Because the IPA met a certain Federal statistical test it was approved and it resulted in a meaningful tax reduction for private health insurers when compared to the HICA, with the State also seeing a significant windfall due to the structure of the tax. The SFA's analysis of the HICA repeal and IPA creation legislation has more specific details on the HICA and IPA tax structure, the rates charged to private insurers, Medicaid health plans, and PIHPs, and the Federal statistical test.[11]

The inclusion of the PIHPs in the tax base was necessary for the IPA to meet the Federal statistical test. It is uncertain, if integration occurred, whether the IPA could be redesigned to meet the Federal statistical test if the PIHPs had a more limited (or no) role at all in Medicaid behavioral health. The SIP approach at least would allow for a structure similar to the IPA structure in place now and that structure could still meet the Federal statistical test (in contrast it would be difficult for a full integration model with behavioral health funding going to the present Medicaid health plans to meet the Federal statistical test). The phased-in approach would further complicate matters; even if there were a way to maintain adherence to the Federal statistical test over the long term, the IPA statute likely would have to be amended at the start of each phase. The structure of the substitutes could have an impact on this process. Because the phases last 24 months it would be possible to ensure each phase would be implemented at the beginning of a fiscal year. Phases that do not start at the beginning of a fiscal year would feature more complex revised IPA calculations and could face more difficulties in gaining Federal approval, so aligning the beginning of each phase with the start of a fiscal year would make the IPA approval process less difficult. The IPA could be at risk of Federal disapproval at the start of any phase as well as in the longer term. It is possible, for instance, that the IPA could be structured in a way that met the Federal statistical test after full integration but could not be so structured during the transition period, in which case, the State would lose the IPA revenue during the transition period. It is possible that the IPA could be structured to meet the Federal statistical test during the transition period but not after full integration, in which case the State would lose the IPA revenue in every year subsequent to the full integration.

The structure of the IPA, with a varying per-member month tax being applied to nonexempt insurers, makes it probable (albeit not at all certain) that a revised IPA meeting the Federal statistical test could be implemented at any new phase of the implementation of the integration outlined in the bills (and because "probable" does not mean certainly, it is possible that the Federal test would be met during most phases but not in all phases, with the corresponding large negative change to the State's balance sheet in any phase where the test could not be met). A secondary challenge involves the potential adjustments to per-member month tax rates to ensure the Federal statistical test is met. The adjustments could lead to significant changes in the net revenue generated by the IPA and could lead to changes in the IPA tax rate for non-Medicaid (private) insurers. So, even if the Federal statistical test could continue to be met, there could be a significant fiscal impact for the State (with a secondary impact in which changes in the IPA rate for private insurers would have an indirect fiscal impact on State and Local government employee benefit costs).

If the IPA did not meet the Federal statistical test for a given year and were not in effect that year, there would be a net reduction in the State's bottom line of at least $450.0 million during that year. This net revenue loss would have a major impact on the State's balance sheet, possibly forcing budget restraint, budget reductions, or alternative health care tax structures, such as the return of a more broad-based replacement health insurance tax.

A Note on Approaches in Other States

While the approach in other states does not directly affect the fiscal analysis of these bills, it is relevant to note that a narrow majority of states have moved toward integration of behavioral and physical health for the mentally ill population, but about three-quarters of those states have chosen to carve out (not integrate) services to the IDD population and do not use an integrated model for the IDD population.

Conclusion

The fiscal impact of these bills cannot be precisely estimated, in large part because the potential changes in expenditures are tied to allocation and policy decisions made by the new integrated entities, which cannot be predicted. Because savings that otherwise would accrue to the State under the two-way risk corridor instead would be transferred to expand or enhance services, the bills would not lead to net reduction in costs for the State.

The potential for efficiencies exists, in particular for services provided to the mentally ill adult and autistic populations. On the other hand, to the extent that these populations are underserved, there is the potential for cost increases (and potentially corresponding improvements in outcomes). Because the SIPs likely would have better capital reserves than the PIHPs, there is clear potential of avoiding the behavioral health managed care entity solvency issues that have faced several PIHPs of late. The administrative cost impact is more difficult to quantify. As noted, the comparisons of administrative costs between the MHPs and PIHPs are not particular useful.

The bills would have a major impact on State payments to local units of government that, when fully implemented, could well put the State below the Headlee amendment limit. There would be the opportunity, over the period during which the bills would be implemented, to adjust State payments to locals in other areas to avoid this problem. However, that would require policy changes independent of the bills' provisions, and so these adjustments cannot be assumed.

There also is the potential, if a revised approach to the IPA did not meet the Federal statistical test, of a short-term or long-term negative change to the State's bottom line in the range of

$450.0 million GF/GP in each year that the statistical test was not met. Revisions to the IPA made to meet the Federal statistical test likely would alter the State's net revenue from the IPA.

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[1] Senate Fiscal Agency historical budgetary spreadsheets and Department of Community Health/Health and Human Services expenditure and caseload reports.
[2] Opinion of the Michigan Supreme Court, Docket Nos. 160658 and 160660 (2021).
[3] "FY 2020-21 Initial Appropriations Report", Senate Fiscal Agency, table 27.
[4] "Report for Section 904: Community Mental Health Service Programs Demographic and Cost Data FY 2019", Michigan Department of Health and Human Services. Retrieved on 9-13-2021.
[5] De Hert, Marc, *et al.*, "Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care", *World Psychiatry*, Volume 10, pp. 52-77, February 2011.
[6] McCarron, Mary, *et al.*, "Effect of deinstitutionalisation on quality of life for adults with intellectual disabilities: a systematic review", *BMJ Open*, Volume 9, pp. 1-19, 2019.
[7] Fujiura, Glenn T., *et al.*, "Health Services Use and Costs for Americans with Intellectual and Developmental Disabilities: A National Analysis", *Intellectual and Developmental Disabilities*, Volume 56, pp.101-118, April 2018.
[8] *Id*. at 106.
[9] *Id*. at 109.
[10] Ackerman, Ellyn, "Autism: Sources of Funding and Historic Appropriations", Senate Fiscal Agency Issue Paper, March 2021.
[11] Steve Angelotti, Senate Fiscal Agency Floor Summary of Senate Bills 992 (S-1), 993, and 994, 5-16-2018. Available at the Michigan Legislature website: http://www.legislature.mi.gov.


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